Police & Ambulance Early Access to Mental Health Assessment via Tele Health (PAEAMHATH) a co-design mental health project with serious legs.

Jay Jones¹, Elizabeth Newton¹
¹HNE Health, Newcastle, Australia

Biography:
Jay Jones: Project Coordinator, health redesign and innovator working currently within HNE health.

Elizabeth Newton: Senior Manager to the Mental Health Consumer unit HNE, Health Redesign, and business owner of Zuchhi.

The PAEAMHATH project is for Police Officers and NSW Ambulance Paramedics, during their early point of contact with a client, to initiate and gain fast, reliable access to specialised clinical mental health assessment.

The PAEAMHATH project will utilise Telehealth technology, and a trained mental health professional to assess the person and provide recommendations about care to the person/carer, Police Officers and/or NSW Ambulance Paramedics.

The patient will be assessed from a HUB based in Newcastle, to any outlying area in the project area, by a trained mental health professional and advised where possible, they can safely remain within the community setting and be seen by other Community Based Services or potentially be transported directly to a Mental Health Unit supported by an evidence-based criteria protocol.

By reducing the number of unnecessary transportations of mental health patients to Emergency Departments & reducing the likelihood of first contact trauma for new mental health consumers and reduce likelihood of re-traumatising of existing users of mental health services.

Reduce the number of duplicate assessments carried out on the consumer.

Empower consumers to find alternative pathways when in crisis, though still within a supportive and structured process.

Results to date, since project go live in April 2017, 44 patients assessed, 39 patients able to avoid transportation.

All consumers followed up within 48 hrs.

Cost avoidance combined for HNE HEALTH ED, NSW Ambulance and Police: $107,000.

Time reduction at scene for Police: 3hrs to 25 minutes

Time reduction for Ambulance: 75 minutes to 17minutes.

Saving for the consumer in terms of mental health: INCALCULATABLE.

Learning Objectives

Learning Objective (1): Hopefully a cost avoidance strategy to reduce ED attendance for mental health patients that do not need to be re-traumatised by being brought to hospital unnecessarily.

Learning Objective (2): Our topic is relevant to mental health services in the context of the big three government services who can’t get along or organise how to best serve the mental health consumer this project is the answer to that relationship crisis that affect the patient daily within Australia.

References

Taking it to the streets - PAEAMHATH - Jay Jones, Elizabeth Newton, Leanne Gow, David Horseman, Anthony Townsend.
Observing verbal information sharing in an adult acute community mental health service the place of self-harm and recovery language.

**Carla Rutherford**, Sizwile Tshuma, Tim Coombs

Illawarra Shoalhaven Local Health District, Nowra, Australia

**Biography:**
Carla has over 10 years’ experience in both community and emergency/consultation liaison mental health nursing. She holds a Master’s degree in Nursing Advanced Practice (2011) and in 2018 commenced a Doctor of Philosophy (Integrated) at the University of Wollongong focused on exploring the carer’s role within the Emergency Department.

The sharing of verbal information between mental health staff is essential to the delivery of good quality mental health care. Indeed, a breakdown in communication has been seen as contributing to 70% of hospital sentinel events in Australia. While there has been work to understand the content and quality of verbal information sharing in general health, particularly in acute inpatient settings, there is little understanding of practice within community mental health. The current paper aims to fill this gap by exploring the content and quality of verbal information sharing within the adult acute community mental health care setting. A tool was developed to capture the content and quality of information being shared between clinicians about individual consumers during clinical reviews or team meetings. 175 instances where information about a consumer were shared between clinicians were observed. Most of this information sharing was brief and focused on the reasons for contact, the background to presentation and plans for future care. There was little information shared about self-harm or suicidal ideation or the consumer’s strengths. This paper will discuss the implications of the results for further practice improvement.

**Learning Objectives**

Learning objective (1): Audience members will be able to consider the importance of verbal clinical handover content and how clinical handover occurs within community mental health settings and how what is discussed may not reflect ideals of best practice especially in regard to the use of recovery oriented language.

Learning Objective (2): Audience members will be able to consider the utilisation an observer checklist of verbal handover practice to understand the type of information being shared during clinical handover, the level of detail that takes place in these discussions and how this can be utilised as a quality improvement tool in community mental health care, especially as a means for creating a case for change in practice and workplace culture that supports recovery oriented care.

**References**


Using IREST Yoga Nidra - an evidenced based form of meditation and relaxation treatment to heal myself of Complex PTSD

Kate Brinly¹
¹Each Person Counts, Melbourne, Australia

Biography:
Kate Brinly runs a coaching, consulting and public speaking organisation called Each Person Counts specialising in Borderline Personality Disorder. Kate has lived experience of Complex PTSD and is a survivor of childhood sexual abuse. She also works part time for Voices Vic as Peer Support Facilitator.

Research shows 1 in 4 Australian adults are survivors of childhood trauma. As a survivor of childhood sexual abuse, I lived for years experiencing states of emotional and body flashbacks that resulted in Complex PTSD. Once I discovered the regular practice of IREST Yoga Nidra, these distressing states disappeared. I came back to my body for the first time in my life and got in touch with my inherent sense of well-being, safety and resourcefulness. My life, permanently, positively transformed.

IREST Yoga Nidra practice is an evidenced based form of meditation and relaxation treatment used for people with depression, anxiety, stress, insomnia, drug dependency and PTSD. Research shows IREST meditation helps to increase happiness and energy levels, decrease stress, anxiety and depression, improve sleep and strengthen our resilience to deal with day to day life.

I’m now a Level 1 Teacher in Training for IREST Yoga Nidra through the Integrative Restoration Institute. I’m passionate about sharing my story and the benefits of this practice. It’s our birthright to feel our natural states of peace, joy and aliveness. IREST Yoga Nidra can give us this and help us to heal our childhood traumas.

Learning Objectives

Learning Objective (1): People will gain an insightful first hand lived experience in the power and possibility for those experiencing PTSD to heal themselves of emotional and body flashbacks using an evidenced based form of mindfulness and relaxation treatment currently used in the US for returning Veterans. People will learn what it feels like to experience the IREST Yoga Nidra practice through setting an intention, connecting with our heartfelt desire and inner resource, doing body and breath sensing, exploring opposite feelings and experiencing joy and integration. The benefits of regular practice include increased happiness and decreased stress, anxiety, and depression.

Learning Objective (2): This topic is relevant to mental health services because there are many people who experience trauma and who aren’t aware of this practice or the positive effect it can have on our wellbeing. This is an evidenced based practice that can be done in an empowering way in the privacy and comfort of people’s own homes which is not depended on a financial cost or on face to face interactions with professionals. IREST Yoga Nidra can be used for treating depression, anxiety, insomnia, addictions and chronic pain. Many consumers suffer from these experiences and may benefit from learning firsthand about the practice.

References


Survivor To Life Thriver

Felicia Johnson
1Personality Disorders Awareness Network (pdan), Tucker, United States

Biography:
Felicia Johnson is a mental health and youth advocate. She is a motivational speaker who shares her life story about surviving abuse and living with mental illness. Felicia has spoken around the world to many diverse audiences. She is a brand ambassador and speaker for organizations such as The National Alliance On Mental Illness (NAMI) and Personality Disorders Awareness Network (PDAN). Felicia Johnson’s first novel called “HER” has gained popularity and recognition from audiences and organizations worldwide. Felicia lives in Atlanta, Georgia USA with her loving husband and their cat that they call Eren Jaeger, named after her favorite anime character. She loves ice cream, hugs and having great belly laughs with friends.

Felicia Johnson discusses her experience with depression, self-harm and being a survivor of suicide of a loved one who had suffered from Borderline Personality Disorder. Felicia brings understanding of BPD within reach of many people afflicted and continues to help many come to terms with mental health issues. She brings remarkable insight and understanding to an illness that affects 1-2% of the population and wreaks havoc on the lives and relationships of young men and women. Felicia Johnson also discusses her own experience surviving child abuse, neglect and homelessness as a teenager. Inspired by her own life story and the journey of her childhood friend, Felicia has authored the novel entitled “Her”. It tells the story of a young girl’s struggle with BPD through her mental breakdown, treatment and recovery. It is a story of hope. Johnson is a survivor who had turned into a life thriver. She deals with mental health issues in her personal and work life. She is actively involved in the efforts to stamp out the stigma on mental illness. She presents solutions that will not only help those who struggle with mental illness, but also their families, friends, loved ones and colleagues. With nearly ten years of experience in working in the field, Johnson continues to help many come to terms with mental health issues with her own story of survival and with her clinical training and background. Felicia Johnson’s presentation will provide an in depth look at mental health issues that affect our youth. Felicia Johnson not only educates her audiences with real clinical information, she also tells her own story of survival. People will learn what it is like to live with mental illness, be a survivor and learn ways to help others in personal and professional settings to become life thrivers. The audience will come out with caring, compassionate and professional ways of approaching and coping with mental health issues. There will be an open discussion at the end of the presentation for audience members to ask questions and share their own experiences.

Learning Objectives
Learning Objective (1): The audience will be able to Define BPD, Bi-Polar Disorder, Major Depression and explain the effects it has on the lives of those who suffer as well as their loved ones and identify the signs to look out for when someone we care about show warning signs of suicide ideation.
Learning Objective (2): Discuss what we can do to help those who are struggling with mental illness and how we can encourage others to talk about it in order to stamp out the stigma that is on mental illness.

References
Elliott, Jeffrey M. and Dr. Angelou, Maya (1989) Conversations with Maya Angelou
Mayne, Brian (2008) Goal Mapping : How to Turn Your Dreams into Realities
Evidence based Relaxation Therapy for Mental Health

Dr Judy Lovas

1Art & Science Of Relaxation, Sydney, Australia

Biography:
Dr Judy Lovas is a highly experienced presenter in the psychological and physical benefits of evidence based relaxation therapy. She conducts seminars around Australia to social workers, psychologists, doctors, nurses and all health professionals. Judy is passionate about teaching Psychoneuroimmunology (PNI), the scientific platform that demonstrates how Relaxation Therapy can enhance health and well being. Her seminars provide effective ways to implement relaxation into daily life for stress-related conditions such as fatigue, pain, depression, anxiety and PTSD.

A strong body of evidence demonstrates that relaxation therapy can reduce stress related conditions such as anxiety, depression, pain, fatigue and trauma. Sophisticated research shows cellular, molecular, chromosomal and genetic expression changes following techniques such as deep, diaphragmatic breathing and guided imagery. This presentation offers details of sophisticated research that supports the use of relaxation for a range of mental health conditions. It also provides an opportunity for participants to experience and practice one efficacious relaxation technique. Relaxation skills can be used for patients with mental health concerns and are easy to teach in clinical practice. Relaxation therapies are evidence based, non-invasive, non-pharmacological, cost effective and important therapeutic options for all mental health professionals.

Learning Objectives
Learning Objective (1): Participants will understand research that supports the clinical use of relaxation therapy for stress related conditions such as anxiety, depression, pain, fatigue and trauma.
Learning Objective (2): Participants will gain experience in the practice of an evidence based relaxation technique.

References

Think It's Just a Story? Progressing Person Centred Care with Persons at the Centre.

Vendra Begonja

1Xtend Life & Behavioural Coaching, Adelaide, Australia

Biography:
Vendra Begonja combines two decades of personal and professional experience as a Coaching Practitioner. A long way from the disadvantage and Guardianship starting her life. Her background includes Health, Clinical Research and Audit and with continuing professional development in psychology, coaching, mental health and wellbeing, she facilitates individual skills development.

Lived experience at does not usually engender a positive attitude socially but rather greater stigma and discrimination. This is twofold for those that experience it socially and within their workplace. Storytelling and sharing lived experience is a significant unharnessed resource and positively influences change. Individuals can suffer secondary trauma. We can more effectively inform Service Delivery, Implementation, and Programs to create person-centred models of care and improved mental health outcomes, inclusive of lived experience. Evidence supports consumer experiences as helpful for healthcare, improving consumer and service outcomes. How does someone with significant lived experience create a voice, which is heard? Who would listen anyway? As a coaching practitioner, with significant lived experience its importance is not lost on me. Improving efficacy of mental health systems, in my view is contingent on doing this, there is no choice. Within the mental sector person-centred care has been a guiding principle for service delivery and implementation. Anecdotally however the reality is very different. With 1 in 5 Australians experiencing mental illness it is likely that within the workplace employees are living with mental health experience either as a diagnosis or supporting others, what an opportunity!

Learning Objectives

Learning Objective (1): New attitudes, perceptions and thinking about individuals with lived experience and the social and economic value this experience offers.

Learning Objective (2): With increasing numbers of Australians diagnosed with mental illness, it is likely that the workforce is made up of individuals who have direct or indirect mental health experience. This represents a vast resource, to tangibly alter attitudes, stigma and discrimination and utilise consumer experience to improve services. A collective approach to a growing burden of disease is the only way forward, and getting comfortable with this sooner rather than later is critical for government, mental health sector, policy makers and economists.

References


Byrne, Louise. (2017). Promoting lived experience perspective: Discussion paper prepared for the Queensland Mental Health Commission. Developed for the Qld Mental Health Commission as an introduction to Lived Experience perspective, providing; background to the lived experience or ‘consumer’ movement in the mental health sector; an overview of some of the benefits of lived experience participation; information on the existing and future scope of lived experience participation; identification of common barriers and enablers.
Mind Your Head: Exploring the Potential of Virtual Reality for Therapeutic Support.

Stephanie Liddicoat¹, Stephen Yuen¹
¹University Of Melbourne, Melbourne, Australia

Biography:
Stephanie is a researcher and architectural design academic at the University of Melbourne, Australia. Stephanie’s research interests are at the nexus of architecture and health, particularly in exploring service user perceptions of the built environment, the relationship between space and wellbeing within healthcare settings, and emerging technologies supporting mental wellbeing.

Stephen Yuen is a digital architect, completing his Master of Architecture at the University of Melbourne with First Class Honours. Stephen's thesis investigated virtual reality spaces as a therapeutic tool to aid individuals with social anxiety, and explored potential accompanying virtual reality applications to be accessible through online platforms.

With recent developments in technology and advanced modelling systems, novel forms of therapeutic intervention are now possible. Virtual reality has already been used to treat mental health conditions such as phobia, psychosis and depression. As a treatment for post-traumatic stress disorder, virtual reality graded exposure therapy involved patients examining their fears related to his or her trauma in a controlled, simulated environment using VR. Further, such technological advancements allow for increased user-customisable experiences including treatment availability, content and delivery environment. However, virtual reality’s recent growth and availability means the technology’s potential is ahead of the research. We investigate how virtual reality experiences are perceived and could be designed to improve young people’s mental health and wellbeing. We report on the findings of two studies investigating participant responses to virtual reality environments and the integration of virtual reality into mental health service delivery. We conclude with the significant advantages we have uncovered relative to the medium of virtual reality specifically, and then implications for mental health service delivery and consumer self-management in addition to other therapeutic support.

Learning Objectives

Learning Objective (1): The audience will gain a greater understanding of the potential uses of virtual reality as a therapeutic tool, the advantages we have uncovered relative to the medium of virtual reality specifically, implications for mental health service delivery and suggestions for future researchers.

Learning Objective (2): This topic is relevant to mental health services and mental health issues as it specifically addresses how to capitalise on new technologies to innovate service delivery. Virtual reality also offers a new means to offer online services/tele-health and as a vehicle for self-management in addition to other therapeutic support.

References


Walking Into the Unknown: Exploring the Importance of Therapeutic Endings.

**Frances Cheverton**

*Berry Street Childhood Institute, Melbourne, Australia*

**Biography:**

Fran Cheverton is an Approved Mental Health Social Worker and Family Therapist, who has devoted her professional career to working in Child and Adolescent Mental health both in Australia and the United Kingdom. Fran specialises in working with children, young people and families drawing on attachment, systemic and psychodynamic therapeutic understandings. Fran also provides supervision to mental health clinicians and social workers. In addition to working in private practice, Fran is the lead consultant for the Child and Family Wellbeing Team with the Berry Street Childhood Institute.

Mental health professionals, from all fields, are in the business of relationships. Our work environment, with its mounting pressures and focus on measuring outcomes is not always conducive to a relational approach. Working at the interface of relationships and throughput is complex and messy terrain, particularly when clinicians come to discharge clients. In her therapeutic encounters in Child and Adolescent Mental Health Services, Fran learnt that how we chose to end the relationships we create with clients has significant implications for the people we work with, ourselves and our organisations. Overtime, Fran observed a clear pattern: that faster client discharge often resulted in prompt re-referral, ultimately resulting in higher clinical caseloads. In her paper, Fran draws on the Attachment Narrative Therapy Framework and her practice experience to explore how we can inventively meet organisational expectations whilst also creating correctional emotional experiences for the people we work with, enhancing and sustaining therapeutic outcomes.

**Learning Objectives**

Learning Objective (1): Participants will gain an introductory understanding of Attachment Narrative Therapy and how it can be applied in practice.

Learning Objective (2): Participants will learn about the inherent value of coherent, consistent and thoughtful endings for clients, workers and mental health services.

The approach to practice discussed in this paper is relevant to mental health services as it provides an alternative and creative way of managing discharge and reducing re-referral rates. Long waiting list and increased re-referral rates have been identified as major concerns for mental health services nationally and internationally. This paper offers a solution.

**References**


Let's have a conversation about voices. An introduction into the Hearing Voices Approach and how to use it in everyday settings.

Inge Remmits¹, Janet Karagounis¹
¹Voices VIC, Uniting Prahran, Prahran, Australia

Biography:
Inge Remmits is the Central Trainer at Voices Vic. Inge has a Bachelor Degree in Social Work. Inge has work experience in mental health & dual disability in Australia and the Netherlands. Inge was trained in using the Hearing Voices Approach by its founders and (inter)national experts.

Janet Karagounis is one of the founding members and the Group Network Coordinator at Voices Vic. Janet was trained in the Hearing Voices Approach by its founders and (inter)national experts. Janet has lived experience in Hearing Voices. Janet is the 2017 Intervoice Inspirational Person Award winner.

‘Hearing Voices’ is a term used to represent the experience of what is also called ‘auditory hallucinations’, or hearing things that other people cannot. ‘Hearing Voices’ can also be related to the experiences of seeing visions, sensing things and beliefs that others may find unusual.

Hearing Voices is more common than people might think. Research has found that at least 4% of the population hear voices on a regular basis and 40% hear voices at least once in their lifetime. Yet less than 1/3 of voice hearers end up seeking mental health support.

The traditional model in mental health services is that hearing voices is a meaningless symptom of a serious mental illness. Medication is the main form and in a lot of cases the only form of treatment provided. People are told to ignore their voices and are taught not to talk about them with threats of increases in medication and hospital admissions if they do.

Figures from the Australian Institute of Health & Welfare show prescriptions for antipsychotic drugs under the PBS have increased by 359% over 24 years! Yet this model and form of treatment is successful for only 38% of people seeking mental health support for hearing voices. This means that what we are doing isn’t working and we need new ways to support voice hearers.

The Hearing Voices Approach is based on the research of Professor Marius Romme & Sandra Escher, which found that many people ‘hear voices’ without distress or even seeking mental health support.

Romme & Escher’s research and also a more recent study by Dirk Corstens & Eleanor Longden found that for 70% (Romme & Escher) to 89% (Corstens & Longden) of people there is a link between their voices and traumatic life experiences, particular adverse childhood experiences. This means that they are not meaningless symptoms to be ignored but meaningful experiences to be explored.

As voice hearer Dr Rufus May says: “Understanding voices helps change the relationship between the voice-hearer and their voices.” This can lead to positive recovery outcomes as Ron Coleman, voice hearer and expert in the Hearing Voices Approach, states: “By becoming the owner of that experience and entering into a relationship instead of rejecting the voices...it becomes possible to become a victor instead of a victim and to shape your own life actively again.”

Romme & Escher found that voice hearers who ‘cope’ have different skills, beliefs and supports compared to those who live with distress. These findings form the basis of Hearing Voices Groups. These groups have been running across the world since 1987 and are currently active in 26 countries including Australia.
Hearing Voices groups are safe spaces where voice hearers can share their experiences, learn new ways to understand, cope and live with voices and create a powerful sense of hope and possibility.

Studies done in the UK and Australia both found that hospital admissions decreased significantly (61% in Australia) once people starting to attend a Hearing Voices Group. Voice Hearers who participated in this research also indicated that they felt less distressed by their voices, had developed more coping skills, had higher self-esteem and felt less isolated.

This all sounds great but how do you go about using the Hearing Voices Approach and start talking about voices! During this interactive workshop, we will give you:
- A better understanding of the Hearing Voices Approach
- A better understanding of the voice hearing experience
- Knowledge of how recovery can look like within the Hearing Voices Approach
- Knowledge of different practical strategies and skills that can support voice-hearers and open up the conversation

This workshop aims to give you a starting point when talking about voices as a support worker, voice hearer or carer/family/friend. To take the awkwardness, stigma and fear away and open up the conversation.

**Learning Objectives**

Learning Objective (1): A better understanding of the voice hearing experience and knowledge of how recovery can look like within the hearing voices approach.

Learning Objective (2): Knowledge of different strategies and skills that can support voice-hearers and open up the conversation.

**References**

Vanessa Beavan, Adele de Jager & Bianca dos Santos (2016): Do peer support groups for voice-hearers work? A small scale study of Hearing Voices Network support groups in Australia, Psychosis, DOI: 10.1080/17522439.2016.1216583

Effectiveness of therapies that Engage Voice Hearers with their Voices: a Systematic Review

Ms Wendy Scott\(^1\)

\(^1\)Joanna Briggs Institute, Adelaide University, Adelaide, Australia

**Biography:**
Wendy is a MHN of 25 years, clinical, managerial and voluntarily both within Australia and overseas. A not for profit social enterprise owner taking mental health professionals/families to Nepal (www.watticando.com.au). Now working casually clinically and studying a Masters as well as parenting and taking lots of holidays! (priorities.)

Wendy will present on a systematic review she is completing as part of her Masters Program at Joanna Briggs Institute, Adelaide University. The aim of this review is to identify, evaluate and synthesise relevant research in regards to the effectiveness of psychotherapies that engage Voice Hearers with their voices. She will present the results found and seek input from the audience as to which of the gaps in research identified may be the most valuable to peruse in the future.

**Learning Objectives**

Learning Outcome 1. Identify changes to peoples Quality of life, Recovery, Coping with life, because of hearing voices and Distress from therapies that engage Voice Hearers with their Voices. Secondary Outcomes that will be reported on include Length of episodes of care within specialist mental health services, Numbers of presentations to Hospital Emergency Departments for mental health reasons, Length of stay in bedded inpatient mental health care facilities, both acute and rehabilitation services where ever available.

Learning Outcome 2: Identifying gaps for future research with discussion from audience as to which of those gaps would be the most valuable to be addressed.

**References**


Introducing Early Intervention: How to integrate Early Intervention methods & principles into an adult mental health service.

Kas Mattes

Ryde Community Mental Health Centre, Sydney, Australia

Biography:
Kas Mattes is a Social Worker with experience working the fields of Mental Health and Juvenile Justice. Most recently he has been involved in establishing the Early Intervention Service for psychosis and mania at the Ryde Community Mental Health Centre.

- Is it possible to change the approach to providing a service to young people with a first episode of psychosis in a busy adult mental health service?
- Can clinicians with years of experience in the broader mental health system adopt new enthusiasm in providing intensive recovery focussed interventions?
- Can we instil vitality, inspiration, a sense of ‘mastery over destiny’ in young people with psychosis?

North Shore Ryde Mental Health Service has recently expanded their Early Intervention Service from operating solely within the Lower North Shore area into the Ryde area. After decades of lacking a funded EIS, thanks to passionate clinicians & creative managers, the Ryde Acute Team has dedicated some resources to provide a specialty service to young people aged 18-30 years experiencing a first episode of psychosis. Being one of the clinicians involved, I found myself witness to the challenges alluded to in the 3 questions above. A recent Clinical Practice Improvement Project is helping to embed the principles & practices of early intervention for psychosis into the service. After reading the EPPIC Clinical Guidelines for Early Psychosis, I wondered how I could change my practice. How could I match the intensity recommended in these Guidelines? How do I justify only having 15 clients? What does Early Intervention mean in this current climate of full Emergency Departments, busy Mental Health Inpatient Units with bed shortages, and Acute Teams with multiple triage, assessment, and case management functions?

Learning Objectives

Learning Objective (1): An account of the practical challenges faced over time when implementing an early intervention service into an established mental health centre.


References


Religion, Love, the Bible & devoted Praying exemplify the healing / dealing of MH Recovery for most who are Spiritual to carry on into this earthly living.

**Evan Bichara**
*Self Employed, Melbourne, Australia*

**Biography:**
Evan’s aim in bringing healing to people who have rough journey’s by giving them better perception / strengthening their outlook so that peace / safe communities ties can be made...there is no single approach and therefore Evan skilled to offer many modalities in healing people back to their feet.

The overwhelming / growing understanding of the great impacts Religion plays favourably towards people with MI. Is becoming more an ordinary living experience so necessary by those who desire it. strongly with self determination, love, caring for each other and it’s various spiritual contemplations. It’s practical philosophy, it’s mystical theology, and its collective nature of approach wholeheartedly serves many preventative measures needed to recuperate, consolidate, validate to an effective Recovery sketched out to follow and promptly adhere to Professionals as well as simultaneously take own initiative / responsibility to healing oneself through the eyes of our Almighty God. In promoting wellness MH Staff often are encouraged and called upon acknowledging and adopting good practices of peaceful living that solidify Recovery...and channel to either valued support. here we are talking about Religion, Church activities, Praying power and following family traditions and their beliefs. The love accomplished through Religion is immeasurable and leads to a strong binding Recovery path...so difficult to stray away from. The major challenges these people ultimately face are trust, acceptance, and love with the fellow man....all found within the Church grounds. Evan will explain more in depth how he has accomplished Recovery via his Greek Orthodox faith.

**Learning Objectives**

Learning Objective (1): The audience will be amazed at the lived experience story Evan will give of his own account of his Greek Orthodox faith and how it has positively impacted in Evan's life to heal / deal with his unfortunate circumstance of having a MI for over 5 decades....his inspired motivated and cultivating way of bringing his Religion into his therapy has being an overwhelming bonus for him.

Learning Objective (2): Spirituality Religion and MI...have great connections...as Evan will plain in his presentation...it has not only accelerated his Recovery, prevented relapses from occurring, but has made Evan a strong and insightful Advocate to helping others...he is inspired motivated and always out in helping others...this has truly made Evan a better person...and his religious faith has helped him all the way.

**References**

Lisa Baranov (2010) Thoughts of each Day
David Beck (2013) Flames of Wisdom
This Is My Brave Australia Inc. breaking the stigma surrounding mental illness one story at a time.

Tim Daly¹
¹This Is My Brave Inc., Ngunnawal, Australia

Biography:
Tim Daly is the EO and founder of This Is My Brave Australia Inc. Previously the General Manager of a very busy company, mental health issues forced Tim to re-evaluate his life and leave his job and combine his knowledge and mental health advocacy.

This Is My Brave Australia is an Incorporated Association and an ACNC registered charity who, through our live theatre shows, website, Facebook pages and YouTube channel, help give voice to others in the community who may be isolated through mental illness, sickness or disadvantage suffered by themselves or a loved one.

A TIMBA show is not cast from experienced story tellers. The cast is drawn from members of your community. Anybody is welcome to tell their story in a TIMBA show. A TIMBA show is authentic lived experience of peoples own stories told in a raw and honest way. It is an opportunity for those who may feel like just another statistic within the system, to be heard. TIMBA is a safe and comforting environment where not only the producers offer support but the collective cast create a bond of understanding and acceptance. Story telling allows our brain to put together thoughts, through the act of writing a story, that are fragmented and disconnected due to a disjointed internal dialogue, into a more linear progression which aligns better with our own values which can help draw meaning from our experiences and help make it easier to plan a way forward.

Learning Objectives

Learning Objective (1): People in the audience will come to understand the importance of those suffering from mental illness in putting their lived experience into words to create a more linear understanding of their experience, also they will come to understand that sharing these lived experiences may increase beliefs about empowerment and recovery, and improve attitudes towards treatment seeking for mental health concerns.

Learning Objective (2): This topic gives in insight into an active contact-based mental illness stigma reduction program, set in theaters, meant to reduce stigma and how it is being delivered throughout Australia.

References


Psychiatric Consultation-Liaison Service in General Hospital: A Singapore Perspective.

Zhenru Zhao¹
¹National Health Group, Singapore, Singapore

Biography:
Dr. Zhao Zhenru is currently a senior resident in national psychiatry residency program in Singapore, he has 5 years of experience in psychiatry practice.

Background: Psychiatric consultations to other health professionals help to bridge the gap between medicine and psychiatry, biology and the behavioural sciences. To date, there are some reports about referral patterns and common psychiatric condition in medical and surgical settings, but there is limited information from general hospitals in Singapore.

Objective: To study to the referral patterns and common diagnosis to psychiatric consultation-liaison service in a general hospital in Singapore.

Method: All patients referred to psychiatric consultation-liaison service at Khoo Teck Puat Hospital between July and December 2017 were identified and studied retrospectively. The reasons for referral and the psychiatric diagnosis were abstracted directly from case notes.

Findings: In all, 229 cases referred to psychiatric consultation-liaison service were identified. The top five reasons for referral are suicide assessment (23.5%), depression assessment and management (20.5%), mental capacity assessment (17.9%), management of psychotic symptoms and behaviour issues (14.3%), assessment of altered mental state (10%). The top seven diagnoses are major depressive disorder (21.8%), delirium (14.4%), no mental illness (10.5%), adjustment disorder (7.9%), psychosis (7.9%), dementia (7.4%), and acute stress reaction (5.6%).

Conclusion: This study was undertaken to better characterize referral patterns and common diagnosis to psychiatric consultation-liaison service in an Asian country, which echoed similar studies in the western world.

Learning Objectives

Learning Objective (1): The audience may understand better about the difficulties and challenges in psychiatric consultation-liaison service.

Learning Objective (2): Psychiatric consultation-liaison service is an important part in mental health service in general hospitals, and focus on patients with both physical and mental health issues.

References

Does implementing individualised Personal Safety Tool’s with adult mental health consumers within a community rehabilitation setting reduce mental health crisis presentations?

Anna Francis, Amily Daw

Northern Community Rehabilitation Program, Northern Mental Health, SA Health, Adelaide, Australia

Biography:
Anna has three and a half years’ experience within an adult community mental health setting. Her primary interest areas are rehabilitation, sensory modulation and trauma informed care. Anna has led a number of clinically focussed quality improvement projects and initiatives to support service delivery and evidence based practice.

Amily has three and a half years’ experience within a community mental health setting. Her primary interest areas are rehabilitation, working with youth and sensory modulation. Amily has led a number of youth specific quality improvement projects which have promoted early intervention and have shaped service delivery and design.

Personal Safety Tool’s (PST’s) are consumer-centered and draw from the principles of recovery, sensory modulation and trauma informed care. There is currently not a consistent PST available for adult consumers within community mental health settings to support crisis reduction and self-management. This research aimed to ascertain the benefit of implementing individualised PST’s within a community rehabilitation setting in reducing mental health crisis presentations. Seven consumers were selected to participate in a 12 week research study to implement PST’s as a crisis prevention strategy. Consumers completed weekly questionnaires to determine if they experienced a distressing or crisis situation that week. The questionnaires explored whether the PST was utilised during distressing or crisis situations and whether it was an effective tool. Outcomes from the research project determined that PST’s are an effective intervention tool in the reduction of crisis presentations. The PST proved to be adaptable as it demonstrated it could be used within the consumers continuum of care. In conclusion, all consumers identified an overall increase in skills in self-management, resilience and adaptive self-regulation to manage their mental health symptoms. Results generated from the research study provide evidence to support implementation of PST’s within clinical practice.

Learning Objectives

Learning Objective (1): The audience will learn of the benefits of implementing an individualised Personal Safety Tool within an adult community mental health setting to reduce mental health crisis presentations.

Learning Objective (2): The research provides evidence supporting the implementation of individualised Personal Safety Tool’s within a community mental health rehabilitation setting to reduce crisis presentations. The research adopts the principles of rehabilitation and recovery, early intervention, sensory modulation and trauma informed care that can inform future clinical practice.

References


Jennifer Smith-Merry\textsuperscript{1}, Ivy Yen\textsuperscript{1}
\textsuperscript{1}Faculty of Health Sciences, University Of Sydney, Sydney, Australia

Biography:
Jen is Associate Professor in the Faculty of Health Sciences at the University of Sydney where she leads Mental Health and Disability Research. She has a strong belief in the importance of lived experience in practice and policy and regularly collaborates with people with a lived experience of mental ill-health.

The National Coronial Information System (NCIS) collects information about deaths investigated by Australian and New Zealand Coroners. The NCIS provides important details about the lives of people at the time of their death, including their health, medication use and recent interactions with services. Until now the information on this system has primarily been used to inform service development for suicide prevention (e.g. Manuel et al 2017; Arnautovska et al 2015). We extend this by investigating non-intentional deaths of people with mental illness investigated by NSW Coroners from 2012-2016. Looking collectively at this very moving and personal information allows for an understanding of the life situations which might lead to unexpected death in someone with mental ill-health.

This presentation demonstrates that people are frequently dying of preventable diseases related to drugs (including prescribed medication) and alcohol, cardiovascular disease, metabolic disorders and accidents. We also point to a number of probable suicides present in the data. Demographic details on people with mental ill-health who died from unintentional causes are compared to those who died from suicide. This demonstrates that people who die from unintentional causes die at similar ages to people who die from suicide, but are far more socially marginalised.

Learning Objectives

Learning Objective (1): Those viewing the presentation will gain an understanding of the causes of death for people with mental illness where the Coroner does not classify the death as intentional.

Learning Objective (2): This topic is very important for services because it demonstrates the information on unintentional deaths available and how it may be utilised for quality improvement activities both in local areas and system-wide.

References


Wellways Community Advocacy Forums; United Spaces for Naming the Issues and Taking Action.

Cassy Nunnan¹, Rachel Lovelock
¹Wellways Australia, Fairfield, Australia

Biography:
Cassy is a passionate advocate for recovery and justice. She has been at Wellways for 12 years. Lived experience has informed roles such as program researcher/writer, helpline coordinator, facilitator and trainer. She is also a fiction author who has a PhD in creative writing and mental health advocacy.

Rachael is a manager and family/carer advocate drawing on community development knowledge to lead, design and implement advocacy strategies, community and peer educations programs at Wellways. Ensuring lived experience is heard, rights upheld and principles of co-production are at the heart of policy, quality systems and services provision.

It is essential that consumers and carers can voice experiences of rights failures, achievements and wisdom in order to influence services, policy makers and society to be more recovery-oriented and equitable (National Mental Health Standards). Throughout 2017, Wellways facilitated 14 advocacy forums in Victoria, NSW, Tasmania, Southern Queensland and the ACT. 395 people were invited to express their concerns, share experiences, skills and resources, and focus their energy into designing grassroots approaches to making change happen. Qualitative data was gathered and analysed to create ‘Spotlight’ documents, which people are actively using to improve conditions in their communities, for example, by lobbying governments, community education, challenging stigma.

We will present some stories were heard and discuss our community engagement model, the outcomes and themes, and what this signals for advocates, service providers and government leaders in the current MH sector climate.

Learning Objectives

Learning Objective (1): People will learn about an effective community advocacy engagement method that can be utilised in multiple metropolitan, regional and rural settings, which results in participants feeling empowered and activated as advocates. They will also take away an understanding of the critical issues – deriving from a strong data set – that effect people living with mental health issues, and their carers and communities, that cause ongoing adverse impacts.

Learning Objective (2): In this era of major service system reform it is essential for services and service users to understand the impacts of such changes from the diverse geographical and cultural perspectives of consumers and carers. This information is essential in service design and advocating for social change. It is also valuable to know the power of lived experience grassroots advocacy when activated at the community level.

References


Flourishing Without Limits: How implementing a mental health curriculum increases student engagement.

Trina Cummins

Wilderness School, Adelaide, Australia

Biography:
Trina is the inaugural Director of Wellbeing & Counselling at Wilderness School, Adelaide SA, where she is a member of the Senior Leadership team and oversees the wellbeing and mental health programs across the school (ELC-12). As a trained psychologist and educator, over the last 20 years Trina has worked as a behaviour specialist, counsellor, teacher and learning specialist. She has managed various wellbeing, counselling and mental health programs across different school sectors (government and independent) in America and Australia.

Trina is a member of the South Australian Mental Health Community Advisory Committee to assist the Commission to write a Mental Health Strategic Plan for all South Australians (2017-2018).

The movement of mental health in education has been growing in response to the need to shift our thinking from how people survive to how they can flourish. There is substantial evidence from well-controlled studies that skills which increase resilience, positive emotions, engagement and meaning can be taught to schoolchildren (Seligman, Ernst, Gillham, Reivish & Linkin, 2009). Teaching wellbeing skills to students so they can flourish in life arguably has a direct impact on academic success and needs to be the focus of every educator whose role is instrumental in helping students grow and develop. Wilderness School has developed a strategic approach to wellbeing and mental health because schools play an increasing important role in assisting youth to develop cognitive, social and emotional skills (Waters, 2011).

Exploring the nexus between teaching wellbeing skills/mental health awareness and student engagement this workshop will share about a whole school improvement initiative (ELC to Year 12) that focuses on flourishing. Reporting on the promising early impact of the initiative this paper wades into the debate that all students can flourish when taught wellbeing skills, arguably increasing student engagement as a result. Our wellbeing strategic approach will be shared with participants hearing how to implement positive education, barriers and enablers, student/teacher perceptions, change levers, data collection (EPOCH/PERMA), staff training, supportive resources and implementation of a school wide mental health curriculum framework (universal, targeted and individual). This interactive presentation will share with participants how to strategically implement positive education with potential transferability to other systems and schools. As a skill-based session it highlights how academics (thinking and learning) and wellbeing (character and resilience) are of equal importance, impacting student growth.

Learning Objectives

Learning Objectives (1): Audience members will learn about how to implement a wellbeing/mental health program into a school system from a strategic leadership perspective. They will have an understanding of what evidence based mental health curriculum they can implement into any school system ELC - Year 12.

Learning Objectives (2): This topic is relevant to mental health services because schools are a key environment to teach life skills and to have a mental health preventative focus and awareness. With 1 in 4 young Australians dealing with a mental health issue (2014, State of New South Wales) it is more important than ever that we have a discussion about addressing mental health needs in schools and the role that school systems can have a positive impact on students' welfare and wellbeing.

References

Storytelling and Mental Health: Evidence from the SANE Australia Hocking Fellowship.

Mark Tayar¹
¹UNSW, Sydney, Australia

Biography:
Dr Mark Tayar has published on learning and teaching, education management and HRM. This includes an article on digital storytelling in 2017.

Mark has worked at ANU, Swinburne University of Technology, Macquarie University, the University of Sydney, Western Sydney University, and now works at UNSW Sydney.

Mark lives with schizoaffective disorder and is an advocate for mental health.

Health and illness narratives interweave between personal, interpersonal, positional and societal levels of analysis (Murray, 2000). This presentation aims to demonstrate the value of storytelling for recovery from severe mental illness. This project was funded by a 2017/18 Hocking Fellowship by SANE Australia. The author is someone with lived experience of severe mental illness. Using evidence from 15 semi-structured interviews, the benefits and dangers of storytelling about illness are assessed. Interviews were conducted with people who have lived experience in three capital cities and four regional towns. Storytelling is found to be a powerful means for reducing stigma in the community. Storytelling can however sometimes retraumatise the storyteller and their audiences and as such, training and audience support is needed for stories to be told safely. Key themes to be presented include storytelling in workplaces, positive and negative reactions to storytelling and the use of humour in stories. There is also an emphasis on digital storytelling with images, video, audio and text which storytellers describe as therapeutic (Hardy and Sumner 2017). Overall, storytelling about mental health can assist with recovery and can create a positive dialogue between those with lived experience, carers, mental health workers and the wider community.

Learning Objectives

Learning Objective (1): Understand the value of storytelling for recovery from mental illness.
Learning Objective (2): Appreciate the benefits and dangers of storytelling in a range of settings.

References


Low Intensity Mental Health Services – what are they, who provides them and do they work?

Harry Lovelock¹, Hazel Dalton²
¹Australian Psychological Society, Melbourne, Australia, ²Centre for Rural and Remote Mental Health University of Newcastle, Newcastle, Australia

Biography:
Harry is the Senior Executive Manager at the Australian Psychological Society. He has overseen a large number of national multidisciplinary projects including suicide prevention, children’s mental health and telehealth initiatives. He is a Board member of the Mental Health Professionals Network and chairs its evaluation subcommittee.

Hazel leads research at the CRRMH, with a translational focus, across mental health promotion (including the Rural Adversity Mental Health Program), mental health service provision, and rural suicide prevention. Some current work includes the evaluation of models of integrated care and evaluation of a stepped care low intensity mental health service.

Primary Health Networks (PHNs) have increased flexibility to use funding to commission regionally delivered primary mental health services suited to local needs. This includes low intensity mental health services for early intervention. These services are targeted to people with, or at risk of, mild mental illness.

This presentation will provide an overview of the literature related to low intensity services, including defining features of these services, the evidence in relation to different types of low intensity services and some of the key considerations for low intensity service delivery.

The Australian Psychological Society (APS) has been funded by the Australian Government to develop recommendations for preferred approaches for the accreditation of low intensity services that will inform future commissioning by PHNs and future training arrangements to support the low intensity workforce.

The APS is working in collaboration with key stakeholders, including the Centre for Rural and Remote Mental Health, Australian Association of Social Workers, Occupational Therapy Australia, Royal Australian and New Zealand College of Psychiatrists, Royal Australian College of General Practitioners, Australian College of Mental Health Nurses and PHNs.

Learning Objectives

Learning Objective (1): Participants will gain an understanding of what low intensity services are, who provides them and whether they work.

Learning Objective (2): Low Intensity Services are proliferating under funding provided by Primary Health Networks and changing technological developments.

References


Lessons from PANDA’s National Perinatal Anxiety and Depression Helpline.

Cathy Wyett\(^1\)
\(^1\)PANDA - Perinatal Anxiety & Depression Australia, Fitzroy North, Australia

**Biography:**
Cathy Wyett is PANDA’s National Helpline & Programs Manager, where she is responsible for the National Perinatal Anxiety & Depression Helpline and a range of programs supporting health professionals and consumers. Cathy has considerable experience across the non-profit sector and maintains a strong focus on the value of lived experience.

Up to one in five expecting or new mums will experience perinatal anxiety or depression, but this illness is not commonly recognised. Since 2010 PANDA - Perinatal Anxiety & Depression Australia has run the only specialised Australia wide perinatal depression and anxiety telephone counselling Helpline. The large volume of calls through the service provides a unique understanding of the experience of perinatal mental illness faced by expecting and new parents. Comprehensive service data shows that lack of knowledge, coupled with stigma, causes people to delay seeking help.

This presentation draws on data from more than 70,000 calls and shares real stories of perinatal anxiety and depression. We also introduce data from a community survey that reveals limited understanding of this common and serious issue. Further data from PANDA’s biopsychosocial framework together with active risk assessment provides practice-based evidence that will assist you in your work with expecting and new parents. We also introduce PANDA’s services so you know where to seek help and refer so people seek appropriate help as soon as possible.

**Learning Objectives**

Learning Objective (1): Attendees will develop a stronger understanding of perinatal mental illness, what stops people seeking help and how we can all support early identification and help-seeking to promote positive outcomes for families.

Learning Objective (2): Perinatal mental illness is a serious and common issue. A significant number of people who experience mental health challenges in the perinatal period have a pre-existing mental health diagnosis, have received treatment in the past or are currently engaged with formal mental health supports. It is important that we are aware of the specific challenges and considerations for expecting and new parents who are dealing with mental health issues and caring for a new baby.

**References**


David Rosenbaum¹,², David Paul²,³, Elizabeth More³, Sisa Rasaku³
¹OPTIMUM NFP, Drummoyne, Australia, ²ATTWISE, Sydney, Australia, ³AIM Business School, Sydney, Australia

Biography:
David is an independent management consultant, researcher, academic and author. His consulting focuses on the nonprofit sector in areas of strategy, risk, governance, change and people development. His research interests include change management and long-term sustainability of the Australian nonprofit sector. His academic teaching focus includes change management, strategic planning and strategic financial management.

David is also an internationally accredited Action Learning Facilitator which enables him to put into practice one of his key passions, expanding the people skills within organisations that support learning through action, and in the process, underpinning long-term sustainable organisational change.

David has published in a range of international academic journals in the areas of change management as well as the use and application of Grounded Theory as a qualitative research methodology. He has also presented at numerous international and domestic academic and industry conferences.

This paper provides an assessment of existing change management models in the nonprofit disability services sector, incorporating service provision in mental health and disability employment, whilst presenting a framework to guide future change initiatives in such organisations.

The study evaluates existing change programs within the nonprofit disability services sector resulting from the implementation of the National Disability Insurance Scheme. The study identifies a framework for future change management initiatives in this sector identifying what makes for success in the context of such organisations that are responding to changing markets, clients, stakeholders and community expectations.

The paper suggests that successful development and application of a new program design and service delivery model that replaces long-standing perceptions and practices within nonprofit disability service providers, may be enhanced by change management practices that deal with four aspects of change enablers within these organisations. These are (1) structured communication frameworks that connect the organisation with those external agencies supervising government policy implementation; (2) developing strong emotional support mechanisms within service providers; (3) adapting sector-specific organisational change management approaches that match with organisational attributes, and (4) creating detailed nonprofit change frameworks that recognise the complex adaptive systems implications of generational change initiatives.

Learning Objectives

Learning Objective (1): Attendees will gain an appreciation as to how major government policy initiatives can best be implemented within their nonprofit organisations.

Learning Objective (2): The presentation reflects research undertaken within nonprofit organisations that deliver mental health-related services. As generational change of the breadth and depth of the NDIS impacts the long-term sustainability of a large number of mental health service providers, understanding how organisational change can be successfully implemented, is an important issue for attendees to understand.

References

YOU SAID IT, WE LISTENED AND NOW WE'RE ACTING ON IT: Consumers and Carers Influencing Policy in Older People's Mental Health.

Kate Middleton, Sharyn McGee

1 NSW Ministry of Health, North Sydney, Australia

Biography:
Kate Middleton is a Senior Policy Officer, Older People’s Mental Health Policy Unit, NSW Ministry of Health. Key achievements include the NSW Service Plan for Older People’s Mental Health Services 2017-2027. Previous roles include statewide policy roles in medical education and workforce, and district roles in quality and service planning.

Sharyn McGee is a consumer who advocates for people with lived experience of mental distress. She was the consumer consultant for the NSW Service Plan for Older People’s Mental Health Services 2017-2027. Other activities include Board Director, WayAhead Mental Health Association NSW; peer educator; volunteer community educator and consumer consultant.

Consumers and carers have a right to be involved at all levels of mental health service delivery and policy development. This was an important consideration in the development of the 'NSW Service Plan for Older People’s Mental Health (OPMH) Services 2017-2027'. The Service Plan was driven by and responds to the needs of consumers and carers.

An inclusive and collaborative approach was followed, involving consumer representation on the project team and upfront consultation workshops with consumers, carers and their peak organisations. This proved to be an effective way of engaging with and understanding the needs of consumers and carers. In general, we found that people highly value the work of clinicians in NSW OPMH service but also identified areas for improvement and key inconsistencies in the delivery of care by services. Much of what consumers and carers want correlates with state and national policy directions and best-practice.

This presentation will explore the key findings of consumer and carer consultation and discuss how they influenced the NSW OPMH Service Plan. The Service Plan provides strategic guidance for OPMH services over the next 10 years, including key strategic priorities for the development, delivery and improvement of inpatient and community services.

Learning Objectives

Learning Objective (1): Participants will gain an understanding of the principles and practice of consumer and carer engagement and how this has influenced statewide policy directions in OPMH services.

Learning Objective (2): This presentation aims to inform policy, planning and service development in older people’s mental health services.

References


Spectrum Intersections - A personal look into Autism Spectrum Disorder in Diverse Gender and Sexuality and its impact on mental health recovery.

Mellem Rose

Spectrum Intersections - The Rainbow Neurodiverse Group, Melbourne, Australia

Biography:
Mx Mellem Rose is the Secretary of Bi-Alliance Victoria, Committee Member of Transgender Victoria, and Education Coordinator of Melbourne Bisexual Network. Mellem’s passion for community advocacy and activism in Intersectionality specifically disability, neurodiversity, and mental illness spurred them to create Spectrum Intersections the LGBTIQA+ Neurodiverse Group.

Autism is a subject which seems to be discussed more frequently in media, communities, and homes around the world, if not equally to stories involving LGBTIQA+. More studies show increasing numbers of people who are on the Autism Spectrum have diverse gender expressions and sexualities.

The aim of this presentation is to educate and provide opportunity for insight and introspection through lived experience and community connection on the importance of self identity and diagnosis in mental health recovery.

My personal story as a Non-binary, Bi/Pan and Autistic person navigating a monosexual, binary, neurotypical world has been challenging and exciting, let me take you on a journey which is multifaceted yet interconnected in its themes.

Discussion topics include
How gender stereotypes have and continue to hinder accurate diagnosis of ASD in female assigned at birth people and anyone who does not fit the gender binary
How Socio-economic status impacts support availability for people with disabilities and LGBTIQA+
How body image and body dysmorphia further impact higher sensitivities and intolerances to food
The increased risks of addictions and boundaries to successful recovery
The impact limited and misinformed education has on mental health recovery in ASD and LGBTIQA+ mental health support spaces.

Learning Objectives
Learning Objective (1): People in the audience will learn how access to accurate diagnosis is essential in recovery settings, what the current barriers are faced by adults in accessing appropriate treatment, and the benefits of understanding intersectionality when working with LGBTIQA+ and neurodiverse people. Also how validation of self identity and understanding of cultural influences can improve the lives and mental health outcomes of LGBTIQA+ people.

Learning Objective (2): These issues are relevant to mental health services and mental health issues in that many LGBTIQA+ and Neurodiverse People have significantly higher poorer mental health outcomes. The lack of understanding and specialist services that work within this intersectionality has and continues to impact the lives and recovery outcomes of these people.

References

Moreno, A; Laoch, A, & Zasler, ND (2017), Changing the culture of neurodisability through language and sensitivity of providers: Creating a safe place for LGBTQIA+ people

Halladay, AK; Bishop, S; Constantino, JN; Daniels, AM; Koenig, K; Palmer, K; Messinger, D; Pelphrey, K; Sanders, S; Singer, AT; Taylor, JL; and Szatmari, P (2015) Sex and gender differences in autism spectrum disorder: summarizing evidence gaps and identifying emerging areas of priority
Implementing Reform: What Works and What Doesn’t?

Geoffrey Smith¹
¹Office Of The Chief Psychiatrist, Perth, Australia

Biography:
Geoffrey Smith is a Psychiatrist with extensive experience as a clinician and senior executive in health. Currently Senior Psychiatrist, Research, WA Office of the Chief Psychiatrist. Special interests include person-centred care and implementation science. He has an appointment as Associate Professor in the School of Psychiatry, University of WA.

The challenges of implementing clinical practice change at the organisational level are well documented. Many of the standard approaches such as clinical practice guidelines, policy directives and training have had limited impact on collective behaviour change.

Evidence suggests that the implementation ‘gap’ can be attributed largely to two critical factors: a view of organizational culture that does not adequately reflect its complexity and diversity and a limited understanding of what motivates individuals and groups to change their practices.

This presentation will provide a brief analysis of selected studies from a literature review highlighting strategies that have been used in the implementation of practice change, focusing particularly on their effectiveness and the lessons that can be learned from them. It will then look at implementation through the ‘lens’ of a motivational theory with the aim of providing a potential explanatory mechanism for understanding the success or failure of various approaches.

We argue that what is critical is not the ‘what’ - the individual strategy or group of strategies or the implementation framework, but rather the ‘how’ – the creation of an autonomy-supportive workplace environment that fosters staff engagement. This presentation describes a practical approach to supporting effective clinical practice reform.

Learning Objectives

Learning Objective (1): Gain an overview of the spectrum of implementation strategies that have been utilised and their strengths and limitations.
Learning Objective (2): Gain an understanding of how the application of motivational theory can further our thinking and practice in organisational change.

References


Whose story is it? Mental health consumer and carer perspectives on ethics in research.

Alyssa R Morse¹, Owen Forbes¹, Bethany A Jones¹, Amelia Gulliver¹, Michelle Banfield¹
¹ACACIA: The ACT Mental Health Consumer and Carer Research Unit, Centre for Mental Health Research, Research School of Population Health, The Australian National University, Canberra, Australia

Biography:
Alyssa is a Research Officer at ACACIA: The ACT Consumer and Carer Mental Health Research Unit, where she contributes to research projects relevant to and for the benefit of ACT mental health consumers and carers. Alyssa is also a PhD Scholar at the John Curtin School of Medical Research, ANU.

The perspectives of people with a lived experience of mental health issues are a vital part of progressive mental health research. These views are critical to ensuring research is relevant to consumer and carer-identified areas and conducted according their needs. Clear ethical guidelines governing the inclusion of consumers in mental health research exist, but there are no equivalent guidelines for carers or consumer-carer relationships. This study investigated mental health consumer, carer, and researcher perspectives on the ethics of consumer and carer participation in mental health research. It comprised three interlinked stages: (1) a survey of international researchers, (2) a discussion forum with consumers, carers and lived-experience researchers, and (3) in-depth interviews with consumers and carers. Data collection and analysis drew strongly on methodological features of grounded theory. Ownership of story, privacy and confidentiality were key issues raised in relation to carer participation in research and the telling of shared stories in a research context. Risks and conflicts arising from these issues may be resolved through communication between researchers and participants, and within relationships. Recommendations for research practice include: considering boundaries of story ownership, managing the impact of information sharing on relationships, implementing ethical safeguards with respect, and maintaining participant autonomy.

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation? Audience members will gain an understanding of the ethical challenges of conducting research involving mental health carers and consumer-carer relationships. They will learn practical recommendations for addressing these challenges, directly developed from the suggestions and experiences of mental health consumers and carers.

Learning Objective (2). How is this topic/issue relevant to mental health services and mental health issues? The findings from this study can inform future mental health research in this field. The ethical challenges and risk management strategies that were identified by consumers and carers can be used to facilitate safe and respectful research practice. These findings are particularly relevant to research involving carers and consumer-carer relationships but can also be applied to mental health research more broadly.

References

The results of this study are currently unpublished.
Media Guidelines for Reporting Drug and Alcohol Issues

Marc Bryant¹, Sarah Bartlett¹, Brydie Jameson¹, Clare Jones¹
¹Everymind, Newcastle, Australia

Biography:
Marc is the Program Manager for Everymind’s Suicide Prevention team. He is a qualified journalist and communication professional, having completed the National Council for the Training Journalists pre-entry course (UK) and a Bachelor of Communication (Honours). He has 11 years’ experience working in the mental health sector.

Sara is Project Lead at Everymind and she holds a Bachelor of Social Science (Honours). At Everymind, Sara has been involved in various project areas including the development of a framework for the promotion of mental health and, the prevention of mental ill-health, and child and youth mental health.

Brydie is a Senior Project Officer at Everymind and is involved in the delivery of Mindframe. She holds a Masters of Public Health and a Bachelor of Health Sciences. She has work in the areas of child protection, sexual health, mental health and has spent time with the United Nations Secretariat.

There is a common comorbidity between mental ill-health and substance use. Misuse of alcohol and illicit drugs is identified as a major and complex health problem in Australia contributing to death, illness, disease and injury, violence, crime, community safety issues and financial burden on the community. The prevalence of these concerns, comorbidity and complex interactions between them, highlights the need for the mental health sector to broaden and enhance its work in this space.

Research shows that psychosocial factors such as stigma and substance use may contribute to depression and that depression has the potential to predispose people to poverty, isolation and substance abuse.¹

The media has an important role to play in shaping and reinforcing social attitudes towards, and perceptions of mental illness in mass communications.

Since 2002, Mindframe, implemented by Everymind, has been providing comprehensive national guidance and education on the responsible, accurate and sensitive portrayal of mental illness and suicide in mass communications.

In 2017, Everymind was commissioned by the Commonwealth Department of Health to develop evidence-based guidelines for the reporting on drug and alcohol issues in Australia. The methodology used to develop the guidelines is same as the original Mindframe guidelines for the reporting of mental illness and suicide in mass communications.

The aim of the new guidelines is to positively influence the quality of reporting on drug and alcohol issues in the media, (including emerging drugs such as crystal methamphetamine) to improve community attitudes towards people experiencing drug and alcohol issues, to remove potential barriers for recovery and to increase help-seeking behaviour by people experiencing such problems.

The Mindframe project team at Everymind in partnership with the University of Newcastle (UoN) have completed a literature review, conducted sector consultations and carried out a survey to examine the perceptions of media representations of alcohol and other drugs by the Australian community.

This presentation will discuss and demonstrate the findings of the evidence collated from sector consultations, literature review and survey results that inform the Mindframe drug and alcohol guidelines. It will also discuss
Mindframe’s methodology to achieve behaviour change when working with the media and other communicators to ensure safe and accurate messaging regarding health issues. A number of case studies will be used to introduce the guidelines and demonstrate how they can be used, in context, to prevent harm, reduce stigma and promote help-seeking.

**Learning Objectives**

Learning Objective (1): Understanding of the comorbidity between mental illness, alcohol and drug use; and the potential of media to improve community attitudes towards people experiencing drug and alcohol issues and in turn remove potential barriers for recovery and increase help-seeking behaviour by people experiencing such problems.

Learning Objective (2): Understand that a comorbidity between mental health issues and drug and alcohol use is common and hence an important area to understand and address in mental health services to prevent ‘whispers becoming roars’.

**References**


'Living Well at PARC' - Linking Physical Health and Recovery at a Step-Up/Step-Down Residential Mental Health Service.

**Chris Murphy**¹², **Louise Radywonik**¹²

¹Mind Australia, Heidelberg Heights, Australia, ²Austin Health, Heidelberg, Australia

**Biography:**

Chris Murphy - Chris is the Mind Australia Service Manager at Austin PARC, and has worked in the community sector in the areas of mental health, justice, and disability over the past 10 years.

Louise Radywonik - Louise is the Team Leader at Austin PARC. She has worked at Mind Australia for 7 years in a variety of roles including both youth and adult residential services. Louise has an academic background in psychology and enjoys working under the recovery framework.

Living Well at PARC is an innovative project developed by Mind Australia and Austin Health. It has been implemented at the Austin Prevention and Recovery Care (PARC) service in Melbourne’s North-East to improve the physical health and wellbeing of residents. Living Well promotes three key domains – Good Food; Active Body/Active Mind; and Restful Sleep – as directly linked to positive mental health outcomes, and embeds these in all admissions to the service. Elements include meal planning and preparation, psychosocial education through groups, access to relevant resources and activities, and distribution of ’Healthy PARC Packs’ to all residents.

PARC services utilise a ‘step up/step down’ model of care, providing sub-acute mental health support and treatment for a period of between 2 and 4 weeks. With PARCs now operating throughout Victoria, implementation of a holistic, evidenced-based approach to the promotion of good physical health can potentially lead to systemic change and a large-scale improvement of physical health for individuals with a mental health diagnosis. Living Well at PARC has made a positive impact at Austin PARC, and is now being rolled out at other PARC services in Victoria.

**Learning Objectives**

Learning Objective (1): The audience will gain an understanding of an innovative approach to synthesizing physical health and recovery goals in a short-term residential setting.

Learning Objective (2): This topic is relevant as it has the potential to lead to systemic change. Living Well at PARC can be implemented across similar services, and has been developed in response to recognition of the relatively poor physical health of people living with a mental illness.

**References**


Gender Diversity Assessment and Consultation Clinical Psychologist Service in WA Youth Mental Health

Nicole Albrecht¹
¹Youth Mental Health, NMHS, Perth, Australia

Biography:
Dr Nicole Albrecht is a Senior Clinical Psychologist within Youth Mental Health in WA. Dr Albrecht obtained her Doctor of Psychology (Clinical) at UWA in 2013. She has since worked in Perth and the USA and has a particular passion for the provision of mental health care to the LGBTQI community.

Transgender and gender diverse youth across Australia are at elevated risk of suicide, self-harm, homelessness, and other mental health and psychosocial difficulties (Strauss et al., 2017). Negative experiences with medical and mental health services contribute to experiences of discrimination and poor mental health outcomes in this group of young people (Strauss et al., 2017; Riggs et al., 2014). The development of a new Gender Diversity Assessment and Consultation Clinical Psychologist service within WA Youth Mental Health is an example of innovation in service provision and a new pathway to care for gender diverse youth in WA. This state-wide service is open to gender diverse young people aged 17-24 years old who are seeking specialist assessment for gender affirming medical interventions (i.e. hormones and/or surgery) and who may also present with complex co-occurring issues or are unable to access these specialist services elsewhere. The service also provides specialist consultation, training, community development, and referral information related to supporting gender diverse youth. The creation of this service aims to increase access to quality gender affirming care and increase capacity within existing services to improve the mental, social and physical health outcomes for gender diverse young people in Western Australia.

Learning Objectives

Learning Objective (1): Gain increased understanding of innovative service development aimed at increasing capacity within the public health system to meet the needs of gender diverse youth.

Learning Objective (2): Negative experiences with medical and mental health care services increases risk and mental health concerns in gender diverse youth. Discussion of this model of care will assist in the consideration of expansion and creation of services to meet the needs of gender diverse young people in Australia.

References


The Capacity Trap: Casual ableism in the psychosocial disability discourse and how to address it.

Terri Warner

ACT Mental Health Consumer Network, Canberra, Australia

Biography:
Terri Warner is a mental health educator and advocate. She uses lived experience to bring about positive change in health services and improve community understanding about mental illness through community education, the delivery of peer-facilitated programs and systemic advocacy. She is the Chair of the ACT Mental Health Consumer Network.

The term ‘psychosocial disability’ is internationally recognised under the United Nations Convention on the Rights of Persons with Disabilities, however it is still a nebulous concept that is not well understood outside of disability and mental health services. This makes it difficult for people to understand the challenges faced by those who experience psychosocial disability, which limits their ability to participate fully in society.

Tied to the concept of ableism in psychosocial disability is the stigma that still exists surrounding mental health conditions. This stigma creates a negative perception that, however unconsciously, feeds ableist narratives in society as well as in mental health and disability services. This impacts people’s day to day lives and can have profound consequences for their ongoing wellness and their ability to lead productive and contributing lives. This is particularly true in the context of the National Disability Insurance Scheme, which questions people’s claims to both ability and disability.

This workshop will explore the concepts of ableism and stigma in a modern, mental health context, using activities, personal stories and theory. It will describe how ableism compromises person centred care and client-directedness. Participants will gain an understanding of what casual ableism is, how it is harmful and how to call it out, as well as learning about the systemic and structural ableism that underpins mental health and disability services and makes it harder for people with psychosocial disability to live the lives they choose to. The workshop will also explore the impact of ableism on a service’s ability to implement trauma informed care.

The workshop will also ask the question of whether the current discourse about stigma, underpinned as it is by Goffman’s work which is now dated and exclusionary, is helpful or harmful, and will explore new frameworks for research into psychosocial disability in the social sciences.

Learning Objectives

Learning Objective (1): Participants will learn what ableism is in a mental health and psychosocial disability context, and how to identify and combat it.

Learning Objective (2): Participants will gain skills and knowledge that will assist them to work with people with psychosocial disability in a way that supports them towards having the best possible health outcomes and to participate socially and economically.

References


Partnering with Mental Health Carers: Changing practice, improving outcomes.

Christine Kaine1, Sarah Pollock2, Patrick Hardwick3, Sharon Lawn4, Jenny Branton5

1Private Mental Health Consumer Carer Network (Australia) Ltd, Adelaide, Australia, 2Mind Australia, Heidelberg, Australia, 3HelpingMinds, , Australia, 4Flinders University, , Australia, 5Mental Health Carers Australia, Heidelberg, Australia

Biography:
Christine Kaine is a qualified Social Worker with experience working in rural South Australian mental health services. Recently, Christine has undertaken project work to develop resources, a Borderline Personality Disorder Support Service website for SA, a free online library to support mental health workers engage with families and carers and development of videos and e-learning for mental health practitioners.

Sarah Pollock has worked at the executive level in social care and mental health sectors for over ten years. She has also held leadership roles in the vocational and higher education sectors, and has substantial experience in teaching and curriculum development. Sarah brings together strengths in research and evaluation, policy analysis and strategy development.

Patrick Hardwick has been a carer advocate for many years. He is the Chair of HelpingMinds, President of Mental Health Carers Australia and Deputy Chair of the Private Mental Health Consumer Carer Network (Australia). He has been a member of many National Reference Groups, Steering Committees and Working Parties in the mental health sector.

Professor Sharon Lawn is highly active in mental health movement in Australia and brings multi-disciplinary skills and experience from being a health clinician for more than 23 years. Her research uses a broad range of qualitative and mixed methods, and focuses on examining the culture of service provision, systems of care, implementation, and service users experiences of care.

Jenny Branton brings extensive management experience in the not for profit and local government sectors, wide ranging experience in the disability sector including lived experience as a carer. Jenny is currently the Executive Officer of Mental Health Carers Australia.

In any given year, almost 2.5 million people care for a person with mental illness in Australia.

A Practical Guide for Working with Carers of People with a Mental Illness is a hands on, standards based tool designed to help mental health services engage more effectively with family and carers, comply with legislative and accreditation obligations and improve recovery for consumers and carers. The Guide, available as a free download, is founded on the UK Carers Trust Triangle of Care model.

The Guide is based on six partnership standards that can be applied across all settings and incorporate age related, cultural and other needs. Each Partnership Standard is accompanied by an easy-to-use self-assessment tool and practical examples and suggestions about how to implement each.

The Guide recognises carers are a crucial component of any partnership approach to service delivery. It has been developed to assist staff across service settings in recognition and support of carers, to enable them to continue in their role as partners in recovery.

The Guide aims to enhance the capacity of mental health providers to meet the increasing number of standards which guide mental health delivery. The Guide assists in streamlining and supporting service providers to meet their obligations under the National Standards for Mental Health Services.

This symposium aims to support service providers, policy makers, consumers and carers by improving outcomes for mental health consumers through collaboration of the knowledge and skills of staff with the knowledge and lived
experience of families and other carers in a partnership approach to service delivery. It is relevant for key stakeholders internationally as a way forward in more effective engagement with carers and is relevant to mental health and broader health contexts.

Since the publication of the Guide in 2016, there have been a number of projects to develop practical resources to supporting Guide implementation. These include: an online library with free resources to support service providers engage with families and carers; online professional development modules; a real-time, self-assessment App and a series of demonstration projects, trialling the use of the Guide in different mental health service settings. These resources will be of significant assistance to service providers in both public and private settings and as clinical leads in mental health.

The Guide recognises carers are a crucial component of any partnership approach to service delivery. It, and the supporting implementation resources, have been developed to assist service providers working in mental health service settings to work more effectively with carers, thus enhancing outcomes for consumers.

This Symposium will provide:
- an overview of the Guide including underpinning research, partnership standards, self-assessment tools and action plans
- practical resources developed to support service providers to effectively engage carers in mental health settings including an online library for service providers, e-learning modules and a self-assessment App;
- interactive discussions providing opportunities to delve into and explore the Guide; and
- reports on outcomes of demonstration projects undertaken in Australia to assess implementation of the Guide.

Learning Objectives

Learning Objective (1): Learning objectives include an increased awareness of the benefits and need to involve carers in mental health service provision; practical tools and learning from demonstration projects to support implementation of the Guide and engagement with families and carers in mental health settings.

Learning Objective (2): This symposium provides a framework for partnership working that enables mental health services to meet their compliance obligations under national quality standards, and enables psychiatrists, clinicians and service providers to establish effective working relationships with families and carers as partners in mental health care, improving outcomes for consumers.

References


Mottaghipour, Y and Bickerton, A 2005 ‘The Pyramid of Family Care: A framework for family involvement with adult mental health services’, Australian e-Journal for the Advancement of Mental Health, 4(3)
Creative Approaches: Understanding the experience of the disconnect between Body and Mind in FND/CD.

Katherine Gill
FND Hope Australia, Sydney, Australia

Biography:
Kate established FNDHope Australia in April 17, because of her personal experiences of FND. She is President of FNDHopeAustralia and has been active in advocacy and raising awareness of FND/CD across Australia. Kate is also Chair of the Consumer Led Research Network and takes a lived experience approach in her research.

Functional Neurological Disorder [FND], also known as Conversion Disorder [CD] is a prevalent, yet poorly understood disorder [1]. FND/CD is classified as a mental illness [DSMV] yet patients are disabled by physical symptoms including paralysis, abnormal and involuntary movements, and sensory issues. The voice of lived experience is lacking within FND/CD research. This study used a peer led; art based qualitative methodological process [2] to understand the experience of FND/CD. Participants were recruited through FNDHope Australia.

Participants were invited to submit a piece of art that represented their experience of FND/CD. They were then interviewed to discuss their personal journey and how the art depicted their recovery or experience or illness. This paper discusses the poignant and powerful images of the internal and external battles of FND/CD. The art depicts the person’s internal thoughts and feelings; the barriers people faced in access to services; and the significant impact of stigma and societies misunderstanding of their illness, along with hope, resilience and ‘persistence of spirit’.

By understanding the lived experience of FND/CD, services can be tailored to meet the needs of people with FND/CD; reducing the economic cost of the illness; improving quality of life and well-being for those who suffer from FND/CD.

Learning Objectives

Learning Objective (1): The audience will gain insight into the experience of life with FND/CD through the use of powerful images that captures experience of recovery and illness. The audience will be better equipped to meet the needs of people with this disorder.

Learning Objective (2): There is a dearth of tailored services to meet the needs of people with FND/CD and the illness is poorly understood across Australia. FND/CD falls through the gaps between physical and mental health care. By understanding the experience of the illness, services can be tailored to meet the needs of people with FND/CD.

References

Co-designing service improvements with staff, service users and carers.

Donna Turner¹, Debbie Childs¹
¹HelpingMinds, Perth, Australia

Biography:
Donna is a sociologist with ten years experience as a systemic advocate for family members and friends who provide ongoing care and support to someone close to them living with a disability of any kind.

Debbie is the CEO of HelpingMinds, a mental health service, who also has lived experience as a mental health carer. She has been a key collaborator in the development of A Practical Guide to Working with Carers of People with A Mental Illness, a co-designed resource to enhance communication between staff and carers in mental health services.

In WA, the Mental Health Act 2014 requires an increased focus on identifying a patient’s supporters, including family members and friends in a caring role, and including them in treatment, support and discharge planning. However, this remains challenging for many reasons that have been identified by researchers, staff, patients and carers. In 2017, four mental health inpatient sites in Perth participated in a trial of the Practical Guide for Working with Carers of People with a Mental Illness. Our presentation describes the key factors identified as vital to supporting cultural change and service redesign within these services; the barriers to carer engagement as identified by staff and carers; and the resources developed in response. We summarise our learnings from this first implementation trial and describe how we built these learnings into a second stage trial involving an additional four sites providing community based mental health services. Lastly, using a checklist completed by staff at all sites, we show the before and after results to analyse the effectiveness of the Practical Guide in supporting cultural change and practice change within mental health services.

Learning Objectives

Learning Objective (1): We believe cultural change is an essential driver of service improvements. We will share the factors identified as vital to driving cultural change in mental health services in our project which include a co-design approach, external clinical peer workers and the active involvement of advice of lived experience advisors, both carers and consumers.

Learning Objective (2): Many staff within mental health services would like to see changes that would deliver more client centred and family centred practice. Guidelines for best practice in mental health services now require person and family centred planning. Mental health services and practice are shaped by decades of culture which has prioritised clinical knowledge over the lived experience and preferences of consumers and carers. Our project valued all forms of knowledge in identifying challenges to service delivery, and in implementing solutions.

References

Cree et al. 2015. Carers’ experiences of involvement in care planning: a qualitative exploration of the facilitators and barriers to engagement with mental health services. BMC Psychiatry, 15:208
My Life as an Ex-Hoarder.

**Biography:**
Judith became an advocate in the mental health system over twenty years ago when her two daughters were diagnosed with Obsessive Compulsive Disorder. Working as a trained nurse enabled her to use the acquired skills of knowledge, awareness, empathy, to advance her drive to reduce stigma and bring about change.

Shopping, collecting and hoarding became a huge part of the presenter’s life whilst dealing with Obsessive Compulsive Disorder, also her husband’s and her two daughters’ OCD. Mental illness dominated her life, as the burden of the person in the middle made her strong.

The collected materials filled her house with “stuff” representing only the best of memories to be firmly held on to. They also filled a vacuum caused by not having emotional needs met. Family breakdown was evident as negative and excessive behaviours, difficult to control, arose and affected each member.

A “light bulb” moment was the essential element which then led help to be sought. The result from interventions of therapy provided the presenter with the very necessary change of attitude and way of living to overcome daily challenges.

Change brought out previous skills and practices gained in Mental Health and Aged Care Advocacy whilst working as a registered nurse. Politician were made aware of the injustices evident in their governance especially minority groups ignored for decade as they do not exhibit enough as worthy of priority and also cost too much money.

These areas of concern consume this consumer.

**Learning Objectives**

Learning Objective (1): The audience will gain an understanding of the reasons, difficulties and issues attached to hoarding experienced by the presenter being overwhelmed with excessive materialism. Uncontrolled collecting led to a thirty year journey where the recovery process maybe almost as long. The presenter will emphasise how time consuming the journey of advocacy has been and yet has given the presenter the benefit of progress, by turning negative experiences into valuable ones to be shared with peers, health workers in the field, families, friends and affected neighbours.

Learning Objective (2): The presentation will highlight the need for acknowledgement the interventions of peer support, the use of television, radio, newspaper and webinars were used to inspire others to bring about change that can address the need to reduce negative effects on self and others. The lived experience shared with health professionals is vital to expand their ability to work with hoarders and gain a positive outcome.
Access for Learning: Innovation in Therapeutic Pedagogy

John Maratos¹, Melanie Cooke¹
¹DECD, Adelaide, Australia

Biography:
John Maratos is statewide Manager, Learning & Behaviour which consists of three service groups that provide restorative educational services for students with social, emotional, behavioural, health and mental health needs. He has led the re-development of these services including the initiation of a teacher-directed mental health service.

Mel Cooke is the Deputy Principal of Hospital School SA for students with Mental Health needs. With an extensive background in Special Education and mental health Mel developed the Access for Learning Program in 2016 as an early intervention program for students with trauma background and subsequent mental health needs.

Access for Learning is a unique mental health service developed by teachers in South Australia. The service provides early intervention assistance for students in Foundation to Year 7, with diagnosed mental illness. Access for Learning uses interagency collaboration, wraparound and a practice model designed to assist teachers to meet the mental health needs of their students.

By aligning selected evidence-based strategies and skills, Access for Learning’s model shows that teachers, without therapeutic or clinical expertise, can teach children and young people how to manage safely and productively their emotions and relationships. This leads to direct and sometimes foundational support for the students’ mental health, often a product of underlying developmental trauma. It also assists the development of primary relationships that, where necessary, can be leveraged for developing the clinical relationships that are needed to assist repair and recovery.

Learning Objectives

Learning Objective (1): A viable therapeutic pedagogy makes it feasible to extend to the daily practice of teachers and schools the shared responsibility for assisting children and young people with mental illness.

Learning Objective (2): Education is a legislatively mandated service that requires government schools in particular to be inclusive of all students, including those with mental illness for whom a therapeutic pedagogy that supports their learning will be a significant protective factor.

References


Choice and Control in Relation to the NDIS

Anthony Stratford
1Mind Australia Limited, Heidelberg, Australia

Biography:
Anthony is the Senior Advisor Lived Experience at Mind Australia. He also is a Visiting Scholar at Yale University School of Medicine and an Expert Advisor to WHO Geneva. He is an honorary Fellow in the Department of Psychiatry, University of Melbourne and Chair of the Advisory Council MHCC.

Mind Australia along with Deakin University and The University of Melbourne is looking at how people with psychosocial disability make choices in the context of the NDIS. The Mind team have heard through interviews conducted in the trial sites that figuring out what supports and services people want from the NDIS can be a difficult and confusing experience. They have also heard that when people are able to make the kinds of choices they want, it can be an empowering and life-changing experience. It was important to give people the opportunity to help demystify the process by sharing their experience of making choices under the scheme. The input of those participants interviewed will contribute to a better understanding of how we can help people to exercise 'choice and control', and enable them to get the most they possibly can out of the NDIS.

With this knowledge and insight, it is hoped that we can then contribute to skill development strategies to help people with psychosocial disability and those who support them maximise their participation in the NDIS. We hope to give guidance to practitioners - in particular planners in the Local Area Co-ordination programme - on how to support choice-making that enables people to lead the lives that they want and that they choose.

Learning Objectives

Learning Objective (1): People will understand the major challenges that many people who have a plan are facing
Learning Objective (2): The research results will assist participants, their family and carers to get the most out of the scheme while educating planners as well.

References


Reclaiming the research agenda for peer work

Alicia King, Hamilton Kennedy, Leah McKenner

Orygen Youth Health, Newport, Australia

Biography:
Alicia King has worked as an occupational therapist in mental health since 2002. Her passion for consumer rights led her to further studies in community development, and coordinating the youth participation program at Orygen Youth Health. Through her work she hopes to be a supportive ally to the peer workforce.

Leah McKenner had her first encounter of mental health services at the age of 14. Through her own experiences and current role as a peer worker, Leah has grown passionate about consumer rights; working alongside individuals to see services improve and working to see alternative forms of support become available.

Hamilton Kennedy has been a consumer of mental health services for the past decade. They are currently a peer worker as part of the Victorian Expanding Post Discharge Support initiative. Hamilton also works in consumer research and consultancy and has a strong interest in ensuring that research and policy accurately caters to the needs of consumers.

NB. We note the maximum number of presenters for a 20 minute paper is 2, and will select one of the two latter authors to co-present, should the paper be accepted. If there can be any exception made, please let us know.

Background:
The current expansion of peer work programs in clinical mental health services in Australia represents both an opportunity and threat to the aims consumer movement. To date, lack of attention to peer work principles and aims in clinical research, has limited the translation of findings to policy and practice.

Aims:
1. This presentation will report the results of a systematic review and content analysis of 37 controlled trials of peer work, published since 1995, which found:
   - variation in quality of descriptions of the services peers delivered and outcomes measured;
   - outcomes measures were limited to measures of individual clinical improvement and recovery rather than systemic impacts (eg. recovery orientation); and
   - significant differences in patient activation, self-efficacy, empowerment, and hope, as a result of peer work.

2. Drawing on their experiences of delivering peer work in a clinical setting, and recognised peer work principles, presenters will expand on guidelines for peer program design and evaluation.

Conclusions:
The privileging of clinical paradigms in peer work research represents a challenge for peer workers, and their allies, who wish to harness the unique value of peer work for individual and systemic change.

Learning Objectives

Learning Objective (1): Audience members will gain an understanding of the tension between lived experience and clinical perspectives reflected in the peer work literature to date.

Learning Objective (2): In order to fulfil the promise peer work offers in creating recovery oriented mental health services, policy makers, services and researchers need to be aware of the privileging of “expert” above “experiential” knowledge in the design and evaluation of peer programs.

References

King, A. J. & Simmons, M. (under review). A systematic review of the key attributes and outcomes of face to face peer work and the development of guidelines for reporting studies of peer interventions. Psychiatric Services
Central Coast Older Persons Peer Worker Project

Raichel Green
\(^1\)

\(^1\)Central Coast Local Health District, Gosford, Australia

**Biography:**
Raichel is currently the Service Manager for Central Coast Specialist Mental Health Services for Older Persons. She is the manager for the Older Persons Peer Worker Program. Raichel has a Degree and Masters in Social Work and a Graduate Diploma in Older Persons Psychiatry. Raichel has worked in mental health services for the past 23 years in a variety of clinical roles and settings and has a passion for integrating peer work into mental health services.

**Aim:** The aim of the paper is to describe the Central Coast Older Persons Peer Worker Model, to outline the process of the models development and describe the outcomes and successes of the program including challenges experienced in the development of the model and its implementation.

**Background:** Central Coast SMHSOP received a grant to design, implement and evaluate an older person’s peer worker program for consumers. To the best of our knowledge, there are no existing peer work models for older people with mental illness.

**Methodology:** The evaluation used an action research design to gain insight into the success and effectiveness of the model from the perspective of stakeholders, in particular peer workers, consumers and clinicians. A range of methods were used, in particular: focus groups and individual interviews with peer workers; consumer surveys; focus groups; field notes; and examination of project documentation.

**Results and Discussion:** Peer work provides a valuable contribution to the recovery of older people. Some of the barriers to implementing peer work models in mental health settings identified in the literature, such as resistance from clinical staff as well as from peer workers themselves are less prominent for the older population. The project experienced a range of staff barriers to implementation, which were mitigated by engaging clinical staff in the development of the model, and the provision of staff training around the purpose of peer work.

**Learning Objectives**

Learning Objective (1): Develop an understanding of how to develop a peer worker model specific to the recovery needs of the older consumer.

Learning Objective (2): Understand the challenges in implementing such a model within a public mental health setting.
Hear the whisper... many people who seek help during a stressful life situation have underlying mental health symptoms that are not recognised or treated.

Julie Rowse

*Healthy Mind And Soul, Ballarat, Australia*

**Biography:**
Dr Julie Rowse is a mental health occupational therapist with 20 years experience across public and private sectors. Julie owns the private practice, Healthy Mind and Soul, and is passionate about assisting people to attain positive mental health so they can live life to the full.

Despite mental health information becoming much more available, people are still not recognising when they have mental health symptoms. People present to services with concerns such as marriage problems, workplace challenges, fears due to a recently diagnosed with a health condition, or parenting difficulties. Not being able to identify or articulate an underlying mental health component can impact on people being able to access appropriate mental health treatment. Rather, people may be linked with a marriage counsellor, be sent for workplace training, or see family services around parenting. Unfortunately, if the underlying mental health issues are not treated the other services can prove ineffective.

As a private therapist I have learnt the value in listening for the ‘mental health’ whisper. The client will share what is distressing them and my job is to not only assist with their concerns but also to hear if there is an underlying mental health issues. Treating anxiety is a core function in my work despite referrals being for stress in marriages, workplace stress, managing physical health, and parenting. Provision of evidence-based treatment for anxiety has been effective in achieving results for clients who did not even know it was anxiety that was affecting them.

**Learning Objectives**

Learning Objective (1): Conference participants will take away an appreciation and specific examples of how people with mental health difficulties may present with general life concerns.

Learning Objective (2): This topic is relevant to all mental health services as it is a known long standing challenge to engage people in mental health treatment and not being able to recognise or articulate the mental health symptoms is a barrier to receiving treatment.

**References**


Lance Sutcliffe1

1NSW Health, Northern Sydney Local Health District, Mental Health Drug and Alcohol Service NSLHD MHDA, Sydney, Australia

Biography:
Lance Sutcliffe is a Clinical Nurse Consultant for Complex & Challenging Behaviour and a Qualified Psychotherapist in Private Practice. He works part-time as a CNC at Macquarie Hospital and has been a Mental Health Nurse for 30 years. He has been a practicing Psychotherapist in Private Practice for 8 years.

This presentation describes the implementation of Safewards in a mental health in-patient hospital setting and the outcomes. The Safewards Model, developed in the UK by Nursing Professor Len Bowers contains a schema showing the potential and dynamic sources of conflict and containment in a mental health setting and how the implementation of positive interventions can result in less aggression and a safer environment of in-patient mental health care. The model describes what Bowers calls the 6 Originating Domains that are a source of conflict that can be both triggered and modified by staff and patient/consumer interactions and even by Outside Hospital influences. There are Interventions in the model that, when applied, aim to have a positive effect on behaviour reducing aggression, conflict and containment. The model is readily adaptable to any inter-disciplinary mental health service setting, has a specific technical language that is easily acquired and contains a particular emphasis on a person centred, positive engagement, positive regard and on having a psychological understanding of conflict behaviour. If there is an essence of Safewards it would be distilled as Empowerment through Positive Engagement with the efficacy of Improved Safety and a more Positive Experience of Mental Health Care.

Learning Objectives

Learning Objective (1): From this presentation the audience will learn about Safewards and how it was implemented at a psychiatric in-patient teaching hospital in Sydney NSW along with the results of a 6 month pilot project that introduced Safewards into 3 trial wards where conflict and containment issues were prevalent. The audience will learn how the implementation of Safewards contributes to international research whereby the replication of the original Safewards project and measured outcomes provides further validation of the Safewards method and improves interactions & safety of staff and patients.

Learning Objective (2): The topic of Safewards is relevant to Mental Health Services as it provides an effective overall schema for the dynamic causes of conflict & containment in a mental health setting and how learning Safewards interventions of clinical staff can lead to reduction in conflict & containment, a more positive experience of in-patient care for both staff and consumers and improved safety for all.

References

The Risk of Over Simplification of Suicide in the Mass Media

Sara Bartlett, Marc Bryant, Rebecca Pryor, Mindframe Team

1Everymind, Newcastle, Australia

Biography:
Marc is the Program Manager for Everymind’s Suicide Prevention team. He is a qualified journalist and communication professional, having completed the National Council for the Training Journalists pre-entry course (UK) and a Bachelor of Communication (Honours). He has 11 years’ experience working in the mental health sector.

Sara is Project Lead at Everymind and she holds a Bachelor of Social Science (Honours). At Everymind, Sara has been involved in various project areas including the development of a framework for the promotion of mental health and, the prevention of mental ill-health, and child and youth mental health.

Suicide is a complex and multi-faceted issue that is rarely the result of a single event or factor. It is usually an outcome of an individual experiencing hopelessness about life due to a combination of biological, psychological and environmental factors. It is vital that this is understood when reporting on suicide in mass media communications to mitigate risk to vulnerable audiences (i.e. copycat behaviour).

Communications around suicide that place too much weight on, glorification or sensationalisation of singular factors, such as bullying or depression, may be problematic to those who are experiencing similar life stressors with suicidal thoughts. Furthermore, hyper exposure in the media and memorialisation of those who have taken their own life may highlight suicide as a positive outcome for those who are vulnerable.

Through the application of the evidence-based Mindframe guidelines, this presentation demonstrates how informing key spokespeople and the mental health and suicide prevention sector more broadly, in their engagement with media around the use of safe language, and minimising problematic content can have lasting effects on individuals and communities.

A number of case studies will demonstrate how restricting mention of problematic content, providing context, balancing the story and highlighting help-seeking behaviour can help to protect vulnerable people in the post-vention stage of community loss after suicide.

Learning Objectives
Learning Objective (1): An understanding of the application of the Mindframe guidelines to reduce harm and prevent suicides through safe, sensitive and accurate communications relating to suicide.

Learning Objective (2): Suicide is complex issue, it’s important to support our sector as it engages with media on this topic. Mindframe’s evidence-based guidelines and approaches to communicating on suicide can reduce harm, and potentially save lives through safe, sensitive and accurate communications relating to suicide.

References


The Journey of Flourish – A Pilot Peer Led Program by The Specialist Rehabilitation Service

Lorraine Ingram
1Northern Sydney LHD, Sydney, Australia

Biography:
Lorraine Ingram is a Specialist Rehabilitation Consumer Worker with the Specialist Rehabilitation Service located in Northern Sydney LHD. Lorraine has been heavily involved in the implementation of a peer led programme, Flourish. Lorraine now leads continued service provision in this area.

Flourish is a 12 week, manualised self-development support program utilising the principles of the Collaborative Recovery Model (Oades et al, 2005), and implemented within the context of The Specialist Rehabilitation Service (SRS). The Flourish model emphasises the concepts of autonomy, hope, and individual experience as central to the recovery movement within mental health. Flourish focuses on working collaboratively with participants to self-identify their strengths and values as the basis of forward visioning and goal striving (Oades et al, 2005).

Flourish has been run twice by the SRS during 2016-2017, within two sectors of Northern Sydney Local Health District. This presentation aims to explore the implementation, development and challenges of a peer led recovery orientated group within a traditional clinical mental health service (Australian Government, 2013). Participants of the two groups were encouraged to share their experiences and these reflections will be discussed alongside the experience of the facilitation team. Future directions will also be explored in this presentation to demonstrate the way that consumer workers can further utilise their lived experience and skills for the ongoing development a therapeutic recovery orientated group programs.

Learning Objectives

Learning Objective (1): Participants will walk away with the knowledge of what a peer led program, specifically Flourish, involves and the understanding of what it takes to implement such a program.
Learning Objective (2): This Learning session will allow participants to see how a peer led group can benefit traditional clinical mental health services.

References


Developments and Directions in Older People’s Mental Health Care and Support: The (second) NSW Service Plan for OPMH Services 2017-2027.

Kate Jackson*1
*NSW Ministry of Health, Orange, Australia

Biography:
Kate Jackson is the Director, Older People’s Mental Health (OPMH) Policy in NSW. In this role, Kate has overseen the development and implementation of the first ten-year statewide plan for OPMH services in Australia, and now the development of a new statewide plan. Kate’s previous roles include policy roles in dementia, carers and disability, aged care and mental health. Kate’s formal qualifications include a Bachelor of Arts (Hons) and PhD in History, and a Masters of Public Administration.

In 2005, NSW Health released its first 10-year state-wide plan for older people’s mental health (OPMH) services. Under the plan, OPMH services were further developed as a specialist clinical stream of mental health services, with an agreed target group and service model. The Plan promoted more equitable access to specialist OPMH clinical care, and greater consistency of practice across NSW. This period saw significant expansion and improvement across OPMH community and inpatient services, and development of new mental health-residential aged care partnership services, supported by state-wide, evidence-based models of care.

A new plan has now been released - the NSW Service Plan for OPMH Services 2017-2027. The Plan is informed by consultation with consumers and carers about what they want and need from services. It builds on developments under the last plan. It promotes recovery-oriented practice and progresses key NSW and national policy directions in mental health and aged care. This paper will outline key evidence-based service models and directions under the Plan, in particular: community OPMH clinical services; mental health-residential aged care partnership models for older people with mental illness and/or severe behavioural and psychological symptoms of dementia, and community mental health care and support programs for older people.

Learning Objectives

Learning Objective (1): Participants will gain an understanding of the key challenges and opportunities in older people’s mental health care and support, and how these are addressed in the NSW OPMH Service Plan.

Learning Objective (2): This presentation aims to share NSW OPMH service development experience and evidence-based OPMH service models to inform policy, planning and service development in other states/territories and services.

References

1. NSW Ministry of Health (2017). NSW Older People’s Mental Health Services SERVICE PLAN 2017-2027.
Continuing to Invest in Recovery - The Specialist Rehabilitation Service

Valencia Taljaard\textsuperscript{1}, Aimee Blackam\textsuperscript{1}
\textsuperscript{1}Northern Sydney LHD, Sydney, Australia

Biography:
Valencia Taljaard works as the team leader of the Specialist Rehabilitation Service in Northern Sydney LHD. Valencia is passionate about improving services to better meet the needs of consumers.

The Specialist Rehabilitation Service (SRS), is a small, district based team of clinicians and consumer workers that provide intensive and individualised support aimed at facilitating individual personal recovery (Deegan, 1995) alongside the consumers and clinical teams of NSLHD MHDA services. “Continuing to Invest in Recovery” details the review of the SRS undertaken between 2012-2017 utilising a retrospective, concurrent mixed methods research design undertaken by both a consumer and clinical researcher in order to explore the contribution made by the SRS to both NSLHD MHDA clinical services and the consumers of these services. The research explored the quantitative data of 396 consumers with additional qualitative data collected from 21 consumers across individual and group service streams. Additionally, quantitative and qualitative data was collected from 89 SRS and MHDA staff to explore the multifaceted contribution of the service more broadly. This presentation will summarise the results of this research and its significance to the ongoing implementation, development and evaluation of truly recovery oriented mental health services (COAG, 2013).

Learning Objectives

Learning Objective (1): Participants will learn how the implementation and development of recovery oriented mental health services contributes to consumer outcomes, and in particular is able to contribute to the facilitation of personal recovery

Learning Objective (2): To understand the contribution that services such as the SRS can make to consumers and the health service at a broader level, as well as demonstrating the way that recovery oriented services can exist and thrive in traditional mental health contexts.

References

Australian Government (2013). A national framework for recovery-oriented mental health services: Guide for practitioners and providers. Author; Canberra

An Exploratory Co-produced Study of the Impact of a Strengths Assessment Tool in a Mental Health Acute Unit.

Katherine Gill¹, Libby Waugh²

¹Consumer Led Research Network, Sydney, Australia, ²NSW Health, Sydney, Australia

Biography:
Kate is Chair of the Consumer Led Research Network and is involved in a number of research and evaluation projects where she harnesses both her lived experience and her professional skills and qualifications.

Libby was a Senior Occupational Therapist at various locations in SESLHD’s mental health services at this research’s inception. Retaining her passion for Recovery supporting practices, she is now relishing her Project Officer role in NSLHD MHDA where she can work on District wide projects for service improvement.

South Eastern Sydney Local Health District (SESLHD) partnered with the Consumer Led Research Network (CLRN) to conduct an exploratory evaluation of the usefulness of the Strengths Assessment tool[2] applied in an acute mental health facility. Data collection involved a consumer-led process, whereby consumer researchers conducted a series of focus groups with participants who were inpatients in the acute mental health unit of Sutherland Hospital. Ten people participated across four groups through a technique called Definitional Ceremony, a story telling narrative of peoples’ experiences of the process and impact of the Strengths Assessment. Outcomes highlighted the value of the Strengths approach in supporting hope, inspiration and a vision for the future, with ‘Stepping Stones’ to get there. People felt empowered to take back control of their recovery journey; the tool enabled them to see a future, and draw on their strengths and past experience. The tool enabled participants to rediscover past interests, strengths and experiences to rebuild their self-esteem. It allowed participants to open up, relate to, and support each other on the ward. The Strengths approach was described as a diamond in the rough, an ‘oxymoron’ to the negative and abnormal environment of an acute mental health unit.

Learning Objectives

Learning Objective (1): “What will people in the audience gain or learn from attending this presentation?”
The Audience will gain insight into the practical use and benefits of a Strengths-based approach and assessment tool within an acute inpatient mental health unit.

Learning Objective (2): “How is this topic/issue relevant to mental health services and mental health issues?
Acute inpatient mental health units primarily operate within a deficit focused, biomedical model. This approach and the associated assessment tools are in stark contrast to the strengths based and personalised approach of the Recovery Framework. As organisations move to implement recovery orientated practice as per the National Recovery Framework (2013)[1], new recovery approaches of assessment and intervention need to replace the deficit-based ‘one size fits all’ approach. The Strengths Model has long been established as an evidence-based approach for community mental health teams, however this study is the first to examine its application in an acute mental health setting.

References

Lived experience champions - a vision for a brighter future for people with mental illness.

Kate Purcell

1Ruah Community Services, Fremantle, Australia

Biography:
Kate Purcell is a passionate survivor of mental illness, as well as mentor, speaker and writer. She is passionate about sharing her story with others - her own lived experience includes anorexia, OCD, depression, anxiety and schizo-effective disorder. She teaches other sufferers of mental illness that recovery, and living an amazing life, is possible for them; given the right attitude and psychological factors - such as resilience, hope and faith.

Kate spoke at the WAAMH 2016 conference as a keynote, and has presented on many other occasions, for WAAMH and other organizations. She has written a memoir that is in the process of being edited and published.

Kate has also worked in the mental health field for the past four years as peer support worker and mental health advocate. Kate is a beacon of hope and her passion to help others continues to be an inspiration - and will create many more opportunities for her in the future. Kate's talk will include real tips and advice, on how to move forward in your life after being diagnosed with a mental illness, despite challenging past or present circumstances. Her talk is not just a story, but is a way of re-connecting sufferers with their own sense of hope, resilience and uniqueness.

I like to refer to myself as a lived experience champion... or a lived experience leader.
What exactly do I mean by this? And what does it take to become a champion?
Well it's simple... I don't just work as a peer worker on Mondays to Fridays 9-5.
I live and breathe mental health recovery.
I live and breathe to assist in the reduction of stigma in society.
I live and breathe to inspire others on their journey of recovery.
I am a peer worker, 24/7.
And I'm so proud of that.
Lived experience workers (or peer workers) are the new ‘in’ thing in mental health recovery and rightly so. It is so great to see that lived experience is being recognized as just as valuable as a university degree. In fact, it is my belief that its importance surpasses that of a piece of paper.
This is because nothing can substitute raw, real, experience.
Those of us that can show our scars and be proud of them, and use them to help and inspire others, are the real heroes of this world. And these very real people help to give hope to those others who are still in the midst of their recovery journey, or even in the midst of their illness.
There are many mental health organizations now whom employ peer support workers and peer community workers; and the inclusion of peer workers in mental health organizations is a very clear way of showing the world that we are just as capable, strong and courageous as anyone else.
But what I would like to see is more champions in the field, more leaders. More people that are 100% devoted and committed to changing the way the world views mental illness, and how the world views people’s capacity to recover from mental illness.
I would like to see more people sharing their stories of illness and recovery, and I would like to see more people speaking out against the negative stigma. I would like to see a peer movement.
Too many of us feel ashamed and/or traumatized by our pasts to use our voices to speak up.
What I want other peers to know is that using your own unique voice, and proudly showing your wounds to others is the one sure-fire way to heal those wounds. It is the one sure-fire way of becoming empowered in your recovery journey.... As opposed to being suppressed and shamed.
We should wear our scars proudly, because each and every scar proves that we survived something difficult. Each and every scar proves that we are resilient and strong.

My journey from being a suppressed, ashamed victim of mental illness, to becoming an empowered, inspiring worker, writer and speaker... is not actually unique or special.

Any number of people could do the same, and become leaders and champions in the field.

It takes a lot of courage, a lot of resilience and it requires that you push through your comfort zone, fearlessly and consistently. But believe me... The change is possible.

I strongly urge other peers to do the same.... Because there is indeed, strength in numbers. And any message that is shared in vast numbers, will become more powerful and the scope of that message will be far wider than anything we’ve ever seen or heard before.

Let me share with you, my vision for a brighter future. Let me share with you my vision of turning peer workers, into empowered inspiring leaders... into lived experience champions.

Learning Objectives

Learning Objective (1): Everybody knows someone with a mental illness. It could be you.... or it could be a family member, friend or neighbour. My talk will change lives in that it will change the perception of what mental illness is and it will change the perception of what people with mental illness can achieve in their one precious life. My talk will above all else, inspire those people out there who have a mental illness, to dream big dreams, and go out and reach their absolute potential. It will show other peers how to become peer champions; in their own work and in their personal lives.

Learning Objective (2): This topic is relevant to mental health services/issues because peer work is now the 'in thing' in mental health recovery. This talk will bring the notion of peer leaders and peer champions into focus and empower people with a lived experience to step up, be seen and make a difference in the lives of others.
The importance of Friendship and Community to wellbeing; Group61 Volunteer Mental Health Befriending

Ketayoon Bhathena¹, Ralph Schier
¹Wesley Mission Qld, Chermside Centre, Australia

Biography:
Ketayoon Bhathena
Kat is the Program Coordinator of Group61, a passionate advocate for social justice and engaging presenter with over 15 years’ experience in NFPs. In her first two years the Group61 program and membership has grown by 50%. Kat draws inspiration from the beautiful friendships and community that is Group61.

Ralph Schier
Ralph’s background is in engineering and management. He began his “second life” when he retired and commenced volunteering after being widowed and experiencing depression. He is both Befriender and Area Coordinator for Group61 and its longest serving member, he is privileged to give back some of the blessings he’s received.

It is now widely acknowledged by international research that social inclusion has a significant impact on a person’s health and wellbeing and their recovery is generally better sustained when living in the community. Yet despite the improved broader discourse around mental health, ongoing issues including attitudes, stigma and discrimination, result in the marginalisation and isolation of people with lived experience. This paper will discuss Group61 an innovative volunteer mental health befriending program. Group61 has successfully rolled out across Southeast Queensland, our purpose is “to see the social inclusion of all our Friends”. The strength of our model is the recruitment and retention of local volunteers, these individuals, generally inspired by their own lived experience, not only support another person but also connect more broadly with their local community. They become natural advocates, raising awareness and understanding of mental health locally and identifying community leaders who will also become mental health champions.

The presentation will identify the importance of community in the recovery and wellbeing journey and highlight pathways for simple local support and advocacy that can foster and sustain wellness while addressing stigma and disinformation. Through community, connection and caring we can achieve the change we wish to see.

Learning Objectives

Learning Objective (1): In learning about the Group61 program the audience will gain understanding of the importance of social inclusion to wellness. They will see how a strong structure and framework of training, ongoing support and regular feedback and engagement, directly correlates to longer term retention of our volunteers and the overall success of our program; measured in terms of lasting friendships, building community relationships and the overall impact of the friendship in our Friends lives. Group61 is an inspirational program and our audience will feel empowered and energised at their own ability to create similar community initiatives to support their own community members.

Learning Objective (2): This program has organically grown in to a Peer Support program. 90% of our volunteers have lived / personal experience of mental illness or mental health issue. Our program offers membership for life; some friendships go on to last, some befrienders move on but our friends are re-matched. Our Friends, Befrienders and Area Coordinators have active input in to the program and how it grows and develops, through reporting, feedback and regular peer group supervision meetings. This is a grass roots program with the Lived Experience at its’s heart.
Pathways to Community Living – Consumer Stories and Models of Care from Older People’s Mental Health.

Jacqueline Wesson¹, Sandra Morgan
¹Older People’s Mental Health Policy Unit, NSW Ministry of Health, North Sydney, Australia

Biography:
Jacqueline Wesson (PhD, MA, B.App.Sc)
Jacqueline is an occupational therapist with experience across a range of clinical services, including older people’s mental health and a metropolitan memory disorders clinic. She has worked on the Pathways to Community Living Initiative in her role in the Older People’s Mental Health Policy Unit, NSW Ministry of Health.

Sandra Morgan (B.Med.Sc)
Sandra has three decades of lived experience. She is passionate about making a positive difference to lives of people living with enduring mental illness. Roles include Mental Health Consumer Advocate (Southern NSW Local Health District) for ten years and Consumer Advisor to the Pathways to Community Living Initiative since 2015.

Aim
Older people with severe and persistent mental illness have had limited opportunity to live well-supported in the community, to date. This presentation will outline innovative mental health reforms and models of care for older people to move from hospital into a home in the community.

Background
The Pathways to Community Living Initiative (PCLI) is a NSW Health reform that strengthens community-based mental health care. It creates contemporary recovery-oriented accommodation and care options for people experiencing long-stays in mental health inpatient facilities, with two stages of service development. People with severe and persistent mental illness who are older or have early ageing issues and/or severe behavioural and psychological symptoms of dementia are in the first cohort of people to transition.

Method
Three consumer stories illustrate the different models of care and partnerships between residential aged care providers and older people’s mental health clinical services. Discussion highlights the barriers and facilitators to the transitions to community for consumers and all partners.

Conclusion
Evidence shows that better quality of life and improved social and health outcomes are possible for people with severe and persistent mental illness who are living in the community. This presentation demonstrates these outcomes with real-life examples.

Learning Objectives

Learning Objective (1): Participants will understand one of the major mental health reform initiatives in NSW Health, which is developing pathways into community living for people with severe and persistent mental illness who have experienced long-stays in inpatient units

Learning Objective (2): Participants will understand the three different partnership models of care that have been implemented for older people and people with early ageing issues who have severe and persistent mental illness and/or severe behavioural and psychological symptoms of dementia. Experiences and benefits from consumer perspectives will be discussed.

References
1. Petersen KL; Nicholls TL; Groden D; Schmitz N; Stip E; Goldner EM; Arnold LM; Lesage, A. (2013) "Redevelopment of tertiary psychiatric services in British Columbia: a prospective study of clinical, social, and residential outcomes of former long-stay inpatients." Schizophrenia Research 149(1-3): 96-103.

Fighting the big bad wolf: How can mental health service providers and researchers help reduce stigma in mental health and autism?

Yulin Cheng

The University of Hong Kong, Hong Kong, Hong Kong

Biography:
The author is a research assistant at the Centre for Suicide Research and Prevention, Hong Kong. Her research interests is in the wellbeing and lived experiences of individuals on the autism spectrum. She is also autistic.

It is estimated that one in a hundred people has autism. Although autism is not a mental disorder, autistic people are at a higher risk of developing mental health problems with suicide being identified as one of the leading cause of early death in autistic adults. While intervention programmes to prevent suicide can be designed to target autistic individuals, it is not uncommon for people with autism to remain undiagnosed. On the one hand, universal programmes directed at everyone in the population fail to recognise the full diversity of human experiences. On the other hand, the autistic voice often remains excluded even in research that concerns them.

The author will share from her experience how researchers and mental health service providers may perpetuate the stigma of mental health and autism. What is needed is an inclusive universal design that takes into account the needs of diverse population. Moreover, we focus on the roar because suicide prevention is often perceived as the end goal and the promotion of mental health merely a means to an end. This prevents us from hearing the whisper. Mental health should be an end in itself. Best research and inclusive practices will be discussed.

Learning Objectives

Learning Objective (1): The audience will learn how they can help to reduce the stigma in mental health and autism thereby contributing to enhancement of mental wellbeing.

Learning Objective (2): The prevalence of comorbid mental health issues in people with autism is higher than the general population. A lack of awareness and understanding of the mental health issues in autistic individuals will impact the effectiveness of targeted interventions.

References


Taking "person centred care" from a concept to a practical approach using Solution Focused Brief Therapy.

David Hains$^{1,2}$
$^{1}$Left Turn, Adelaide, Australia, $^{2}$Southern Adelaide Local Health Network, Adelaide, Australia

Biography:
David is a mental health nurse with 16 years’ experience working in emergency departments. His main clinical interest is in Solution Focused Brief Therapy (SFBT). In 2016 he was awarded the S.A. Premier’s Nursing Scholarship. David recently established a private business "Left Turn" for consultancy, counselling, coaching and teaching.

www.leftturnsolutions.com.au

One of the most important concepts to come into mental health care in recent times is “person centred care”. Many services espouse to be person centred but have but have no specific policy or practice, and therefore in “real world” service provision it remains simply a concept despite many clinicians believing it is what they want to do. The question remains as to how do we bring this from a concept into practice.

I am reminded of my original nursing training in 1993 when one of the main concepts we were taught was “holistic care”. While in theory this made sense to me, when I entered the nursing work force in 1996 the reality of the medical model being the dominate discourse was obvious even to the novice. There are many similarities between holism and person-centred, including the lack of specific working models of care, and the lip service that is often provided.

This presentation will not argue against person centred care, in fact I am a strong believer of putting the person in the centre of what we do. I will however present a practical approach using Solution Focused Brief Therapy (SFBT) as the main tool/therapeutic dialogue.

SFBT is a strength based, positive, and future focused approach which can be used to identify a person’s “best hopes” within any therapeutic encounter/episode of care. The working relationship remains collegiate, removing the power differential usually associated within the medical model. Interventions are planned around a series of questions to identify what the person wants to be different in their life. A “common project” is established within the therapeutic/working relationship. The clinician/support person works as a guide, empowering the person to move towards their “preferred future”. Questions to establish and guide care may include things like:

“What are your best hopes of our working together?
“What would you need to see in your life/situation to make you think that you are happy that you came here”
“What would your partner (or other person) see about you as you start to move towards your preferred future?”

During my study tour of Canada as a recipient of the S.A. Premier’s Nursing Scholarship, and in my work both in the public mental health service and a private business, I have observed many examples of how SFBT can be used to create a person-centred approach, including:

• casual corridor conversations in an inpatient mental health unit
• community walk-in brief therapy clinics
• emergency departments
• voluntary and involuntary care
• psychosocial rehabilitation unit which had a successful but radical approach to consumer-led ward rounds

Some of these experiences will be presented, along with references to further information. I will specifically mention the work currently being done in Morier Ward, a psychiatric inpatient unit in Noarlunga Hospital.

Learning Objectives

Learning Objective (1): Delegates will learn that SFBT is a simple yet effective approach to person centred mental health. SFBT is a strengths-based approach and does not require a lengthy analysis of the problem (deficit); we only need to know that someone wants something to be different, we can then establish what “different” would look like and how to get there. It is a forward-focused approach.
Learning Objective (2): SFBT is simple to learn, simple to teach, amazingly good for mental health (has a strong evidence base), a very cost-effective approach, and can be implemented in virtually any area and any service with a very easy training program.

References


Schizophrenia and Gambling Related Harm: The need for improved prevention and intervention.

Monya Murch-Gangemi

1 RASA, Adelaide, Australia

Biography:

Holding a Doctorate in Social Sciences, a Master of Mental Health and a Postgraduate in Counselling, Monya Gangemi is currently working with individuals and families affected by problem gambling and gambling-related harm. Monya has special interest in Attachment Theories, Neuroscience and Perinatal Mental Health.

While many people gamble occasionally and without any visible harm, for some, gambling can result in loss of finances, family and intimate relationships, community support, and deterioration of mental health and wellbeing. Notably, problem gambling has been associated with suicidality, co-occurring psychiatric conditions and other adverse health measures in community samples.

Although high rates of problem gambling are found in psychiatric populations, the extent to which individuals with schizophrenia present symptoms of problem gambling has not been adequately researched. Furthermore, clinicians due to diagnostic overshadowing often overlook identification and attention to co-morbid gambling problems.

Clinical work undertaken within the Gambling Help Services at Relationships Australia, South Australia, offers a unique opportunity to better understand the dynamics and impact of the frequent co-occurrence between schizophrenia and problem gambling, which is largely unexamined in research and clinical practice. This highlights the importance to raise professional awareness and understanding of how the emergence of gambling related harm is often misunderstood or missed entirely, and to promote the need for improved prevention and intervention for this population.

Learning Objectives

Learning Objective (1): “What will people in the audience gain or learn from attending this presentation?”
This presentation seeks to raise awareness and increase understanding of the co-occurrence of problem gambling and schizophrenia; the ‘allure’ of recreational gambling and the impact to individuals with schizophrenia when gambling becomes problematic.

Learning Objective (2): “How is this topic/issue relevant to mental health services and mental health issues?”
To guide and support prevention and promote effective intervention where co-occurrence of problem gambling and significant mental health issues, such as schizophrenia, are present.

References


Peer Work and Partnerships - Supporting Discharges from an Acute Mental Health Unit Through Shared Lived Experience.

Cat Langmead\textsuperscript{1,2}, Lester Burford\textsuperscript{1,2}

\textsuperscript{1}Mind Australia, Heidelberg, Australia, \textsuperscript{2}Austin Health, Heidelberg, Australia

\textbf{Biography:}

Cat Langmead is a Peer Practitioner who has been working for Mind Australia and Austin Health’s Post-Discharge Peer Support Initiative since it began in April 2017. She is also currently working for the community arts organisation, Wild at Heart. Cat has studied psychology and theatre arts.

Lester Burford has been the Lead Practitioner for Austin Health’s Post-Discharge Peer Support Initiative since it began and has been working for Mind Australia since 2013. He is also currently working as the Acting Team Leader at the Austin Prevention and Recovery Care Service. Lester’s academic background is in psychology.

The Post-Discharge Peer Support Initiative (PDPSI) supports people in their transition from a psychiatric hospital admission back into the community. This presentation will provide information about this innovative program and learnings from its first year of implementation. Research shows that in the first four weeks after discharge from a psychiatric ward people are at a greater risk of adverse outcomes such as homelessness, suicide and hospital readmission. The PDPSI provides recently discharged patients with support from peers who have their own lived experience of mental ill-health and recovery. The peer practitioners are based in the Acute Psychiatric Ward at Austin Health and provide community follow-up for the first 28-days after a patient is discharged. Contact generally occurs three times and may include phone calls, meeting for a coffee and a chat, attending appointments together or a home visit. Furthermore, the PDPSI is unique in that it is a collaboration between Mind Australia and Austin Health, a partnership that combines the strengths of a community-based organisation and the skills of a clinical service. The PDPSI aims to assist recovery by inspiring hope in what can be a vulnerable time of transition.

\textbf{Learning Objectives}

Learning Objective (1): Discuss the learnings from the first year of implementation of Austin Health’s Post-Discharge Peer Support Initiative.
Learning Objective (2): Understand the advantages of collaboration between a community-based organisation (Mind Australia) and a clinical service (Austin Health).

\textbf{References}


Meeting core mental health needs using a hands-on approach to neurodevelopment: Use of the First Touch Program with Infants to level-out mental health risk factors.

Deborah Lockwood, Alice Campbell
1Relationships Australia South Australia, Adelaide, Australia, 2Baby in Mind, Australia

Biography:
Deborah is General Manager of Children’s Programs across Relationships Australia SA. Her multi-disciplinary teams provide therapeutic support to children and psycho-education to parents and families experiencing the effects of trauma, where mental health is compromised and those at risk of child protection department involvement. With a focus on the first thousand days of a child’s life and on infant mental health in particular, Deborah has designed and implemented a range of infant and parent programs that support attachment and attunement, increase parent wellbeing and confidence in their parenting.

Alice is a registered nurse and CEO of Baby in Mind. She has worked extensively with vulnerable children in community, mental health, child protection and early intervention services, and is an experienced educator. She holds several postgraduate qualifications, and is currently completing her Masters degrees in early childhood and neuroscience.

Early indicators of mental health vulnerability are often observable during infancy, but typically only as whispers: small behaviours perceptible only to trained observers, or using sensitive brain imaging and genetic testing tools. However, the evidence is clear: any genuine attempt to reduce mental illness must more closely respond to the voices of babies about their mental health development needs. For the past five years, Relationships Australia South Australia (RASA) has been listening and responding to these whispers. Working in partnership with Baby in Mind, RASA has equipped staff with skills to deliver the First Touch Program®. This simple, low-cost and culturally adaptable intervention directly addresses some of the neurodevelopmental processes occurring in infancy that directly impact on life-course mental health outcomes. This paper will describe the First Touch Program® and its underpinnings in neurological and mental health literature – particularly the current research in Affect Regulation and Polyvagal theories. We will then explore some of the practical applications of the program in different settings, and evaluation evidence. The paper will conclude by examining the work undertaken by RASA in using the program to more broadly strengthen their capacity in applying evidence-informed approaches to influence life-course mental health outcomes.

Learning Objectives
Learning Objective (1): It is anticipated that by attending this paper, participants will be able to recognise some of the opportunities and challenges in applying neurodevelopmental principles to promote family mental health in their own roles; and
Learning Objective (2): Identify the ways in which core developmental needs might be used to more effectively inform the delivery and direction of mental health, mental illness and recovery services to play a stronger role in infant mental health promotion.

References
Australian Research Alliance for Children and Youth, & Australian Association for Infant Mental Health. (2013). Halving rates of mental illness in Australia - by starting at birth. ARACY.
Many paths, one partnership.

Maryann Matikainen\textsuperscript{1,2}, Miriam Mutasa

\textsuperscript{1}NSW Health, Hunter New England Older Persons Mental Health Service, Newcastle, Australia, \textsuperscript{2}University of Newcastle, Newcastle, Australia

Biography:
Maryann Matikainen (MMHN, B.Nursing).
Maryann is a Clinical Nurse Consultant working on the Pathways to Community Living Initiative for the Older People’s Mental Health Service of the Hunter New England Local Health District. She has extensive experience working in the Neuropsychiatry service and in generalist mental health.

Miriam Mutasa
Miriam Mutasa is a Residential Manager at Catholic Healthcare’s, Charles O’Neill Hostel overseeing the operation of the 10 bed MHACPI unit in partnership with Hunter New England LHD. Miriam has extensive clinical and management skills gained through various roles in aged care and critical care.

Aim:
To highlight a successful public private partnership between mental health services and an aged care provider in delivering recovery focused patient centred care.

Background:
The Pathways to Community Living Initiative (PCLI) is a state led public private collaboration to provide an innovative approach to service delivery for older consumers experiencing long stays in mental health inpatient units. These consumers have aging related issues including behavioural and psychological symptoms of dementia (BPSD) and have an enduring and severe mental illness.

Method:
This cohort has experienced difficulty transitioning out of hospital due to the lack of suitable accommodation options that provide for their complex needs and the scarcity of mental health supports in community settings. In 2015 the Ministry of Health commenced the PCLI program and established three residential Mental Health Aged Care Partnership Initiative (MHACPI) units in privately owned aged care facilities with publicly funded mental health clinician support.

Conclusion:
Evidence shows that people with prolonged admissions in hospital experience health disadvantages and reduced quality of life. This presentation demonstrates the challenges, outcomes and success of the partnership as highlighted through the journey of one of these consumers.

Learning Objectives
Learning Objective (1): As a result of this presentation attendees will gain knowledge and understanding about an innovative public-private partnership initiative by exploring the journey of one long stay mental health consumer and the challenges he experienced transitioning into the community setting.

Learning Objective (2): This innovative initiative is relevant to mental health services because it demonstrates the success of a public private partnership in offering a supported accommodation option for mental health consumers who have experienced long inpatient admissions and who present accommodation challenges when transitioning into a community setting.

References

Consumer perspectives on how the therapeutic alliance facilitates personal recovery.

Shifra Waks¹²³, Peter Saunders³
¹University Of Melbourne, Melbourne, Australia, ²Swinburne University, Melbourne, Australia, ³Australian College of Applied Psychology, Melbourne, Australia

Biography:
Shifra is a consumer researcher at the University of Melbourne. She has finished honours in psychology and has a Masters in International Public Health. Shifra is a current PHD candidate at Swinburne University and hopes to continue to strengthen consumer voices in the mental health system, education and research spaces.

Dr Peter Saunders commenced at ACAP in 2016. Prior, Peter worked at RMIT University and Birkbeck University. Peter completed his PhD at RMIT University in 2013. Peter has been a registered psychologist since 2008 and has worked in a range of different clinical settings.

The relationship between a mental health consumer and their therapist has long been an important subject of mental health research from clinicians' perspectives. The current mixed methods study aimed to investigate consumer perspectives of the therapeutic alliance (TA) and personal recovery (PR). This research aimed to test the hypothesis that TA is positively correlated with PR and explore the research question: 'How does the therapeutic alliance facilitate consumers' personal recovery?'. In the first phase of the research, participants completed an online survey to measure the quality of consumers' TA and the progress of their PR. In the second stage, individual semi-structured interviews were conducted with participants to explore their lived experiences of the TA and PR. One hundred consumers completed the online questionnaire and 5 participants completed an interview. There was a positive correlation found between TA and PR. Three themes emerged: the therapeutic alliance as a unique relationship, therapist and consumer aids and what recovery means to consumers. This research aimed to strengthen consumer voices in mental health research. A number of suggestions for improving service provision and education of mental health professionals are discussed in the context of current policies, tertiary education and training of mental health professionals.

Learning Objectives

Learning Objective (1): People in the audience will learn about the changing nature of the therapeutic alliance, how the recovery model asserts that consumers are drivers in their own care and will gain a better understanding on consumer perspectives of what facilitates their own recovery within the therapeutic alliance.

Learning Objective (2): The therapeutic alliance is the term used to describe the relationship between the therapist and consumer. Being better informed on what helps facilitate consumers’ recovery in this collaborative relationship may help consumers and professionals develop more helpful robust relationships within diverse mental health settings.

References


Care coordination can facilitate interagency collaboration in providing comprehensive mental health care to people with SPMI.

Anton Isaacs
Monash University School Of Rural Health, Traralgon, Australia

Biography:
Dr. Anton Isaacs is a senior lecturer with the School of Rural Health at Monash University. He is a trained public health physician with research interests in public mental health, suicide prevention and mental health services.

The aim of this presentation is to discuss the potential of a care coordination model in promoting interagency collaboration using exemplars from the literature and lessons learnt from Australia’s Partners in Recovery [PIR] initiative. The presentation will first discuss the importance of addressing the multiple needs of individuals with severe and persistent mental illness [SPMI] and the challenges faced by them and the mental health system in addressing those needs. With the help of previous literature on service system integration, Australia’s PIR initiative and care coordination, the presentation will then make the case for care coordination as a potential way to foster interagency collaboration by overcoming common challenges.

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation?
By attending this presentation, the audience will learn that:
1. Individuals with SPMI have multiple needs - most of which are not mental health related. Such individuals can only experience recovery when most, if not all of these needs are addressed.
2. These multiple needs can be addressed only when the relevant services are able to work together or collaborate. The current mental health system is ill-equipped to address all these needs in a coordinated way.
3. Care coordination as demonstrated by the PIR initiative has the potential to overcome the hurdles associated with service system integration

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues?
This topic is relevant to mental health services because it is a contemporary issue worldwide with mental health service providers trying to identify ways of providing comprehensive recovery oriented care to individuals with SPMI.

References
1. Isaacs, A.N., Fenn, S. Enabling interagency collaboration in providing comprehensive mental health care: the rise of the care coordinator. Australasian Psychiatry. (In press)
A Collaborative Partnership Between Supported Residential Services and Training Providers

Lyn Brennan Jesson¹, Ava Freeland¹

¹Holmesglen Institute, Waverley, Australia

Biography:
Lyn Brennan-Jesson
Lyn has qualifications in Trauma counselling, Community Services and Mental Health, she has worked in the sector for over 20 years before becoming a full time teacher in Mental health at Holmesglen 6 years ago. She is also a qualified Youth and Standard Mental Health First Aid instructor.

Ava Freeland
Ava has qualifications in Youth work, Mental Health, AOD and is currently studying her masters in Mental Health Practice. She has worked in the sector for 10 years before becoming a Co Ordinator of Mental Health programs at Holmesglen.

Holmesglen Institute’s Diploma of Mental Health is training the next generation of the mental health workforce. Through their experience of working in the sector, trainers became aware of the significant lack of resources available within Supported Residential Services (SRSs). In addition, they wanted to provide students with practical ‘hands on’ learning to equip them with the skills to work in a challenging environment. This led to the development of a collaborative and innovative project designed to address both educational and community needs.

The aim of the project was to place students in SRSs for a period of 9 weeks in their last trimester of study. The subjects that are attached to placement were taught within the SRS. Students were supervised by Holmesglen trainers and they worked individually with the residents to plan, resource and implement, self-sustaining, recovery based programs.

Through this project Holmesglen aims to give students the opportunity to develop skills in recovery based practice and to make a valuable contribution to the community. The project is currently being evaluated and outcomes of the evaluation will be presented. The hope is that it will continue to grow and inspire others to look for opportunities to create partnerships with community based organisations.

Learning Objectives

Learning Objective (1): What will People in the audience gain or learn from attending this presentation? The audience will be inspired to look for opportunities to create strategic community partnerships that service the needs of learners and the community. They will discover that service gaps can be filled by using a creative approach that serves both the consumer and organisation, creating a true partnership.

Learning Objective (2): How is this topic relevant to mental health services and mental health issues? Many people living in Supported Residential Services, SRS’s, are living with mental health conditions. This presentation will focus on how there is opportunity for mental health services to work collaboratively with training providers and SRSs to enhance their lives and support recovery goals. People living within SRSs often fall between the gaps of the service system and lose connection within the wider community.

References

We have been unable to locate 2 suitable references for our submission, we have looked for both education in SRS and in service gaps in SRS along with Training in community and everything we have looked at has not come close to our project. We are evaluating this project and will be hopefully putting a journal article out about it ourselves.
Cracks in the Ice: Disseminating evidence-based information about crystal methamphetamine in Australia.

Stephanie Kershaw¹, Cath Chapman¹, Katrina Champion², Louise Birrell¹, Hannah Deen¹, Lexine Stapinski¹, Frances Kay-Lambkin³, Maree Teesson¹, Nicola Newton¹
¹National Drug and Alcohol Research Centre, UNSW, Sydney, Australia, ²Northwestern University, , USA, ³University of Newcastle, Newcastle, Australia

Biography:
Stephanie manages ‘Cracks in the Ice’: a Commonwealth Department of Health funded project disseminating information about crystal methamphetamine in Australia. After completing her PhD, Stephanie worked at the World Health Organization focusing on the impact of illicit drugs on public health and the translation of evidence-based research into international policy.

Introduction
Crystal methamphetamine (ice) is associated with significant societal harm, and methamphetamines were rated by 40% of Australians as the drug of most concern in the 2016 National Drug Strategy Household Survey. Cracks in the Ice is a public health initiative that launched in April 2017 in response to recommendations of the Australian Government’s National Ice Taskforce and provides the first national online portal for evidence-based information about ice relevant to the Australian community.

Method
Cracks in the Ice was developed with input from >450 Australian community members, in collaboration with experts and researchers. A Cracks in the Ice smartphone application (app) has been developed to extend the reach of the portal’s information, after a systematic review identified a lack of high-quality apps about ice.

Key findings
The portal has had >51,000 users, and >60,000 hard-copy information resources have been distributed to mental health, AOD services and community groups. Web traffic is predominantly from major cities, however there is also interest from regional areas. Latest usage data for the app will also be presented.

Implications
Digital approaches stand to overcome structural, geographical, and attitudinal barriers to AOD prevention. This presentation will interest policy makers, service providers and the general community.

Learning Objectives
Learning Objective (1): The audience will gain:
• knowledge of methamphetamine use, related harms and community concern in Australia
• knowledge of how Cracks in the Ice aims to help reduce ice-related harms in Australia
• understanding of the development of the Cracks in the Ice website and new mobile app, and how they are being utilized in Australia
• appreciation of co-design process for AOD prevention tools and initiatives
• appreciation of how digital approaches like Cracks in the Ice stand to overcome structural, geographical, and attitudinal barriers to AOD prevention
• appreciation of how research and evaluation can inform the development and ongoing maintenance of digital health promotion initiatives.

Learning Objective (2): This presentation is relevant to:
• mental health services providing support to individuals who use ice or their friends and family
• mental health researchers interested in prevention and early intervention for AOD issues, particularly via digital channels
• policy makers interested in AOD prevention and early intervention, particularly those wanting to understand the role of health information dissemination at a national level
• community members wanting to know more about methamphetamine use and related harms in Australia and what role Cracks in the Ice plays in preventing these harms.
Creating Public Value: The Application of Moore’s Strategic Triangle in Peer Support Work

Grace Zeng¹, Donna Chung¹
¹Curtin University, Perth/Bentley, Australia

Biography:
Grace is trained as an Occupational Therapist and has worked previously in mental health, particularly with children, adolescents and persons recovering from addiction. She is currently completing her PhD project on how peer support works for people recovering from a mental illness and hopes to document the effect of peer support on recovery, the work of peer support and the factors that influence its development in Western Australia.

In keeping with recovery-oriented practice in policy, a number of mental health organisations in the public and non-government sectors have begun to employ a growing number of peer support workers. Given the emergence of this unique workforce in recent years, it is important to capture and learn how organisations have responded to this growing group of workers within existing mental health service delivery. In order to do so, we conducted a scoping review of the enablers and challenges of peer support work. We also conducted in-depth interviews with fifteen stakeholders and sixteen peer support workers from non-governmental organisations and public mental health services. We applied Moore’s Strategic Triangle to understand the influence of policy and organisational culture on the implementation and value of peer support work; the legitimacy and support it receives; and the resources required to do so. We make recommendations as to how managers can position themselves in practice to ensure that peer work continues to thrive in the agency.

Learning Objectives

Learning Objective (1): To learn how organisations have responded to the employment of peer workers within existing mental health service delivery.
Learning Objective (2): It is hoped that in the application of Moore’s strategic triangle, that managers will be equipped to position themselves to enhance the value that peer support offers to the service; consumers and stakeholders.

References


Zeng, G., Chung, D., & McNamara, B. (Under Review). What are the challenges and enablers in the provision of formal peer support? A scoping review. Administration and Policy in Mental Health and Mental Health Services Research.
Co-production and Implementation of the Collaborative Recovery Model in an Australian Tertiary Mental Health Service

Phoebe Williamson¹, Kevin Ong¹, Elizabeth Fraser¹, Chris Dixon¹, Margie Nunn¹
¹Eastern Health Mental Health Program, Melbourne, Australia

Biography:

Chris is a keen Star Wars fan. He enjoys swimming, reading and watching films. He has a lived experience of mental health for over 18 years. He has worked as a consumer consultant, peer support worker and now is a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

Phoebe is an occupational therapist who is motivated by food, people and human potential for change. She has worked in acute and community mental health, public and private settings, and is currently the Team Leader for the CRM Workforce Development Team at Eastern Health Mental Health Program.

Margie enjoys working with groups to explore ways to connect, inspire each other and remain resilient. She has worked as a trainer and public speaker in the mental health sector for nearly twenty years and now is a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

Elizabeth enjoys gardening, yoga, and team work. Her work is informed by principles of person-centred practice and working with individuals and organizations in a way that both empowers people and promotes mental health and wellbeing. She is a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

Kevin is a forensic psychiatrist who enjoys cycling, cooking, campfires and chasing his kids. He is a keen advocate for balancing risk assessment and management within a recovery oriented framework. He is now a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

Background: The Collaborative Recovery Model (CRM; Oades, Deane & Crowe, 2017) has been implemented across Eastern Health Mental Health Program (EH) to provide a standard of care consistent with National Framework for Recovery Oriented Mental Health Services (Department of Health, 2013). CRM is an evidence-informed coaching model and training package that supports individual and family recovery-focused practice, as well as organisation and workforce development. It signals a move away from a focus on risk and deficits (“the roar”), towards valuing strengths, wellbeing and resilience (“the whisper”).

Method: Mapping the EH CRM Workforce Development Team journey of co-production; contextualising the original licensed package (University of Wollongong; NEAMI), co-facilitating initial 3 day – and booster training by medical, nursing, allied health and lived experience workforce, developing lived experience stories, and quality improvement processes to support CRM Trainer growth and to embed the model. Preliminary findings from Pre/Post training evaluation of staff knowledge, attitudes, skills and strategies to support transfer of training into practice are highlighted.

Conclusion: Coproducing and implementing CRM encourages individuality, collaboration and autonomy support. This embeds recovery oriented practices whilst balancing the realities of everyday clinical practice.

Learning Objectives

Learning Objective (1): To gain an understanding that Recovery Framework Implementation is complex, resource intensive and requires a whole of workforce approach if it is to translate into practice.

Learning Objective (2): To describe the successful strategic journey of co-production and co-facilitation of Collaborative Recovery Model implementation in a large Australian tertiary mental health service.

References
Finding One’s Voice above the Roar: The Lived Experience of Training Clinical and Medical Mental Health Staff in the Collaborative Recovery Model.

Chris Dixon¹, Margie Nunn¹, Phoebe Williamson¹, Elizabeth Fraser¹, Kevin Ong¹
¹Eastern Health, Melbourne, Australia

Biography:
Chris is a keen Star Wars fan. He enjoys swimming, reading and watching films. He has a lived experience of mental health for over 18 years. He has worked as a consumer consultant, peer support worker and now is a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

Margie enjoys working with groups to explore ways to connect, inspire each other and remain resilient. She has worked as a trainer and public speaker in the mental health sector for nearly twenty years and now is a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

Phoebe is an occupational therapist who is motivated by food, people and human potential for change. She has worked in acute and community mental health, public and private settings, and is currently the Team Leader for the CRM Workforce Development Team at Eastern Health Mental Health program.

Elizabeth enjoys gardening, yoga, and team work. Her work is informed by principles of person-centred practice and working with individuals and organizations in a way that both empowers people and promotes mental health and wellbeing. She is a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

Kevin is a forensic psychiatrist who enjoys cycling, cooking, campfires and chasing his kids. He is a keen advocate for balancing risk assessment and management within a recovery oriented framework. He is now a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

Implementing the Collaborative Recovery Model (CRM) at Eastern Health Mental Health Program reflects the evolving role of Lived Experience of recovery in mental health workforces. CRM is a strengths-based coaching model and training package (Oades, Crowe & Nguyen, 2009). People with Lived Experience have an essential role in supporting systems to rise above the roar (focusing on what’s wrong) and move towards wellbeing (focusing on what’s strong). Stories of change, hope and growth sparks practitioners to empower people, their families and support people to take charge of their health and wellbeing. The co-facilitation and co-production of CRM at EHMHP attempts to address power imbalance of “us and them”. This paper describes the experiences of co-producing and co-facilitating CRM training to mental health staff.

CRM Trainers reflect on the trials, tribulations and triumphs of training and “coaching” a mental health service, with clinicians who ranged from the sceptical to the enthusiastic. Filmed stories will bring to life the lived experiences that emphasise the importance of collaboration and the strength of the working alliance as the best predictor of recovery outcomes.

Lived Experience leadership within a tertiary mental health service builds and sustains collaborative recovery and balances the whisper with the roar.

Learning Objectives

Learning Objective (1): To gain inspiration and evidence of how the voice of Lived Experience can be embedded in a large tertiary mental health service to lead recovery framework implementation.

Learning Objective (2): To recognise the value of lived experience in addressing the power imbalance of “us and them” to promote strong working alliances, wellbeing and resilience.

References
Climate Schools Plus (CSP): Implementing & evaluating an integrated online intervention for students and parents to prevent alcohol and cannabis harms among adolescents.

Chloe Conroy1,2, Nicola Newton1,2, Tim Slade1,2, Louise Thornton1,2, Ina Koning3, Katrina Champion1,2, Lexine Stapinski1,2, Maree Teesson1,2, Cath Chapman1,2

1NHMRC Centre of Research Excellence in Mental Health and Substance Use, Randwick, Australia, 2The University of New South Wales, Sydney, Australia, 3Universiteit Utrecht, Utrecht, Netherlands

Biography:
Chloe is a research assistant to A/Prof Nicola Newton on the Climate Schools Plus study (an online substance use prevention program, targeting students & parents). Chloe enjoys volunteering with Headspace and Youth Off The Streets and finds the opportunity to with individuals who’ve lived experience to be especially rewarding.

Learning Objectives

Learning Objective (1): Audience members will learn about the latest addition to the Climate Schools series (i.e., the newly developed parenting component) and gain an increased understanding of the role parents can play in influencing their adolescents’ substance use. Members of the audience will also learn about the results of the study to date and gain insight into the perspectives of the parents involved in the study, based on the feedback we received.

Learning Objective (2): Early initiation of substance use significantly increases the risks of an individual developing a substance dependence or other mental disorder later in their life. The CSP study aims to delay the onset of adolescent substance use and reduce the related harms, including mental health issues, by providing a comprehensive, evidence-based program for both students and their parents. The presentation will highlight the approach of the Climate Schools Plus program to reducing substance use and associated harms (e.g., mental health issues) in adolescents and will discuss the preliminary results obtained from the study.

References


Complaints - A Compelling Narrative about Mental Health Service Culture

Jennifer Black

Mental Health Complaints Commissioner (MHCC), Melbourne, Australia

Biography:
Jennifer is an Occupational Therapist who has over 30 years experience as a senior mental health clinical leader. She is passionate about using consumer experiences to drive practice change. She is currently the Deputy Commissioner for the Mental Health Complaints Commissioner in Victoria.

This presentation will discuss the work to date of the Victorian Mental Health Complaints Commissioner and outline the key themes stemming from complaints about public mental health services from consumers. It will discuss how the office has used complaints data to influence change in the Victorian Mental Health Service System. The presentation will provide detailed aggregated data on numbers and types of complaints which would be useful for service leaders in thinking about their own service improvement. It will provide insight into the importance of hearing consumers experiences at the service level and how this information can provide valuable information about the culture of the service. It will unpack how service leaders can work with people’s experiences in a more meaningful way to influence change within their own organisation, as well as highlight some of the barriers and pitfalls to effective use of lived experience stories in this context. In addition the presentation will include some personal reflections of the Deputy Commissioner who has moved from a position of a Clinical Service Director into this statutory oversight role.

Learning Objectives

Learning Objective (1): To provide participants with a greater understanding about the key themes arising from complaints about public mental health services in Victoria and how this information can be used to promote change at the service level.

Learning Objective (2): To provide insight into how mental health service leaders can use complaints and complaint data to improve services and address internal cultural issues.

References

Improved and innovative emergency response pathways for mental health crisis callers.

Anne Bateman¹, Sharryn Gannon¹
¹National Telehealth Service, Auckland, New Zealand

Biography:
Anne Bateman, MSW, MPA – Head of Mental Health, National Telehealth Service
Anne has had various roles, including governance, development, management, planning and funding, quality improvement, executive management and clinical practice. She is certified in Six Sigma and a Prince 2 practitioner with membership in the Institute of Directors (MinstD) and the American Evaluation Association.

Sharryn Gannon, BN,RN Assoc Dip Comms -Clinical Director National Telehealth Service
Sharryn has extensive experience in public and private health services including engagement with not for profit organisations, academia and the contact centre sector. She is a recognised leader in tele-enabled health services in Australasia. Sharryn has extensive clinical governance and change management experience across multi-disciplinary and multi-agency teams.

Improving care for people experiencing mental health conditions is a problem that health systems around the world continue to grapple with. Finding appropriate entry to care and pathways is needed.

Mental distress in the community continues as evidenced by New Zealand’s high suicide rate (MoH 2014). The number of Police 111 calls for mental health related problems is increasing by 4% each year, with and expected 65,000 calls in a year. DHB crisis assessment and response activity increased by over 50% since 2008.

The New Zealand Earlier Mental Health Response (EMHR) is a new innovative pathway for health and emergency care sectors to support people in mental health crisis who are calling emergency services. The goal of the service is to improve health responses to mental health callers and reduce impact on emergency services.

EMHR has developed in partnership with Police, Ambulance and Health and is delivered by the National Telehealth Service. Using contact centre technology and information systems, clinicians provide clinically safe pathways to integrate care.

Robust consumer and stakeholder co-design was used to develop the model of care. Using a phased approach, a national rollout has been completed and a post implementation review is underway. This session will focus on the co-design process as well as the implementation framework and learnings. We will share the service delivery model, learnings from implementation, and patient stories and feedback will be shared. Collaboration, including governance and service delivery frameworks will also be presented.

Learning Objectives
Learning Objective (1): Participants will have an enhanced understanding of co-design use in program implementation for crisis mental health services
Learning Objective (2): Participants will be able to identify alternative health response pathways for those who are contacting emergency services (ie Police and Ambulance).

References
An innovative approach to the implementation of Trauma Informed Care and Practice in NSW.

Katherine Gill, Kathleen Schelling

Agency For Clinical Innovation, NSW Health, Chatswood, Australia

Biography:
Kathleen has extensive experience in health service, nursing and project management in the public mental health sector with a keen interest in evidence based leadership and service improvement endeavours.

Kate is Chair of the Consumer Led Research Network and is involved in a number of research and evaluation projects where she harnesses both her lived experience and her professional skills and qualifications.

In 2016 the NSW Agency for Clinical Innovation (ACI) Mental Health Network prioritised the implementation of Trauma Informed Care & Practice (TICP) in NSW mental health services. Trauma is highly prevalent in people using mental health services[1], has a relationship with the development of mental health conditions and adversely affects the response to care, treatment, service delivery and personal recovery,[2,3] leading to the decision that the implementation of TICP using an innovative approach is a network and system priority. An Expert Working Group was established bringing together people with a lived experience of mental illness, people with a lived experience of trauma and practitioners with expertise in the field to conduct a codesign project to approach the formulation of evidence based strategies to implement TICP. The overall approach to the problem will be outlined and results from the diagnostic will be presented. The diagnostic included a broad state-wide survey, focus groups with consumers and the mental health workforce, interviews with clinical and operational leads and analysis of current data. The TICP project seeks to achieve the development of implementable strategies and solutions that will be evaluated to understand what works and the effects on consumer, workforce and system outcomes.

Learning Objectives

Learning Objective (1): The audiences will understand the importance of Trauma Informed Care & Practice and the approach NSW is using to implement TICP. The audience will gain deeper insight into the current state of TICP, including the barriers and enablers to implementation of TICP.

Learning Objective (2): Where evidence based strategies and approaches to TICP are implemented in mental health services it increases the likelihood of effective treatment, decreases adverse events in care and improves safety for consumers and the workforce. Trauma-informed care is a crucial component of recovery-oriented practice and the delivery of person centred care and is a priority within public mental health services and the mental health sector more broadly. This work aims to prevent some of the problems that were highlighted in the recent Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities. December 2017

References
Staying Sane in Uncertain Times: The importance of looking after ourselves as we transition to the NDIS.

Judith Drake

1Independent Mental Health Consumer Advocate, Melbourne, Australia

**Biography:**
Judith is involved in consumer/community advocacy at local, state and national levels with various organisations covering the mental health, family violence and emergency service sectors. She has particular interests in consumer engagement, peer support, research & evolution, trauma & dissociation, self-care, suicide prevention, Hearing Voices and NDIS & psychosocial disability.

NDIS holds a lot of promise for consumers, especially around the provision of on-going support, recovery-focused service provision and the ideals of choice and control. However, as with any significant social reform, the realities (at least in the short-term) don’t always feel as rosy as the promises, as we are faced with a great deal of change, uncertainty and even fear as the services we currently rely on have to re-invent themselves to fit into an NDIS model. Whilst is it extremely important that services focus on innovation, support planning, documentation requirements and even marketing plans, sometimes the fast-moving, ever-changing whirl-wind that is the NDIS implementation can seem to forget about the often extreme vulnerability of those impacted by these changes. Many services are doing a good job of planning for support provision models post NDIS implementation, but coping with the continuing uncertainty in the meantime has almost become the ‘elephant in the room’ as jokes circulate about the latest advice regarding NDIS ‘changing weekly’. So, where does this leave consumers, and the people supporting them? This presentation aims to provide tips and suggestions, from a lived-experience perspective, around coping with some of those fears and anxieties, such as:

- NDIS terminology
- psycho-social disability & functional impairments
- educating yourself about the new system
- balancing the pessimism of ‘permanent disability’ with the optimism of hope for a better future
- practising self-soothing strategies
- sitting with uncertainty
- remembering self-care basics
- seeking out short-term supports
- maintaining perspective
- having brave & honest conversations with your carer/s about each other’s needs,
- surviving the application process
- planning for planning meetings
- reviewing wellness/safety plans
- resources

There are many things that consumers and carers can do to look after their own self-care and ensure they don’t lose their sanity whilst navigating the NDIS.

**Learning Objectives**

Learning Objective (1): This presentation aims to provide information, tips & suggestions, from a lived-experience perspective, around coping with some of the fears, anxieties and uncertainty around applying for, or transitioning to, the NDIS when you have, or are supporting or working with someone who has, a psycho-social disability.

Learning Objective (2): This topic is highly relevant to mental health consumers, carers and services in the community mental health sector as the NDIS continues to be rolled-out across Australia. One of the biggest social policy changes since the introduction of Medicare, the NDIS hold a lot of promise for consumers with a significant psycho-social
disability, yet this does not mean that everyone who is eligible will necessarily have a smooth experience applying, for or transitioning across, to the new scheme.

References


Becoming “more recovery-focused”: Workers’ experiences of using the SMART interactive website with consumers in mental health services.

Anne Williams1,2, Ellie Fossey2,3, John Farhall2,4, Fiona Foley1, Neil Thomas1,5
1Swinburne University, Melbourne / Hawthorn, Australia, 2La Trobe University, Melbourne / Bundoora, Australia, 3Monash University, Melbourne / Frankston, Australia, 4NorthWestern Mental Health, Melbourne, Australia, 5Monash Alfred Psychiatry Research Centre, Melbourne, Australia

Biography:
Anne Williams is an occupational therapist, educator and researcher with an interest in understanding how services can best support people experiencing mental illness in their personal recovery. Her current research has explored the experiences of workers and consumers who used the SMART recovery-oriented online resources together.

Introduction: Technology and online resources are increasing options for mental health service delivery. Self-Management And Recovery Technology (SMART) is an interactive website that consumers used independently and accessed on a tablet device with their mental health worker. SMART made lived-experience and evidence-based resources available in face-to-face meetings.

Aim: To explore workers’ experience of using the SMART website with consumers, including factors that facilitated or limited website use and their perceptions of benefits gained.

Method: Fifteen mental health workers used SMART resources for up to six months with consumers who had lived experience of psychosis. Workers shared their experiences in individual semi-structured research interviews. Data analysis and collection occurred concurrently, following constructivist grounded theory methodology.

Findings: Workers perceived benefits of overcoming feeling stuck and opening-up productive conversations with consumers when SMART was integrated into meetings. They valued consumers choosing topics to discuss, having access to lived-experience videos and the discussions that ensued. However, despite persevering to engage consumers in SMART, technological and time barriers often limited website use.

Conclusion: Integrating web-based resources into face-to-face mental health practice demonstrated benefits for recovery-focused communication between workers and consumers. Establishing processes that enable regular website use may be necessary to fully realise these benefits.

Learning Objectives

Learning Objective (1): Audience members will learn about potential benefits from introducing online resources into practice, from workers’ perspectives. Issues that support and hinder such initiatives will also be outlined, providing useful knowledge for those considering similar developments in service delivery.

Learning Objective (2): Re-orientating mental health services towards recovery-oriented practice has been a priority for health services in Australia and New Zealand in recent years. This topic adds to evidence from the SMART research program about the effects on recovery-oriented practice when web-resources were integrated into mental health services.

References


Happy Snappers Adelaide: A unique and free peer-led service offering the experience of Mindfulness and Flow through the use of digital photography.

Alex Mausolf¹
¹Happy Snappers Adelaide, Adelaide, Australia

Biography:
Alex Mausolf, the creator and voluntary facilitator of Happy Snappers Adelaide lives with intense, constant auditory hallucinations as a result of chronic abuse and trauma in his childhood. He is an extremely passionate and published photographer who holds three popular weekly Mindful Photography groups in the Southern suburbs of Adelaide.

Alex Mausolf, the creator and voluntary facilitator of Happy Snappers Adelaide lives with intense, constant auditory hallucinations as a result of chronic abuse and trauma in his childhood. He is a passionate photographer.

In late 2016, Alex had an idea of holding sessions for those living with mental health challenges to explore the world and their creativity through the simplicity of mobile-phone photography. A weekly group established in Adelaide’s Southern suburbs in early 2017, this proved popular and the participants expressed a desire to explore further through the use of digital cameras. Alex set out to make this desire a reality, based upon his own regular positive experiences of Mindfulness and Flow, as achieved through the use of a digital camera.

Reaching out to his fellow photography acquaintances around the world, donations of equipment were received, assisting Alex to make this dream a reality very quickly and easily, with him then providing the other half of the gear needed out of his own pocket.

In early 2018, three free weekly groups commenced, assisting others to also regularly experience Mindfulness and Flow through the use of a digital camera. The benefit to the various participants has been wonderful to witness.

Learning Objectives

Learning Objective (1): An understanding of the power and efficacy of digital photography as a means for anyone to regularly, easily and quickly experience Mindfulness and Flow.
Learning Objective (2): The effects upon overall wellbeing when regularly experiencing Mindfulness, Flow and spending time in Nature are of major benefit to those living with mental health challenges in their lives.

References


Jennifer Bibb¹²
¹St. Vincent’s Hospital Melbourne, Fitzroy, Australia, ²University of Melbourne, Southbank, Australia

Biography:
Dr Bibb is a senior music therapist at St. Vincent’s Mental Health Service in Melbourne and a tutor and researcher in music therapy at the University of Melbourne. She is also Mental Health Liaison for the Industry Engagement Committee of the Australian Music Therapy Association.

People’s relationships with music can become complicated during mental health recovery. Painful memories and emotions can be triggered by music, which can be amplified when listening to music in isolation. Music has the potential to be a helpful resource for coping and processing emotions during recovery, but it may also be used in unhelpful ways during acute episodes of illness, if consumers are not supported with their music use during this time. This presentation will draw on the latest music therapy research and use case examples to explore a variety of ways people can use music to promote their recovery. Strategies for supporting healthy and helpful music use during recovery, and beginning a conversation with consumers around healthy music use will be discussed. An introduction to the role of music therapy in recovery, particularly in acute periods of illness will also be presented.

Learning Objectives
Learning Objective (1): Audience members will learn a variety of ways that people can use music during recovery, and when and how to support people to use music as a helpful and healthy resource.
Learning Objective (2): This topic is relevant to people working as mental health clinicians or carers as they will develop an awareness of the potential of music to promote or hinder people’s recovery, and gain helpful tools/strategies to support consumers to use and access music for recovery promotion.

References

Postnatal Depression: Engaging and Including Fathers

Monya Murch-Gangemi

Biography:
Holding a Doctorate in Social Sciences, a Master of Mental Health and a postgraduate in Counselling, I am currently working with individuals and families affected by problem gambling and gambling-related harm. I have special interest in Attachment Theories, Trauma-Informed practice and Perinatal Mental Health.

Depression in mothers is common and it raises concerns for its potential to disrupt aspects of caregiving as the association of depression with parenting and infant’s development is complex. Maternal Postnatal Depression (MPD) is well recognised in clinical medicine however, by comparison, Paternal Postnatal Depression (PPD) is less well researched and rarely screened for.

Paternal depression has high co-morbidity with maternal depression; about half of all fathers with PPD have partners with postpartum depression. Partners rely predominantly on one another for emotional support, when a partner is depressed, this support mechanism maybe lost, increasing the risk of depression in the otherwise well partner. Recent studies show that paternal influences have an important effect upon child socio-emotional development, underlining how the two dyadic relationships may be different and complimentary.

Fathers play an important role in their child’s life as attachment figures. It is important to increase fathers’ visibility in clinical work by recognising fathers’ struggles, paternal postnatal depression; to highlight the importance of father-child relationships and quality of paternal care, and the need for increased screening and better inclusion of fathers in antenatal and postnatal care programs.

Learning Objectives

Learning Objective (1): The presentation will raise audience’s awareness of paternal postnatal depression and its detrimental impact on child’s socio-emotional development; to provide recommendations for further research and clinical work.

Learning Objective (2): Identifies the importance of early intervention, to address the mental health needs of fathers for positive children and families’ outcomes.

References


Mentally Fit EP's Rotary Men's Wellness Campaign

Joanne Clark¹, Lain Montgomerie¹
¹West Coast Youth And Community Support, Port Lincoln, Australia

Biography:
Jo Clark is the CEO of WCYCS, supporting a Mentally Fit EP. She has a variety of roles on community boards. Interests: passionate about localised community responses, Youth Health, Mental health and links between below average social outcomes and negative health outcomes and homelessness and poor physical and mental health.

Lain Montgomerie is the Community Development Officer for Mentally Fit EP. She has a background in Visual Arts and Education which brings a range of diverse skills to her role. Interests: community connections; especially in sport and arts, mental wellness, and inspiring others to do well and make good choices.

Mentally Fit EP and local photographer, Robert Lang, joined forces “to flip mental illness on its head” throughout Eyre Peninsula, with the 'Rotary Men’s Wellness Campaign’ a photographic exhibition featuring 60 poster sized photographs of 30 men living on Eyre Peninsula aged between 18-82.

The travelling exhibition will be displayed in 10 different towns in the region, accompanied by a service support guide, the ‘Mentally Fit Bloke’.

Each photograph captures the ‘ambassador’ in a space where they feel happy together with a personal quote relating to their wellbeing that will resonate with men.

Facilitating conversations, connections and supports, the campaign also reduces stigma, strengthens resilience, encourages vocabulary associated with mental wellness, and shares information about locally available services.

The aims of the presentation are to share the campaign’s processes, research, successes and learnings, so other regions can replicate the project.

Statistics show that men are a high-risk group in isolated regions, often combined with stigma, a lack of mental health services, or long wait times, so the importance of building resilience and self-empowerment is paramount.

Learning Objectives

Learning Objective (1): Participants will gain an understanding of how we address mental health stigma in regional areas and inform communities about seeking help, regardless of isolation, and lack of services and funds. Through viewing photographs of ‘blokes from their region’ sharing their stories about mental wellbeing, conversations begin, resilience is formed, and stigma is reduced – Flipping mental illness on its head!

Participants will identify factors men find important in their lives and that men in our region do consciously look after their own mental wellbeing. Underlying themes in the ways they do so include connections and time with family, following outdoor pursuits, and engaging in purposeful activities of their choosing – choices which are available to every man. The exhibition is a testament to the capacity we have to look after our own mental wellbeing.

Learning Objective (2): Men’s wellness is critical due to the fact that they represent a high-risk group, of death by suicide. By starting conversations, as men see and recognise other men from their region sharing their photograph and mental wellbeing message, together with the Mentally Fit Bloke’s brochure regarding local services, this project’s successes could be replicated and utilised in other regions.

References

“Take Charge of Your Life: How to Get What You Need with Choice Theory Psychology”, W Glasser, 2011. iUniverse, Inc. Bloomington, USA
How a knock-back from an NGO blossomed into a beautiful thing. The incredible benefit, value, power and ownership of peer-support networks created by and for those living with mental health challenges in their lives.

Alex Mausolf1

1Happy Snappers Adelaide, Adelaide, Australia

Biography:
Alex Mausolf, the creator and voluntary facilitator of Happy Snappers Adelaide lives with intense, constant auditory hallucinations as a result of chronic abuse and trauma in his childhood. He is an extremely passionate and published photographer holding three free popular weekly Mindful Photography groups in the Southern suburbs of Adelaide.

Alex Mausolf, creator and voluntary facilitator of Happy Snappers Adelaide lives with intense, constant auditory hallucinations as a result of chronic abuse and trauma in his childhood. He is a passionate, creative, published and awarded photographer, exploring and living well with his mental health challenges through photography.

With the gentle and supportive peer-assistance of his PHaMS worker in late 2016, Alex had his idea of holding sessions for those living with mental health challenges to explore the world and their creativity through mobile-phone photography come to fruition. A desire by those participants to explore photography through the use of digital cameras was denied them by the NGO Alex had created this group in conjunction with.

This allowed Alex the opportunity to act autonomously in regard of evolving this unique peer-led service; available free to all, not just those eligible for NDIS assistance.

In early 2018, three free weekly groups commenced, assisting others to also regularly experience nurturing time in Nature, Mindfulness and Flow through the use of digital photography. The benefit to the various participants has been wide and varied.

That a user of peer-supports could create and become part of a positive peer-support network for others is extremely validating.

Learning Objectives

Learning Objective (1): An understanding of the power and efficacy of peer-support networks in assisting and enabling individuals to create positive opportunities for themselves and their community by becoming unofficial peer-supports for others via peer-network community based groups.

Learning Objective (2): Large NGO’s are commonly bogged down in bureaucracy, making them very slow to react and change, whereas peer-network mental health community based groups can be created quickly, easily, by and for the participants.

References


Peer Support Work in Public Mental Health: Don't see me as my diagnosis and I won't think of you as a clinician.

Jeremy Le Roux¹, Kerrie Clarke¹
¹St Vincent’s Mental Health, North Fitzroy, Australia

Biography:
Jeremy Le Roux is a Peer Support worker with St. Vincent’s Mental Health Footbridge Community Care Unit. Jeremy facilitates systemic change within mental health services and has a special interest in Intentional Peer Support, the NDIS and psychosocial disability.

Kerrie Clarke is a Senior Clinical Psychologist at St Vincent’s Mental Health Melbourne working across short term and longer term recovery services. She is passionate about recovery oriented practice from an individual and system perspective and strives to continually build her skills in working in equal partnership alongside peer workers.

The landscape of public mental health services is changing. Traditionally, boundaries between staff with a lived experience of mental illness and mental health clinicians have been rigid and inflexible. However, with the recent changes to the Victorian Mental Health Act (2014), and the growth of the lived experience workforce, these boundaries are being challenged.

In order to remain relevant we need to think differently about the way clinicians, peer support workers, and consumers navigate multiple relationships.

This paper tells the story of a ‘whisper’ of change in a public mental health setting in Melbourne, Australia, and provides an example of where traditional boundaries between a ‘peer support worker’ and ‘clinician’ have been transcended. Through the use of role play, multimedia and discussion we will demonstrate the benefits of negotiating multiple relationships in the workplace. Our story highlights the rewards that come from confronting discomfort, risks, vulnerabilities, the relinquishing and attaining of power involved in the development of new relationships and friendships in the landscape of public mental health services.

We will draw on Intentional Peer Support principles as a framework and demonstrate how these principles can be used by others navigating multiple relationships in their workplace.

Learning Objectives

Learning Objective (1): Gain skills and confidence in being able to successfully develop, maintain and navigate multiple relationships within services

Learning Objective (2): With an increase in the lived experience workforce it is becoming more likely that workers will have to navigate multiple roles and boundaries. This paper will provide a successful example of transcending boundaries and roles while maintaining trust and respect.

References


Actually Treating Developmental Trauma

Roger Gurr¹
¹Headspace Youth Early Psychosis Program, Mt Druitt, Australia

Biography:
A psychiatrist recovering from developmental trauma, who has finally learned how to treat trauma. Clinical Director of the headspace Youth Early Psychosis Program, where many young people also have developmental trauma. Chair of the Board of the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) which has been treating all types of psychological trauma for 30 years.

While developmental trauma has largely been ignored by mainstream psychiatry until recently, technology has enabled us to get a much better understanding of the ways trauma changes the brain structures and functioning. In turn this is now enabling us to re-regulate brain functioning, so that people can better make use of talking therapies. There is a large volume of unmet need and government must be pressured to invest in effective specialist trauma treatment services. An up to date review of these findings will be presented.

Learning Objectives

Learning Objective (1): The audience will have an understanding about the treatments and services they should demand from government, to address the large volume of unmet needs.
Learning Objective (2): The topic is relevant to the redesign of mental health services to address under-served high prevalence disorders.

References

Quantitative EEG in Practice

Roger Gurr

Headspace Youth Early Psychosis Program, Mt Druitt, Australia

Biography:
A psychiatrist who thinks we should better examine the organ we treat - the brain. Being the Clinical Director of the headspace Youth early Psychosis Program in Western Sydney, he is aware that the 12-25 age group is going through major brain changes, and it is possible that we can identify neuromarkers that enable better diagnosis and more personalised treatment.

Quantitative EEG has been around for many years, but it has been progress in the analysis software that is now revealing functional neuromarkers for psychiatry, with applications for diagnosis and treatment. In order to see what difference this may make in routine practice, we have been recording QEEGs, while people undertake psychological tasks, and comparing their QEEGs with healthy controls. Our experience so far will be presented, as we explore the value of the outcomes versus the steep learning curve required.

Learning Objectives
Learning Objective (1): The audience will leave with an understanding of the challenges of implementation and the value of QEEG in diagnosis and treatment of mental health disorders.
Learning Objective (2): If QEEG turns out to be useful in practice, it will be tipping point in examining the organ psychiatry diagnoses and treats.

References
"Why can't you hear me?" - Understanding the Meaning Behind the Complex Behaviours of Borderline Personality Disorder - from a Lived Experience Perspective.

Kaye Stanton

Biography:
A former National and International Athlete, Kaye endured her biggest challenge by surviving more than 30 years with Mental Illness. On recovering from Borderline Personality Disorder, she now devotes her time to inspiring others and sharing her wisdom and experience through Forums and Conferences. Kaye is currently writing her Memoir.

The Lived Experience perspective is crucial in the detection and early intervention of people with Borderline Personality Disorder. Interpreting the meanings behind the destructive behaviours associated with this complex Mental Illness is a challenge for Clinicians and Mental Health Services. Treatment for BPD can be punitive, reinforcing the negative messages Borderlines learnt earlier in life. Attitudes must change, as the stigma and discrimination attached to this diagnosis inhibits recovery. Effective communication is essential to hearing the whisper and understanding the needs of someone in mental distress.

Knowledge is a valuable tool when applied to Lived Experience and with recovery brings insight and understanding. Sharing my story is an important part of my recovery. Spanning three decades, my journey was difficult and enduring. Why did they ignore the whisper and wait for the roar? What did I really need from my Therapists? Were they really listening to me? Hearing the whispers and responding to their true meaning is acknowledging the value of every person presenting with a Mental Illness.

Learning Objectives

Learning Objective (1): The voice of lived experience is important in the future of service delivery and implementation. Greater understanding of BPD through lived experience can improve quality of care and treatment outcomes.

Learning Objective (2): Listening and communicating effectively to people with BPD is a skill that can save lives. Early intervention and greater input from the lived experience workforce is an important part of Mental Health Services today.

References

Adoption and Mental Health

Sharyn White
Adoptee Advocacy & Information Service Sa Inc, Oaklands Park, Australia

Biography:
Sharyn White is a mature age 3rd Year Psychology student at the University of Adelaide, passionate about publicising the damage caused by maternal deprivation and the psychological effects on adoptees of their publicly condoned ostracism and other cumulative trauma in adoption.

The adoptee Roar is not heard in mental health - let alone our whispers - because the mental health issues of adoption are attributed to other causes.

The presentation will discuss the higher mental health vulnerabilities of adopted people due to the cumulative traumas caused by the combination of maternal deprivation, genealogical bewilderment, legalised social ostracism and the creation of a new identity, among other issues in adoption.

Any discussion of adoption first needs to break through a barrier - we are expected to first explain that our trauma exists. Society assumes that adoption is not based upon trauma. As the Reverend Keith C. Griffith, MBE (and adoptee) stated: "Adoption Loss is the only trauma in the world where the victims are expected by the whole of society to be grateful". Any effects of adoption are put down to other causes and long-term outcomes are rarely followed up.

There will be a discussion of issues affecting adopted people at different stages of their lives, and the invalidation inherent in their legalised ostracism from their ancestry and kin and its effects on mental health. The effects of invalidation on the symptoms of Post Traumatic Stress Disorder will also be discussed in relation to adoption.

Thomas Graham's Australian paper on Suicide and Adoption (reference 1) will be drawn on, and also the work of the Australian Institute of Family Studies, and the large scale study (reference 2) of 13,111 Danish adoptees showing significant excess mortality of adoptees under 65 through infections, vascular deaths, cancer, alcohol-related deaths and suicides - and this will be compared with the limited data available from Australian Adoptees.

An argument for the need for data collection to provide an evidence base will be made as well as the need for awareness that the adoptee population is ROARing but is not counted, and so not heard.

Learning Objectives
Learning Objective (1): People in the audience will gain awareness that this silent (not even whispering) population exists.
Learning Objective (2): Very relevant topic/issue in mental health services and issues as adoptees are over represented in having mental health issues plus in South Australia there are around 30,000 adoptees - 1.8% of the population.

References

Living Beyond the Shadow of Abuse - A facilitated group for adult survivors of childhood trauma and abuse.

Stephanie Mitchell

*Humane Clinic, Adelaide, Australia

**Biography:**
Stephanie is a psychotherapist in private practice specialising in complex trauma and working with voices and other alternative experiences. She is passionate about creating safe spaces for sharing and brings with her an extensive history of therapeutic group facilitation, along with her own lived experience of recovery from child abuse.

Stephanie is interested in the transformative space that is generated within the human to human relationship and how this simple way of working is easily overlooked due to a bias for the use of 'techniques'.

Survivors of childhood abuse and trauma have often been considered to be too fragile to work together in a group setting for fear that they might re-traumatize each other through the sharing process in group work. As such most groups are based around education, 'wellness' promotion and strengths-based group processes.

This presentation will explore, how a 'process oriented and group lead' approach to working with abuse survivors in groups leads to spaces of personal empowerment, new understandings of self and greater resilience for group members.

Through person centred facilitation that focuses on 'negotiated group safety' and 'negotiated group process', the facilitator and group members safely navigate their way to co-creating spaces that are safe for all members to share and grow together and has enabled the group to make its own decisions and work out the bumps along the way towards new understandings and steps on the path of personal recovery.

This pilot group has led to an ongoing process orientated group being facilitated in South Australia, that provides an alternative space for individuals who have survived childhood trauma and have shown the courage in embracing new environments in recovery that can provide valuable lessons and opportunities to many others.

**Learning Objectives**

Learning Objective (1):
- Understanding of how process oriented and group lead approaches are more trauma informed and also more transformative than diagnosis or 'education' based groups for survivors of abuse.
- How individuals can be supported to explore alternatives in recovery journeys, including the groups run by an individual who brings together lived experience and professionals experience and skills.

Learning Objective (2):
- The Adverse Childhood Experiences study shows the dose relationship between adverse childhood events and adult mental health issues. The focus on the biological model of mental illness has taken us away from understanding the potential for meaning and recovery within relationship.
- Sharing experiences within groups helps normalise experiences of distress and find the purposefully 'adaptive' skills in what are often labelled maladaptive behaviours. This leads to empowerment of the individual and new narratives of self resilience and transformation.

**References**

Creating a Framework for Lived Experience Involvement: The Pathways, Processes & Supports you Need.

Ellie Hodges

*Ellie Hodges*, Littlehampton, Australia

**Biography:**
Ellie Hodges is a Lived Experience Counsellor and Consultant with more than 18 years of experience working in the community and mental health sectors as a practitioner, manager, educator, advisor, advocate and consultant. Most recently she has been a Lived Experience Advisor to the South Australian Mental Health Commission. At the heart of all of Ellie’s work is her commitment to innovation, social justice and leading together. She is informed and transformed by her work and knows that everyone has a story to tell... we just need someone to hear it. Ellie integrates her lived, learned and imagined experiences; she knows that they all matter.

Involving people with lived experience at all levels is enshrined in policy and accreditation processes and it is known good practice, with wide-reaching benefits, to do so. With this in mind it is critical that organisations and departments have frameworks, practice standards, processes and supports in place that create environments for involving people with lived experience that are robust, authentic, safe-enough and inclusive.

The workshop will explore the important elements to be addressed when creating a framework for lived experience involvement. Participants will practically explore together what this looks like in practice in their context and begin to develop a clear plan for implementation or refinement of what they are already doing.

**Workshop outline:**
- The nuanced wisdom that lived experience offers
- Understanding the experience of lived experience
- Discussing the complexity of experience and related (potential) vulnerabilities
- Parallel process and integrity of process for domains of involvement
- Addressing dilemmas of involvement: reductionism, spiritual pain and cultural safety
- Creating a framework, pathways, processes and supports for lived experience involvement: the unique value of lived experience, addressing stigma and discrimination, sharing power, structuring safety, leadership support, building the capability of people with lived experience as well as organisational capacity, and more
- Considerations for your context and your next steps

**Learning Objectives**

Learning Objective (1): The workshop will explore the important elements to be addressed when creating a framework for lived experience involvement in their organisations and projects. Participants will practically explore together what this looks like in practice in their context.

Learning Objective (2): Involving people with lived experience at all levels is enshrined in policy and accreditation processes and it is known good practice, with wide-reaching benefits, to do so. With this in mind it is critical that organisations and departments have frameworks and practice standards in place that to create environments for involving people with lived experience that are robust, authentic, safe-enough and inclusive.

**References**

Building a person-centred outcome approach; national learning from ongoing system and service development.

Kevin Harper

Ministry Of Health, Wellington, New Zealand

Biography:
Kevin is passionate about making mental health system change focussed on equity of outcome for service users and their family / whanau. He contributes to this as a Principal Advisor for the Ministry of Health in New Zealand.

We want to share our learning from putting emphasis on a people’s perspective to develop the New Zealand mental health and addiction system and services.

Our challenge is to contribute to all people in New Zealand thriving in their communities by promoting mental health and wellbeing and reducing the impact of mental distress, mental illness and addiction. Our approach has been to prioritise equity of outcome, an inclusive population focus, and a collective response. Yet, it has been surprisingly difficult to hold people’s needs at the heart of all development discussions.

Action has been taken to develop frameworks to engage those who contribute to mental health and wellbeing outcomes across the health, social and justice sectors and to understand who we need to help, how and with what benefit. But, we have learnt how quickly development becomes dominated by system and service needs, over people’s needs.

We will present the frameworks and their role in developing the system and services. Also, we will identify the practical and innovative steps we now think we can all take to help put people’s needs first.

Learning Objectives

Learning Objective (1): To identify and understand people-centred approaches and levers to support system and service change and our experience of using these.

Learning Objective (2): To challenge the audience to overcome barriers to change with options and tools based on our experience of what we have and have not done.

References

'They who begin a conversation, do not foresee the end'.

Kevin Harper

Ministry Of Health, Wellington, New Zealand

Biography:
Kevin is passionate about making mental health system change focussed on equity of outcome for service users and their family / whanau. He contributes to this as a Principal Advisor for the Ministry of Health in New Zealand.

I like to think that ongoing, open and visionary conversation will build trust, understanding and unity and help facilitate change that all people who want better mental health and addiction outcomes can contribute to.

I believe that we need a national consumer conversation to understand what it means and what is needed to build a people powered mental health system and services. Conversation participants would listen to the experience and knowledge of others, create new connections and be open about how these impact on their own thinking and action. To be most effective, this must be an ongoing conversation, one that is allowed to build its own momentum as well as support others to develop their contribution.

Through round table discussions, I seek feedback from Symposium attendees about whether there is support for my belief in a consumer conversation and the assumptions I cannot afford to make and the things I must consider; how to facilitate the conversation or build on those already happening; and what is needed to build the conversation?

Learning Objectives

Learning Objective (1): To give critical thought to how consumers are engaged in system and service design and the people power afforded by this
Learning Objective (2): To challenge participants with a new and innovative approach and test the reasoning and reality.

References

Choosing a disclosure strategy to improve your likelihood of getting employed.

**Craig Holz**, Amy Brockbank

 Walsh Trust, Auckland, New Zealand

**Biography:**

Amy Brockbank is a Senior Practitioner for Peer support services at Walsh trust in Auckland, New Zealand. She is an experienced and skilled practitioner and Peer Zone group workshop facilitator. She has a Diploma in Mental Health Support Work, Masters in Human Geography and is trained in Intentional Peer Support.

Craig Holz is a Registered Social Worker at Walsh Trust and 2015 Golden Globe award winner for his client support work. Craig has a Bachelor of Social Work and Social Policy, as well as a Master’s in Management. A proud member of Toastmasters NZ; Craig is an experienced persuasive speaker.

What and when to disclose is a significant question for any jobseeker with experience of mental distress. Craig Holz researched the perception of employers in Auckland to different disclosure strategies. All read a job seekers job description, CV, references and the transcript of an interview. There were three different transcripts. A third of the transcripts did not disclose any psychiatric disability. The next transcripts disclosed the applicant being unwell in the past but focused on how this job matched the person’s strengths. The last third of the transcripts stated a diagnosis of schizophrenia. The employers were asked to rate their likelihood of hiring the applicant on a four-point Likert scale (1 very unlikely to 4-very likely). The first transcript scored an average of 3.60. The second transcript scored an average of 4.00. The third transcript scored an average of 3.29. And in this group, two out of seven said they were unlikely to hire due to fear. So employers presented with an applicant with a psychiatric disability, having the necessary skillset and experience, were likely to hire them. WALSH peer support workers encourage people to develop their identity as a thriving person who successfully counter the disabling attitudes of others.

**Learning Objectives**

Learning Objective (1): Research shows that employers are willing to hire people with lived experience who have the skillset and experience for the job. Peer support workers can enable people to develop their identity as a successful person who can look for work and confidently use a disclosure strategy that increases their likelihood of being hired.

Learning Objective (2): Further research on employers’ perceptions always needs to include information on the skills and abilities of a job seekers with a psychiatric disability before asking employers whether they would hire them. Peer support workers can successfully support people to develop their identity and disclosure strategy to improve their likelihood of getting employment.

**References**

Lennan, M and Wyllie, A. (2005). Employer attitudes and Behaviours relating to mental illness Wellington Ministry of Health

Using body mapping to explore lived experience.

**Katherine Boydell**

1Black Dog Institute, Sydney, Australia

**Biography:**
Professor Boydell’s research program focuses on advancing qualitative inquiry, specifically, in the area of arts-based health research. She explores the use of art genres in the creation and dissemination of research - including documentary film, dance, digital storytelling, found poetry, installation art and body mapping.

Body mapping is an arts-based research tool, which, due to its focus on embodied experience, lends itself to exploration of sensory and psychological experience. Body mapping involves ‘...tracing around a person’s body to create a life-sized outline, which is filled in during a creative and reflective process, producing an image representing multiple aspects of their embodied experience...’ (de Jager A, Tewson, Ludlow & Boydell, 2016). Body mapping is beneficial for knowledge translation purposes due to its flexibility in presentation possibilities, e.g. an exhibition, photo book, or explored in research papers. The use of body mapping in research allows for an exploration of embodied experience that is more creative, which is not possible when conducting surveys or interviews (de Jager, 2016). It is participant focused, so there is less of a hierarchical structure when considering the relationship between researcher and participant. This presentation provides an overview of the use of body mapping to depict the lived experiences of young people with psychosis, depression and anxiety. Both the creation and dissemination process will be described. These studies demonstrate the positive impact that body mapping has had on research participants in the process of creating the body maps depicting their experiences. They also highlight the impact of disseminating empirical research using this arts-based method on mental health awareness, stigma reduction and the creation of a socially engaging space in which conversations about mental health issues can occur.

**Learning Objectives**

Learning Objective (1): To gain an understanding of the value of using art genres in the research process, in the generation and dissemination of new knowledge

Learning Objective (2): To understand the relevance of arts-based research methods in knowledge translation

**References**


An Integrated Approach; Utilising Therapeutic Yoga & Cognitive Analytical Therapy (CAT) for Mental Health Self Care.

Jennifer O'Brien¹, Christina Browning
¹Australian Catholic University, Melbourne, Australia

Biography:
Jennifer is an Occupational Therapist and ANZACAT practitioner that works in private practice and also as academic at the Australian Catholic University in Melbourne. She is involved in a broad spectrum of work within her field including clinical work, research, teaching and presenting at conferences and workshops.

Christina is a yoga therapist that specialises in therapeutic yoga for anxiety and depression. Her classes incorporate mindful breathing synchronised with movement. Her interest in yoga spiked after the practice helped her own recovery from burnout, deep seated anxiety and depression.

There has been an increase in the use and acceptance of complementary therapies such as yoga for treating depression[1], anxiety[2] and for general mental health self care.[3]

However, the existing evidence has a lack of theoretical framework reporting, and small research sample sizes. Research focuses on yoga as an adjunct to therapy and few studies focus on integrating these approaches.[3]

This presentation provides an overview of current literature including yoga psychology frameworks supporting the integrated approach of Yoga Therapy and CAT for improving mental health self care.

CAT is a collaborative therapy that aims to understand how the individual's past relationships shape current ones and contribute to deeply ingrained patterns.[4] The foundation of yoga is about becoming aware of deeply ingrained patterns and allowing them to change shape.[5] These patterns are often enacted in relationships with others and are often present on the yoga mat.

This integrated approach utilises language, movement and breath providing a short therapy process to uncover deeply ingrained patterns with the aim of transforming these patterns into restorative ways of caring for self.

Learning Objectives

Learning Objective (1): Participants will be introduced to yoga psychology frameworks and the current research evidence base in yoga therapy.
Learning Objective (2): Participants will learn about an integrated approach to yoga and therapy for improving mental health self care and therefore consider integrated approaches within their own practice.

References

Engaging and working with refugees: Using a relational framework to support mental health practitioners and services to engage and work with refugees.

Jennifer O'Brien¹
¹Australian Catholic University, Melbourne, Australia

Biography:
Jennifer is an Occupational Therapist and ANZACAT practitioner that works in private practice and also as an academic at the Australian Catholic University in Melbourne. She is involved in a broad spectrum of work within her field including clinical work, research, teaching and presenting at conferences and workshops.

The Syrian refugee crisis has highlighted how the public and political responses to the refugee experience are often polarised. These responses reinforce the themes that already dominate the trauma narratives of refugees. Mental health practitioners and health and social services in countries of re-settlement struggle to engage and meet the complex set of psychiatric and psychosocial needs. The crucial question, therefore, given the current political and economic climate, is how do practitioners and services respond humanely and effectively to the needs of refugees, either directly or indirectly? The aim of this presentation is to explore how a relational framework (CAT, Ryle & Kerr, 2002) can be used when working with refugees. This presentation takes a CAT relational lens and maps it onto an existing trauma framework (Silove, 1999; VFST, 1998). In doing so it provides a relational ‘mirror’, which highlights the dominant relational patterns in the refugee experience. The narratives of survivors, practitioners and services are drawn upon to illustrate these relationship patterns. There is real potential for this framework to be of value not only as a therapeutic framework but also as a conceptual framework for indirect work with mental health practitioners and services and has potential as a tool for advocacy.

Learning Objectives
Learning Objective (1): To utilise case examples in order to describe dominant relational patterns related to the refugee experience.
Learning Objective (2): To consider how a relational approach can support mental health practitioners and services design and improve services to better support this population.

References
Debt Recovery: Supporting consumers in an involuntary setting to actively engage in managing financial responsibilities.

Paul Clare, Sharon Campbell
Forensic And Secure Services, Brisbane, Australia

Biography:
Paul trained as a Social Worker and has worked for a Non-Government Organisation, The High Security Inpatient Service, Prison Mental Health Service and the Mental Health Alcohol and Other Drugs Branch prior to his current role. Paul leads the Allied Health team in Forensic and Secure Services, West Moreton.

Sharon worked in finance in the Queensland Department of Health prior to working as a Senior Revenue Manager in West Moreton. Sharon’s role involves identifying opportunities to improve revenue collection. Sharon enjoys direct contact with consumers. Consumers recognised her work nominating her for a mental health week award in 2017.

Queensland’s State-wide Forensic Inpatient service levies accommodation fees for consumers admitted longer than 35 days. This approach is consistent with long stay services in the state. Historically, few financially capable consumers have been willing to pay or negotiate payment plans. In addition to financial pressures this causes the service, it has generated inequality between those with capacity to manage financial affairs and those receiving support for this. Previously, the responsibility for pursuing payment and debt notionally resided with clinical teams, however, this has not always been a high priority for clinicians balancing competing demands. Inadvertent organisational support for accruing large unpaid debts arguably undermines rather than enhances consumer agency. This contrasts with recovery oriented practice with involuntary consumers discussed by Courtney and Moulding (2014).

This paper will outline a revised, collaborative approach adopted by the Revenue and Social Work teams to support consumers to meet fee payments. It explores a number of challenges in implementing the change within a workforce with competing priorities. The paper will draw on preliminary evaluation to demonstrate positive outcomes and reflect on the relevance of Corrigan’s (2016) observation of the tension between ‘pity’ and ‘parity’ in confronting and reducing stigma within organisational practices.

Learning Objectives

Learning Objective (1): Participants will gain an understanding of the principles underpinning the collaborative work between Revenue and Social Work to support consumers to increase their contribution to accommodation payments.

Learning Objective (2): This topic is directly relevant to services aiming to improve the collection of fees from service users and is of broader interest in stimulating reflection about organisational approaches that potentially stigmatisate rather than genuinely support consumers to exercise responsibility and agency as part of their recovery.

References


Collaborating with community to develop a Social Issues Strategy in response to the suicide and ice challenges our communities face.

Kylie Fitzmaurice¹, April Edwards¹
¹Weave Youth And Community Services, Sydney, Australia

Biography:
Kylie is the Team Leader for the Speak Out Dual Diagnosis Program at Weave Youth and Community Services. Kylie has a background in psychology and counselling and is passionate about looking at mental health and alcohol and other drug challenges through a trauma informed, strengths based and person/community centred lens.

April is a young leader in the Youth Advocates Program at Weave Youth and Community Services. She has helped to test, pilot and deliver the recommendations Weave have made through their Social Issues Strategy work. April is passionate about young people having a voice.

Weave Youth and Community Services has been working on developing a Social Issues Strategy in response to the suicide and ice challenges our communities are facing. For 12 months, we worked through a Human Centred Design approach which involved us looking to our communities, clients, stakeholders, experts in the suicide and ice fields and current research for clues on existing gaps and challenges within this work. From these hundreds of insights, we identified opportunity areas existing for this work and we brainstormed, developed and tested the prototypes we developed. The question we asked ourselves regarding our work on suicide was, “How do we support and nurture children and young people in the community so that suicide is not seen as an option? Love me while I’m here, don’t celebrate me when I am gone.” The task we set ourselves regarding our work on ice was, "To accurately understand how ice is affecting our community and to develop our service/treatment to best support ice users and their families". We are currently developing and implementing the many recommendations we have made and we hope to share our innovative and community driven Social Issues Strategy work at TheMHS Conference in 2018.

Learning Objectives

Learning Objective (1): We hope our presentation highlights the importance and relative ease with which services and supporting organisations can engage their local communities to address the mental health and AOD challenges they face. This piece of work will show a strengths based, person centred and trauma informed approach in action and we will demonstrate how this ensures the work remains relevant, meaningful and most importantly helpful to the people in our communities.

Learning Objective (2): Our topic is directly related to mental health and wellbeing. Our Speak Out Dual Diagnosis Program supports young people experiencing coexisting mental health and AOD challenges and our Social Issues Strategy work is informing the support we provide from 2018. Our clients and communities are impacted greatly by suicide and ice use and this presentation will present creative and innovative ways to support people facing these challenges.

References


Workplace Change: Nothing about us without us.

**Belinda Brown**¹, **Keryn Robelin**²

¹Mental Health Coalition Of South Australia, Unley, Australia, ²UnitingSA, Port Adelaide, Australia

**Biography:**
Joining the NGO sector in 2006, Belinda Brown’s expertise in Education was invaluable in the development of SA’s first Peer Work training and Certificate IV in Mental Health Peer Work. As Senior Project Officer for the MHCSA’s Lived Experience Workforce Project, Belinda passionately supports growth of this incredible workforce.

Keryn Robelin is the Consumer Consultant/Peer Worker for UnitingSA, leading a LE team within MHS. She is driven by opportunity for change and education, alongside people lived experience and those who deliver supports when needed. Kez works from the understanding of recovery as a daily practice of "welling".

Mental Health Peer Work was introduced to South Australia in 1998 and by 2013, the Peer Work Project led by non-Government Organisations (NGOs) Baptist Care SA (BCSA) and Mental Illness Fellowship SA (MIFSA), had successfully trained more than 350 people with Lived Experience (LE) in the values, principles and core skills of LE as an employable skill set.

Through evaluation it was discovered that whilst the majority of Peer Workers (PWs) felt they had received good foundation training for the role, their experiences in integrating within the workplace were not always positive. Findings concluded that “Some peer workers felt that they had to explain their role to their colleagues, and that there had been misunderstandings. Furthermore, a few peer workers felt that lack of role definition may have exacerbated a lack of acceptance in their workplace” (SACHRU Endpoint Report Baptist Community Services Peer Support Project Evaluation: Integrating peer work into workplaces 2008) and “...many of these workers have been employed without regard to the tensions inherent in their role and with little support to address these.” (National Consumer and Carer Forum, 2010).

Over time, the Lived Experience Workforce (LEW) in SA has matured to become a skilled and specialised workforce. The Certificate IV in Mental Health Peer Work has been refined and is a valuable professional qualification for the LEW. Yet in many instances, the work environment is yet to catch up. Strong commitment to LEW and effective leadership are seen as critical to the success of LEW within organisations. “The culture needs to support peer work and then other staff would follow. As a single peer worker you’re not going to be able to change the culture.” (Peer Worker in Franke, Paton and Gassner Implementing mental health peer support: an SA experience 2010).

The Lived Experience Workforce Project (LEWP) was funded in late 2014 by the State Government to deliver, amongst other outcomes, a set of Standards and Guidelines for NGOs to support the effective recruitment, retention and growth of their LEW. These best practice principles have been co-produced by the LEWP Reference Group (Lived Experience Workers (LEWs) and Leaders of LEW from the NGO sector) and will be shared with the Government sector for adaptation to support the needs of their LEW.

Designed as a self-assessment tool, the Standards and Guidelines are in pilot implementation across the NGO sector. LEWP has been able to gather feedback on the positive changes the Standards and Guidelines are having on the organisations – for Management and Leaders, LEW and general workforce.

Whilst workforce planning is traditionally carried out at a Management and HR/Quality level, LEWP believes the best people to lead the Standards and Guidelines implementation process are members of the LEW themselves – as people with LE across the world have noted, there should be “Nothing about us without us.”

This workshop will provide LEWs from across Australia with an opportunity to:
- Learn about the LEWP NGO Mental Health LEW Standards and Guidelines
- Consider what their workplace does well and what it could do more effectively, in order to support the unique roles of LE Practitioners
- Identify gaps, opportunities and begin to think about strategies for advocating for LEW within their workplace context
Drawing from the best practice principles contained in the Standards and Guidelines, the workshop will be chaired by Shandy Arlidge, Project Manager of LEWP and facilitated by two experienced NGO LEW leaders; all three have been involved in the Standards and Guidelines from co-production to implementation.

The workshop structure will be:
• 5 minutes: Chair introduces the session and facilitators
• 30 minutes: Facilitators present an overview of the Standards and Guidelines:
  - Co-production process
  - What they say and how this may look in practice
  - Facilitators’ personal experiences with the implementation process
• 45 minutes: Interactive workshop (small groups/talking circles):
  - When it comes to the LEW, what currently happens within your organisation/service (recruitment, support, growth)?
  - What could your organisation do more effectively?
  - How could you advocate for this within your organisation?
• 10 minutes: Sharing key ideas from workshop (large group) and closing remarks from Chair

Learning Objectives

Learning Objective (1):
• Understanding of what best practice looks like regarding recruitment, retention and development of the Lived Experience Workforce (LEW)
• Reflection: current practice within own organisation
• Opportunity to consider gaps and think about strategies for advocating for best practice within the Lived Experience Worker’s own workplace
• Best practice principles can be applied to NGO and Government LEW and other disciplines where Lived Experience (LE) skill set is utilised. Can also be applied across general workforce: almost half of Australians will feel the impact of mental illness in their lifetime

Learning Objective (2):
• The Fourth National Mental Health Plan (Commonwealth of Australia, 2009) included the employment of people with LE and development of a supporting workforce strategy, as an area of priority
• NDIS is an opportunity to grow this specialist workforce, which continues to form an integral part of our national and state strategic direction through the Fifth National Mental Health and Suicide Prevention Plan and the SA Mental Health Strategic Plan
• 2015 LEWP Training Needs Analysis identified that the LE skill set is not clearly understood by leaders and colleagues; professional development around this skill set is vital for effective employment and leadership of LEW

References

• HWA MH Peer Workforce Study
• National Mental Health Consumer and Carer Forum 2010 Supporting and developing the mental health consumer and carer identified workforce – a strategic approach to recovery
Independent Mental Health Advocacy, Supported Decision Making and the Convention on the Rights of Persons with Disabilities.

Lucy Ledger

*Independent Mental Health Advocacy, Melbourne, Australia*

**Biography:**
Lucy is a Senior Advocate in the Victorian Independent Mental Health Advocacy service where she supports the service’s Melbourne team. Lucy qualified as an Occupational Therapist, however her more recent roles have focused on disability rights advocacy both in Australia and overseas which has been complemented by her Master of Human Rights Law.

This presentation aims to provide an overview of how mental health advocacy services can operationalise a supported decision making approach. The development of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2006 was a landmark for the disability rights movement globally. In particular, the acknowledgement of universal legal capacity (Article 12) and the imperative this created for supported decision making to replace substituted decision making regimes, heralded great significance in the context of mental health systems. Supported decision making refers to a system that comprises various support options which give primacy to a person’s will and preferences and respect human rights. This presentation will explore how the doctrine of supported decision making enshrined in the CRPD can be operationalised practically through a service, using the Independent Mental Health Advocacy (IMHA) program in Victoria as an example of this. An introduction to the international law giving rise to supported decision making will be provided before systematically demonstrating components of this in action through the collaboration of people using our service and non-legal advocates in the IMHA service.

**Learning Objectives**

Learning Objective (1): Understand what supported decision making is according to international human rights frameworks and how it can be operationalised in mental health advocacy services.

Learning Objective (2): Be equipped to consider elements of a supported decision making approach in service design in light of evidence about its benefits for consumers and services, as well as the human rights imperative.

**References**


Reflections from three years of operation of Australia's first Independent Mental Health Advocacy service.

Lucy Ledger

Independent Mental Health Advocacy, Melbourne, Australia

Biography:
Lucy is a Senior Advocate in the Victorian Independent Mental Health Advocacy service where she supports the service’s Melbourne team. Lucy qualified as an Occupational Therapist, however her more recent roles have focused on disability rights advocacy both in Australia and overseas which has been complemented by her Master of Human Rights Law.

This presentation aims to provide an overview of lessons learned from three years of operation of Australia’s first Independent Mental Health Advocacy (IMHA) service. This Victorian service provides representational advocacy and coaching for self-advocacy for people who are experiencing compulsory mental health treatment or those who are at risk of it. The presentation will explore two key areas: themes arising from common advocacy requests and reflections on service development over the service’s first three years. Themes arising from advocacy requests will include coercive treatment of voluntary consumers, service responses to family violence and sexual assault, limited access to non-medication based interventions and limited implementation of supported decision-making mechanisms. Reflections on service development will examine lessons learned about ways IMHA has sought to engage consumers, including through a consumer advisory group, advocacy models – both individual and systemic, and strategies for strengthening relationships with mental health services. The presentation will support mental health services in understanding how they can work with mental health advocates, provide information for government or non-government organisations wishing to replicate the model and information for stakeholders interested in identifying opportunities for mental health service system reform.

Learning Objectives

Learning Objective (1): Understand common advocacy issues identified by consumers experiencing compulsory treatment and lessons learned from service development of a mental health advocacy service.
Learning Objective (2): In light of the contemporaneous push for human rights informed service delivery, understand how mental health advocacy services and mental health service providers can work together and how consumers can be supported to access advocacy services.
A new Mental Health First Aid Course to help the Older Person: A description and pilot evaluation of the course.

Kathy Bond1,2, Leonie Marks1
1Mental Health First Aid Australia, Parkville, Australia, 2University of Melbourne, Parkville, Australia

Biography:
Kathy Bond is the Senior Research Officer at Mental Health First Aid Australia and holds an honorary position at the University of Melbourne. She conducts Delphi expert consensus studies that inform MHFA curriculum and conducts pilot evaluations on newly developed courses.

Leonie is the Older Person Program Manager and Instructor Coordinator. She is a Principal Master MHFA instructor, accredited to deliver a number of MHFA courses. Leonie is an advocate of personal recovery and views MHFA as a valuable and effective tool in inspiring new levels of insight, responsiveness and care.

Good mental health is an important factor in facilitating senior Australians to live healthy lives. In older age, mental illnesses can particularly occur in association with physical illnesses, loss of independence, bereavement and brain changes that occur with ageing.

The new 12-hour Older Person Mental Health First Aid Course is suitable for aged care workers and community members who live or work with people aged 65 and over. Launched in November 2017 by Mental Health First Aid Australia, the curriculum is based on expert consensus guidelines using both professional and consumer experts from English speaking developed countries. Learning outcomes include: signs and symptoms of common mental health problems and crises, confusion and dementia; skills in how to offer initial help; where and how to get appropriate and effective help.

Initial pre- and post-course results from 100 home care workers in Victoria will be presented as part of an ongoing uncontrolled trial of the course. Early evaluation data shows improvements in intentions to assist older people with depression or confusion, and in their confidence in providing help. Stigmatising attitudes were also found to be reduced. The course was found to be highly acceptable to the participants.

Learning Objectives
Learning Objective (1): Attendees will learn about the Mental Health First Aid for the Older Person course, which may be helpful to their work and their family, friends and community.
Learning Objective (2): Attendees will learn how community-based education programs can be informed by a consensus driven evidence-base, incorporating the expertise of professionals and consumers.

References
Kitchener BA, Jorm AF, Kelly CM. Older Person Mental Health First Aid: A Manual for Assisting People Age 65+. Melbourne: Mental Health First Aid Australia; 2017.

Bond KS, Jorm AF, Kitchener BA, Kelly CM, Chalmers KJ. Development of guidelines for family and non-professional helpers on assisting an older person who is developing cognitive impairment or has dementia: a Delphi expert consensus study. BMC Geriatrics. 2016; 16:129.
Teen Mental Health First Aid for years 7-9: A pilot study of a new course for adolescents assisting their peers.

Kathy Bond¹²
¹Mental Health First Aid Australia, Parkville, Australia, ²University of Melbourne, Parkville, Australia

Biography:
Kathy Bond is the Senior Research Officer at Mental Health First Aid Australia and holds an honorary position at the University of Melbourne. She conducts Delphi expert consensus studies that inform MHFA curriculum and conducts pilot evaluations on newly developed courses.

The teen Mental Health First Aid 7-9 course (tMHFA 7-9) teaches high school students in years 7-9 how to provide mental health first aid to their friends. The course was developed in response to research indicating that young people have a preference for sharing problems with peers. The course curriculum is informed by a study undertaken to determine the best actions a young person can undertake to support a peer with a mental health problem.

The course teaches students about the tMHFA Action Plan, information about mental health problems and mental health crises in young people, and the relationship between thoughts, feelings and behaviours. Rather than focusing on specific mental illnesses, the course teaches participants to recognise when a friend is experiencing major changes, that may indicate the presence of a mental health problem.

This presentation will focus on a pilot uncontrolled trial of the tMHFA 7-9 course that took place in five Victorian high schools, thanks to funding from the Ian Potter Foundation. The study evaluated changes in knowledge, attitudes, behaviours and confidence in providing assistance to a peer before and after the course.

Learning Objectives

Learning Objective (1): Attendees will learn one potential method for evaluating a school-based mental health first aid education intervention.

Learning Objective (2): Attendees will learn how school-based education programs can be informed by a consensus driven evidence-base, incorporating the expertise of professionals and consumers.

References


Rickwood DJ, Deane FP, Wilson CJ. When and how do young people seek professional help for mental health problems? MJA. 2007; 187.
Recovery orientated education programs: A rapid integrative review of the literature.

Keith Sutton
^Monash University Department Of Rural Health, Moe, Australia

Biography:
Keith has extensive experience as a clinician, manager and bureaucrat in the mental health field. A registered psychiatric nurse, he has worked in the UK, Queensland, Melbourne and Gippsland. Keith is the mental health academic based at Monash University Department of Rural Health.

The early iterations of recovery orientated education programs began to emerge in the USA in the mid-1980s through to the early 1990's, with the aim of assisting people to manage their long-term mental health problems. Early approaches used psycho-educational principles as their basis (Mowbray et al, 2005); however, in the 1990s recovery principles began to underpin the design and delivery of programs. Interest in supporting personal recovery through education has grown as evidence for the effectiveness of adoption of recovery-focused practice has spread around the globe (Slade et al, 2014). This presentation focuses on the findings of a rapid integrative review of the recovery orientated education literature, including the characteristics and effectiveness of recovery orientated education programs. The presentation will conclude by considering the implications of delivering recovery orientated education programs to those living in rural and remote areas.

Learning Objectives

Learning Objective (1): Those attending this session will leave with an understanding of the development, characteristics and effectiveness of recovery orientated education programs. The audience will also learn about the importance of considering factors such as learning strategy, embedding lived-experience and enabling access to the delivery of recovery orientated education programs in rural and remote locations.

Learning Objective (2): The emergence of recovery colleges is a relatively recent phenomenon and the evidence for the effectiveness of recovery colleges is yet to emerge. Understanding the broad context of the characteristics and effectiveness of recovery orientated education programs may drive innovation and increase service access to people who live in rural and remote settings.

References


Tackling Tobacco in clinical mental Health services: What works?

Shane Sweeney¹, Kevin Gregg-Rowan
¹NorthWestern Mental Health, Parkville, Australia

Biography:
Shane Sweeney, Program Manager, SUMITT (NWMH) is a social worker with over 30 years’ experience in clinical mental health and alcohol and other drug services. He is interested in organisational change and service improvement. He is passionate about involving people with lived experience in projects.

Kevin Gregg-Rowan, Project Coordinator Mental Health (Quit Victoria) is a registered nurse and social researcher who has worked in clinical, research and health promotion roles in public health over the last 25 years. His particular focus is on translating research into practice change in drug and alcohol, mental health and chronic disease prevention.

Tobacco use is a significant contributor to the early mortality and morbidity of people with serious mental health issues. Despite the availability of smoking cessation clinical guidelines and increased attention to physical health, embedding smoking cessation support into usual care is challenging for the mental health sector.

Quit Victoria and NorthWestern Mental Health (NWMH) partnered in 2016 to pilot the Tackling Tobacco Framework and determine if the framework is a feasible and acceptable model for embedding smoking cessation supports into routine care for people living with mental illness.

The four mental health sites include:
• a youth community service and youth inpatient service,
• a community team,
• a residential community care unit,
• a secure inpatient rehabilitation unit.

Initial consultation with staff and consumer/carer representatives identified strategies to address the barriers and enhance opportunities to improve practice and support consumers to stop smoking and manage nicotine dependence. Strategies address the six elements of the framework.

Mid-point staff survey results indicate improvements in staff knowledge, including understanding consumers’ desire to quit smoking. Along with these results, the results from client file audits and consumer case studies will be presented, with a focus on which strategies have been effective and improvements required.

Learning Objectives

Learning Objective (1): Understand the Tackling Tobacco framework and identify the different strategies used by NorthWestern Mental Health and Quit Victoria to support smoking cessation at three adult and one youth mental health service within northwestern Melbourne.

Learning Objective (2): Understand which organisational change strategies are most effective in embedding smoking cessation supports in both adult and youth clinical mental health services.

References

Mental Health First Aid: An appropriate public health intervention across lifespan, culture and context.

Ms Nataly Bovopoulos¹², Dr Kathy Bond¹²
¹Mental Health First Aid Australia, Parkville, Australia, ²University of Melbourne, Parkville, Australia

Biography:
Nataly Bovopoulos, CEO, joined MHFA in 2011 and has worked as a Program Manager and Deputy CEO. Nataly has 15 years' experience in the NFP mental health sector and has a particular interest in the workplace. She is completing a PhD on mental health first aid strategies in the workplace.

Kathy Bond is the Senior Research Officer at Mental Health First Aid Australia and holds an honorary position at the University of Melbourne. She conducts Delphi expert consensus studies that inform MHFA curriculum and conducts pilot evaluations on newly developed courses.

Mental health first aid is the help offered to a person developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis. Mental Health First Aid (MHFA) Australia develop and evaluate courses that equip community members to provide assistance to people experiencing mental health problems. A meta-analysis conducted in 2014 found that MHFA courses increase participants' knowledge regarding mental health, decrease their negative attitudes, and increase supportive behaviours toward individuals with mental health problems.

MHFA Australia have courses for adolescents assisting their peers, adults assisting young people, adults assisting other adults, and adults assisting people over 65. There are also courses for assisting people from specific cultural groups including Aboriginal and Torres Strait Islander people. The course has also been tailored for specific contexts - tertiary students, the workplace, as well as for pharmacies and the legal profession. There are also specialist courses for how to help people experiencing suicidal thoughts and behaviours, gambling problems, and non-suicidal self-injury (to be released later in 2018).

Mental Health First Aid courses equip community members to offer mental health first aid across the lifespan and in a variety of contexts.

Learning Objectives

1) Attendees will be exposed to the idea that culture, development across the lifespan and context are all important factors when assisting a person experiencing mental health problems.

2) Attendees will learn about a public health intervention that improves mental health literacy, decreases stigmatising attitudes and increases supportive behaviours towards a person experiencing mental health problems.

References


Safewards Implementation in the Mental Health Intensive Care Unit - Hornsby Ku-ring-ai Mental Health Service.

Neil Hepple¹, James Ward¹, Regan Runnalls¹
¹Hornsby Mental Health Service - Northern Sydney Local Health District Mental Health Drug & Alcohol, Hornsby, Australia

Biography:
Neil Hepple has worked in nursing for 35 years, with 29 years specifically within Mental Health. His career has included experience in both inpatient and community acute and non-acute mental health settings, acute admission units, rehabilitation areas as well as Community Acute Care Teams and in Community Health Centres as a community case manager and in Emergency Departments as part of a Mental Health Assessment Team. The position held, associated with this presentation was, Clinical Nurse Consultant at the Mental Health Intensive Care Unit Hornsby-Ku-Rin-Gai Hospital part of Northern Sydney Local Health District. His current position is as and Educational Consultant, Nurse Educator with the primary portfolio being violence prevention and management.

Safewards is a model of care designed to reduce conflict (behavioural disturbance, rule breaking) and containment (coerced medications, restraint and seclusion) in acute adult mental health inpatient units. Research shows that a small minority (6%) of patients were responsible for 71% of violence and aggression incidents. In 2015 the Mental Health Intensive Care Unit (MHICU) at Hornsby Mental Health Service implemented Safewards as part of a wider research project. The MHICU is a 12 inpatient bed unit located in a metropolitan health service. The MHICU implemented the top ten evidence based interventions utilising champions.

Outcomes since implementation:
• Conflict decreased by 14.6% (CI 5.4 – 23.5% P=0.004).
• Containment decreased by 23.6% (CI 5.8 – 35.2% P= 0.0099)

Your Experience of Service (YES) survey results increases:
• Feeling safe on the ward 16%
• Individuality and values respected 17%
• Staff engagement 18%
• Access to a treating doctor 24%
• Opinions of family and friend involvement 20%
• Being listened to in all aspects of care 16%
• Relevant consumer activities 19%
• Opportunity for family and friends to be involved 15.8%
• Development of a care plan that considered your needs 18%
• Effects of future hopelessness 19%

Learning Objectives

Learning Objective (1): How to practically implement a Safewards model of care using a champion model.
Learning objective (2): Implementing a model of care that reduces conflict and containment in mental health services.

References
Introducing Open Dialogue to an adolescent inpatient and community team in the Illawarra Shoalhaven Local Health District: Acceptability and feasibility for staff, consumers, and their families.

Anna Sidis¹, Rajiv Singh¹, Christopher Marsland¹, Felicity Wiseman¹, Niels Buus², Kristof Mikes-Liu³
¹Illawarra Shoalhaven Local Health District, Nsw Health, Shellharbour, Australia, ²University Of Sydney Nursing School, Shellharbour, Australia, ³Napean Blue Mountains Local Health District, Shellharbour, Australia

Biography:
Dr Anna Sidis is a Senior Clinical Psychologist with over 15 years experience providing psychological assessment and treatment to young people and their families. Anna has worked in a number of inpatient and community services including Headspace, ORYGEN Youth, Early Psychosis team (SESAHS) Canteen youth cancer service and the Brain and Mind Centre.

The Child, adolescent and youth mental health service (CAYMHS) for the Illawarra Shoalhaven Local Health District includes specialist services for children and adolescents and youth with moderate to severe mental illness between the ages of 14 and 25. A recent stakeholder and consumer consultation has reflected a call for improvements in family and network engagement and continuity between inpatient and community settings.

Open Dialogue is an approach to the delivery of mental health services developed in Finland (Alanen et al, 1991). This recovery-oriented approach includes a particular dialogical approach to psychotherapy and an emphasis on organising responsive and seamless healthcare pathways (Seikkula 2000). A number of studies have indicated that Open Dialogue led to improvements in social function, vocational outcomes and reductions in rates of hospitalisation for young people presenting with a first episode of psychosis (Siekkula et al 2001b; Siekkula et al 2003; Altonen et al 2011; Gromer, 2012). A review of studies into the implementation of Open Dialogue concluded that clinicians, consumers and their families generally welcomed this approach (Buus et al 2017). We have obtained two Health Education and Training Institute (HETI) allied health grants to engage trainers in Open Dialogue for the community and inpatient unit CAYMHS teams.

Our intention for this project is to examine the impact of training in the Open Dialogue approach and implementation of Open Dialogue practice commencing with consumers on the SAMHIPU and continuing in the CAYMHS community team.

Learning Objectives

Learning Objective (1): An understanding of consumer and family oriented approach, developed in Finland. Challenges to implementing this approach in the ISLHD.

Learning Objective (2): Results of qualitative interviews from families regarding this approach and what was helpful.

References


Social prescribing interventions: what is the current evidence base?

Katherine Boydell¹
¹Black Dog Institute, Sydney, Australia

Biography:
Professor Boydell’s research focuses on advancing qualitative inquiry in arts-based health research. She explores the use of art genres in research creation and dissemination - including documentary film, dance, digital storytelling, poetry, installation art and bodymapping. Her work explores theoretical, methodological, ethical challenges of engaging in arts-based translation.

The use of non-drug, non-health-service interventions have been proposed as a cost-effective alternative to improve the health and well-being of individuals experiencing mental health difficulties. Interventions normally involve accessing activities run by the third sector or community agencies and may also be described as non-medical referral, community referral or social prescribing. Social prescribing schemes commonly use services provided by the voluntary and community sector and can include an extensive range of practical information and advice, community activity, physical activities, art and cultural involvement, art therapy, walking and reading groups, nature-based activities, as well as support with employment, debt, housing and legal advice. This presentation provides an overview of 6 current models of social prescribing classified as signposting, light, medium and holistic. The evidence base for social prescribing is reviewed along with identification of factors that facilitate or hinder the implementation and delivery of such programs.

Learning Objectives

Learning Objective (1): To gain knowledge regarding the impact of social prescribing as a mental health intervention
Learning Objective (2): To acquire knowledge about the relevance of social prescribing to mental health via review of best evidence in the field

References


Shining light to support improvement: Monitoring and Advocacy of New Zealand's Mental Health Commissioner.

Jane Carpenter¹,²
¹Office Of The Health And Disability Commissioner, Wellington, New Zealand, ²Mental Health Commissioner, Wellington, New Zealand

Biography:
Jane Carpenter was the lead author of the New Zealand Mental Health Commissioner's 2018 report into mental health and addiction services and lead architect of the monitoring framework underpinning it. Jane has a policy background. Her expertise is in weaving information strands together to tell a cohesive story.

New Zealand's Mental Health Commissioner is delegated by the Health and Disability Commissioner a statutory watchdog role to monitor mental health and addiction services and advocate for their improvement.

In February 2018, the Commissioner released his first report into mental health and addiction services. The report is underpinned by a monitoring framework developed with the sector that asks:
Can I get help for my needs?
Am I helped to be well?
Am I a partner in my care?
Am I safe in services?
Do services work well together for me?
Do services work well for everyone?

These questions were answered by analysing: complaints data; consumer and family feedback; sector engagement; and key performance indicators and sector reports.

Findings included: growing access to services, leading to workforce and service pressure; a need to broaden the range of interventions, re-think service and financial models to increase flexibility and respond earlier, continue focus on reducing and eliminating restrictive practices; and improve coordination of care, physical health outcomes, outcomes for Maori, and access for young people.

The primary recommendation was for the Minister of Health to develop an action plan in collaboration with the sector to regain traction towards a wellbeing and recovery-oriented system.

Learning Objectives

Learning Objective (1): Ways of monitoring and assessing service performance, and making choices about what to focus on. Lessons / reflections about information gathering and engaging with consumers and the sector.
Learning Objective (2): Mental health and addiction services are meant to help people be well and compete for funding within a rationed health / government budget. Systems owe it to people who access mental health and addiction services to be able to measure effectiveness and improve, and to be able to advocate for adequate resourcing for effective interventions.

References


References cited in the report include:
Office of the Auditor-General, Mental health: Effectiveness of the planning to discharge people from hospital. Wellington: Office of the Auditor-General; 2017
There’s no place like home: Experiences of housing and home from people living with mental health issues.

Irene Gallagher

*Being, Woolloomooloo, Australia*

**Biography:**

Irene Gallagher has played an active role in the mental health sector for more than 20 years and is passionate about using her living experience voice to bring about change. She is the CEO of Being, the NSW peak organisation for people with lived/living experience of mental health issues and emotional trauma.

This presentation is the launch of the “There’s No Place Like Home” report, which explores the experiences of housing and home for over 545 people in NSW living with mental health issues. This report and presentation discuss the importance of having a place to call home, in contrast to simply having a roof over our heads, and the positive impact this has on mental health and wellbeing.

The presentation will discuss:
- People’s experiences of different types of housing, including public & community housing, private rental & ownership, and experiences of homelessness;
- The impact of the wider environment and community;
- The effect of other contributing factors including stigma and discrimination, as well as formal and informal supports

The overarching theme of the presentation is the way in which people’s experiences of the issues above affect their wellbeing, and which factors contribute both positively and negatively to their perceptions of “home.”

The presentation will provide a greater understanding of the many definitions of “home” from the perspective of people with lived experience, as well as an awareness of how those involved in policy-making, service provision and research can help shift attitudes about the contribution of housing to wellbeing.

**Learning Objectives**

Learning Objective (1): People in the audience will develop an understanding of the importance of having a “home,” and the diverse meanings “home” has for different people, and will learn about its impact on mental health.

Learning Objective (2): The presentation is relevant to mental health services as it highlights the wide variety of ways in which services can improve access to “home” for people with lived experience, and the benefit this will have for their wellbeing.
An Exploratory Study Addressing Psychologically Safe and Recovery Orientated Mental Health Workplaces for People with Lived Experience.

Katherine Gill¹
¹Consumer Led Research Network, Sydney, Australia

Biography:
Kate is Chair of the Consumer Led Research Network and is involved in a number of research and evaluation projects where she harnesses both her lived experience and her professional skills and qualifications.

An exploratory study addressed the effectiveness of services safely including people with lived experience in the MHDAO workplace, as per recovery principles[1]. Fifty-Six people participated in the online survey, and eight attended focus groups.
Participants reported experiences at the two extremes of satisfaction; ‘Totally Satisfied’ or ‘Totally Dissatisfied’; indicating that while some organisations are psychologically safe, an equal number are not. People newer to peer work were more likely to be satisfied than people who had been working longer in the sector. On average, participants were ‘nearly satisfied’ with the meaningfulness of their work. They felt ‘satisfied’ with their skills/knowledge to undertake their role. On average participants were ‘dissatisfied’ with career progression pathways; job security; and reward/pay. Issues of concern related to tokenism; discrimination; isolation; victimisation; bullying and ‘serious suicide attempts’ due to the work environment were raised. Thirty-Six percent of respondents indicated they are ‘likely/very likely’ to leave the MHDAO sector within five years, and 18% indicated they are ‘not sure’ if they will remain in the MHDAO setting.
In order to safely expand the peer workforce, concerns people identify in current work environments need to be addressed to ensure safety for all.

Learning Objectives

Learning Objective (1): “What will people in the audience gain or learn from attending this presentation?”
The audience will understand the issues and concerns people with lived experience face in the workplace, and how to address the concerns to ensure authentic and safe inclusion of the lived experience voice in the mental health and drug and alcohol [MHDAO] sector.

Learning Objective (2): “How is this topic/issue relevant to mental health services and mental health issues?
The National Recovery Framework[1] identifies the importance of including people with lived experience at all levels of the organisation, in both identified and non-identified roles, yet workplace culture and the provision of mentally safe workplaces has in some cases lagged behind the implementation of the peer workforce. With Government making a commitment to fund more peer roles [2], it is imperative that workplaces safely accommodate people with a lived experience, and ‘Do No Harm’.

References

2. NSW Health, More peer workers to help mental health consumers back into the community. 2017, NSW Health: Sydney.
The National Disability Scheme (NDIS) - an opportunity to improve mental health?

**Tiana Gurney**

1. Lifeline Darling Downs South West Queensland, Toowoomba, Australia, 2. Deliver With Strategy, Toowoomba, Australia

**Biography:**

Dr Tiana Gurney is the Director of Deliver With Strategy, a social research, strategic planning and data analysis organisation. Dr Gurney has extensive experience working with community organisations on research projects, assisting in their strategic planning activities for long-term benefits and is passionate about building vibrant, inclusive and healthy communities.

Partners in Recovery Darling Downs South West Queensland (PIR DDSWQ) commissioned the research project "Sharing experiences on the transition from PIR to NDIS" in October 2016. The project has been an opportunity to reform, reflect and review the impact of the NDIS on people who are suffering from severe and persistent mental illness in the DDSWQ region.

This presentation aims to:
1. Illustrate first hand stories of people with severe and persistent mental illness who have transitioned from PIR to NDIS, through video footage.
2. Provide the results of research around the social and emotional impacts for people with severe and persistent mental illness after 12 months of NDIS implementation.

This project has tracked PIR participants from pre-NDIS rollout to the present and used the concept of storytelling to 'build the story'1 and gain a better understanding of related emotions and issues2 on the community and personal impacts of such a major government policy change. The relationship between mental health and the NDIS has been documented through this research project and will be illustrated in this presentation.

**Learning Objectives**

Learning Objective (1): Attendees of this presentation will see first-hand, both the positive and negative impacts, of the NDIS roll-out on people experiencing severe and persistent mental illness.

Learning Objective (2): Outcomes from receiving an NDIS package or not receiving an NDIS package, for people with severe and persistent mental illness will be illustrated in this presentation.

**References**


Respecting Lived Experience: LGBTIQ Service Provision in Family and Intimate Partner Violence

Kate Foord¹, Marie August¹
¹Queerspace, Drummond Street Services, Melbourne, Australia

Biography:
Kate Foord is general manager of queerspace, an LGBTIQ health and well-being service within drummond street services. queerspace sees LGBTIQ people of all ages and all family types, and includes an increasing number of specialist programs developed in response to identified issues within queer communities.

Marie August is a senior practitioner at queerspace, who works with individuals, families and couples within LGBTIQ+ communities.

There is greater recognition now of the importance of lived experience in the provision of responsive and appropriate service delivery. queerspace at drummond street services has a lived experience workforce: clinicians, case workers, peer workers, community development workers and researchers, all of whom have lived experience of the systemic and personal effects of being LGBTIQ in our society and communities.

In 2017, drummond street services became the lead agency in a consortium providing LGBTIQ specialist integrated family violence services, ranging from prevention, early intervention, crisis and recovery to people in queer communities experiencing family violence or intimate partner violence. Alongside this service, we have workers who are both queer-identified and have a lived experience of family violence or intimate partner violence, and these workers are providing support in the recovery process.

In this workshop, we explore how the notion of “lived experience” informs clinical work? What does it mean to work from a place of “lived experience” in the queer space? How do we acknowledge the notion of “lived experiences” versus the notion of a unspoken shared understanding because we have the “same” “lived experience”? How do we pay attention to the difference within the difference? How might we take up the notion that we all work from a place of “lived experience” and how this deeply informs the kind of therapeutic relationships/alliances we form with the people we work alongside in the clinical work? This workshop will explore notions of “lived experience” and the questions that arise from working in a space where one can be chosen by service users based on identity in relation to sexuality and gender.

We will also explore the question of what difference it makes to have a lived experience workforce at the intersection of queer and family violence/intimate partner violence. We examine this question in relation to key ideas—gender, sexuality, family, community— as well as in relation to key clinical skills like listening, hearing, recognising, responding, interpreting, referring, and advocating.

Learning Objectives

Learning Objective (1): The audience will take away enhanced understanding of the role of lived experience in clinical work and in case work. They will also gain greater understanding of how intersectionality is put into operation in service provision.

Learning Objective (2): These two learning outcomes are relevant to mental health service provision because they show how service provision can change, and is changing, in response to the experiences of people who report difficulty when accessing mainstream services. The greater the 'intersectional load', the greater is this reported difficulty.
Co-design and co-delivery have become recognised by funders as a valid and perhaps vital contribution to effective service provision, including in mental health, and the recognition of lived experience is an important part of genuine co-design processes.
Towards Professionalisation: Exploration of best practice models in mental health peer work to inform the establishment of a national professional organisation.

Christine Kaine

Private Mental Health Consumer Carer Network (Australia) Ltd, Adelaide, Australia

Biography:
Christine Kaine is a qualified Social Worker with experience in rural mental health services. Christine currently undertakes project work for PMHCCN including resource development, development of a Borderline Personality Disorder website, an online library supporting mental health workers engage with carers, and development of e-learning for mental health practitioners.

“Peer support is transformative: it transforms stigma to understanding, it transforms people from passive recipients of what the medical model and society have always told them was good for them, into allies who see another way. It changes people into vital leaders in their own and others’ recoveries” (Beales & Wilson, 2015; p. 322).

This presentation is based on a literature review which aimed to explore Australian and international best practice standards for mental health peer workforce development and to inform professionalisation of the peer workforce in Australia through the establishment of a professional membership organisation.

Six key themes emerged from the research and will be explored including:

1. The importance of recovery oriented practice and exploration of organisational culture to support the successful integration of peer support services

2. Issues of stigma and discrimination and the impact this can have on the peer support workforce, effective integration and delivery of peer services.

3. The need for role clarity and a clear identity for peer support workers

4. Exploring boundaries and self-disclosure in the peer worker role

5. Supporting the ongoing health and wellbeing of peer support workers

6. Training, development, certification and professionalisation of peer support workers

Learning Objectives

Learning Objective (1): Learning objectives include an increased understanding of key requirements for the mental health peer workforce in Australia, understanding the issues facing peer workers and the organisations they work within, exploring international best practice in peer work, exploring the current literature and resources, and an opportunity to consider recommendations to support the development of a professional association for the mental health peer workforce in Australia.

Learning Objective (2): Mental health peer support services are becoming more common both in Australia and internationally. In Australia, there are existing and emerging policies and priorities within the mental health sector recognising the importance of peer support on the recovery outcomes of consumers. With the increasing priority of having a lived experience workforce in Australia, it is critical that organisations introduce and implement peer support programs appropriately and that the workforce is supported to ensure ongoing development and recognition, with a focus on best practice. This literature review provides an overview to support successful implementation of the mental health peer workforce.
References


Flourish Australia's Supported Outplacement Program: Redefining Supported Employment.

Clare Evans¹, Matthew Schipp¹
¹Flourish Australia, Sydney, Australia

Biography:
Clare Evans: Capacity and Marketing Manager, Flourish Australia Community Businesses
Clare has worked for Flourish Australia for close to six years and has played a key role in coordinating the outplacement program. With a lived experience herself, Clare finds it highly rewarding to support people to achieve their employment goals and contribute to the further development of the program.

Matthew Schipp: Supported Outplacement, Administration CSIRO
After enjoying good mental health through his early twenties, Matthew then found himself in the grips of mental illness. Determined to get back on his feet, he completed a Business Administration Diploma with the support of Flourish. Through the outplacement program, Matthew now works as a receptionist for the CSIRO.

In March 2017 Flourish Australia initiated their innovative Supported Outplacement Program to provide people with a lived experience of a mental health issue the opportunity to work in an open workforce environment at an award level wage complimented with mental health support tailored to individual needs. In essence, this program is similar to the Individual Placement and Support (IPS) model with one notable difference, that being the eventual goal of full participation in the open workforce (without workplace-specific supports provided by Flourish Australia) making for a transitional employment experience that supports mental health recovery.

To date, work placements have been secured through tender with National Disability Services providing participants with roles in administration, reception, support services and customer service with the Department of Industry, TJS and the CSIRO. Outplacement roles are completely integrated within the outplacement organisation to provide the most authentic work experience. Individually tailored support is provided through Flourish Australia Peer Workers and may involve mentoring, site visits and phone/email contact.

At the time of writing, twelve people have been engaged in the outplacement program and outcomes have been largely positive. Matthew Schipp is a current outplacement with the CSIRO who has been with the program since May 2017. "I have found the outplacement program to be the perfect way to enter the workforce. Working has certainly helped my recovery and given me the chance to use the skills I built doing my Diploma of Business Administration. Patricia (Peer Worker) is also really helpful and very inspiring." Matthew Schipp - Supported Outplacement, CSIRO

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn? from attending this presentation? (Don’t say what you are going to teach, but what they are going to take away from the session.):
Presenting Flourish Australia's innovative supported outplacement program from the dual perspectives of the program manager and a program participant, the audience will gain insight into the potential for supported employment to provide a recovery-focused vocational pathway to open employment.

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues?:
Flourish Australia's supported outplacement program is an example of how supported employment can be adapted to provide an individually-tailored, recovery-focused, transitional employment experience for people living with a mental health issue who have the goal of open employment.

References

Edwina Keelan - Trans-Tasman, Transgender.

**Edwina Keelan**
Flourish Australia, Sydney, Australia

**Biography:**
Edwina Keelan is a transgender woman with lived experience of mental health issues. She lives in Sydney, NSW and works with Flourish Australia's Prestige Packing Co. Edwina has studied and practiced fashion creation including millinery (hat making). She was also once a paper boy!

I was born a male in New Zealand, but since 1999 I have lived full time as a woman in Australia. Transgender people face many challenges. I have lived experience with childhood trauma, drug addiction, mental health issues and I have been homeless. Today, my recovery is all about being a team player and enjoying the company of my work colleagues. I only wish there were more hours in the day as I like to give it 150%.

In many countries, it is legal to discriminate against transgender people who are harassed, arrested and denied access to education or medical care or public services. So transgender people can carry a great weight of sorrow on their shoulders. We all have challenges, but that does not give us any special privileges.

I showed early promise as a fashion designer, but things didn't work out for me. I make an effort not to revisit some of the bits and pieces of my past, instead meditating on the now. I am supported in pursuing my goals by Flourish Australia, a non-government mental health service which has a welcoming approach towards transgender people and people of diverse backgrounds.

**Learning Objectives**

Learning Objective (1): Participants will hear something about the life of a transgender person from childhood to adulthood and of the many challenges that they will face.

Learning Objective (2): Participants will hear how mental health services can play a valuable role in educating against discrimination as well as fostering social inclusion by being open and welcoming towards LGBT*IQA+ people.

**References**

Keelan, E. (2017, December, pp.8-9) 'Life and Fashion: Trans-Tasman Transgender' in Flourish Australia's Panorama Magazine #66 December 2017

Keelan, E. (2017, March, p.21) 'Trans Aged Care' in Flourish Australia's Panorama Magazine #63 March 2017
Let’s Talk: Co-creating ways to really listen to our community about mental health and wellbeing.

Emma Willoughby¹, Julia McMillan¹
¹SA Mental Health Commission, Adelaide, Australia

Biography:
Emma is a human being with a range of experiences, skills and qualifications including Social Work, Health Promotion, alongside training in Mindful Self-Compassion. Emma has spent 12 years in the NGO and Government sectors focussing on lived experience, and currently works in Community Engagement at the SA Mental Health Commission.

Julia has a degree in Psychology and worked in the non-government mental health sector for 14 years before moving to the government sector in 2010 as a Carer Consultant – a lived experience position in the Office of the Chief Psychiatrist.She is currently the Associate Director – Community Engagement at the SAMHC and loves her job.

This presentation will describe the practice and learnings from the dynamic and creative community engagement process, co-designed by and implemented with lived experience and community members, by the SA Mental Health Commission to inform the development of the SA Mental Health Strategic Plan. Using a range of innovative strategies, including facilitated or ‘Do-It-Yourself’ (DIY) options, art, stories, forums and pop-ups; community conversations; direct submission, and surveys, the Commission gathered information and ideas from over 2270 South Australians including; Aboriginal and Torres Strait Islander people, people from 38 different culturally and linguistically diverse (CALD) backgrounds, people with lived experience, educators, the prison sector, young people, older people, care leavers, gender and sexually diverse (GSD) people, parents, rural and remote communities, mental health service providers, local councils, community service providers, artists, gamers, blacksmiths, musicians, veterans and first responders, amongst many others. 570 people provided feedback on the Key Findings Paper developed from this engagement process, with many people describing feeling truly heard for the first time. Meaningful, purposeful engagement is essential to ensuring mental health system and service reform is responsive to people’s and communities’ needs – we can’t know unless we ask, and this session will teach you how!

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation? Practical strategies for listening to and engaging creatively with people about mental health and wellbeing, including communities, individuals and groups that may be difficult to access for their views and voices.

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues? Mental health and wellbeing is a topic that impacts everyone. Engaging effectively in such a broad and complex area to inform mental health reform strategies ensures they are meaningful, relevant and owned by the people they serve.

References


Increasing the Capacity of the Workforce to meet the Healthcare Needs of Older Refugees and Holocaust Survivors

Patty Loukas¹
¹Multicultural Health Service SESLHD, Sydney, Australia

Biography:
Patty is a Learning and Workforce Development Program Manager at Multicultural Health Service, South Eastern Sydney Local Health District. She also manages the Refugee Health portfolio for the District. Her key role is to increase the capacity of the health workforce to meet the healthcare needs of the culturally diverse community.

The largest wave of migration to Australia occurred after World War 2 and this population is now ageing and seeking our healthcare services in large numbers. The mental health impacts on survivors of the refugee and war experience are well documented. These can be further complicated later in life by the effects of ageing, cognitive decline and the onset of dementia, and as a consequence many older refugees may experience a re-emergence of their trauma. Families and carers are also often challenged by these issues.

The ‘Working with Older Refugees and Holocaust Survivors’ training module was developed as a multimodal workshop targeting healthcare staff in South Eastern Sydney to increase their understanding of the unique needs of this target group, with a particular focus on Holocaust survivors and their families. The workshop provides participants with an understanding of the refugee experience, responding to triggers of trauma, working with families and intergenerational trauma, local supports available, as well as the opportunity to hear the personal story of a Holocaust Survivor. Evaluation of this training identified that participants rated it exceptionally high, that it provided practical skills they would implement in their workplace, and encouraged them to reflect on their practice.

Learning Objectives

Learning Objective (1): The audience will learn of a highly successful training program and partnership that assists staff to manage the complex healthcare needs of older refugees and Holocaust survivors. The strategies may be adapted for implementation within other health settings which support this target population.

Learning Objective (2): The topic is relevant to mental health services/issues because it provides an understanding to staff of the impact of trauma in the context of ageing. The culturally diverse population in Australia is ageing, and many are re-experiencing their earlier trauma. Providing staff with insights to the impact of the refugee experience, understanding triggers and strategies for managing them, has great implications for providing support and refugee sensitive care when these vulnerable patients engage with the healthcare system.
Compassion and Kindness: Within our role, our organisation and in life.

Belinda Brown¹, Emma Willoughby²
¹Mental Health Coalition Of South Australia, Unley, Australia, ²SA Mental Health Commission, Adelaide, Australia

Biography:
Emma is a human being with a range of experiences, skills and qualifications including Social Work, Health Promotion, alongside training in Mindful Self-Compassion. Emma has spent 12 years in the NGO and Government sectors focussing on lived experience, and currently works in Community Engagement at the SA Mental Health Commission.

Compassion and kindness for self and others is important to delivering effective mental health services. It is an important strength in the Lived Experience Worker’s (LEW’s) skill set. This workshop will provide people in designated Lived Experience (LE) roles with an opportunity to reflect on theory and practise, with a LE leader and with each other.

Presentation and interaction will allow attendees to:
• Recognise compassion and kindness not only as personal characteristics but as strengths and essential components of the LE skill set
• Understand the range of benefits (enriches relationships, saves time and money, prevents burn out and stress, and enhances wellbeing and recovery) of working compassionately in service environments, personal practice and with the people we serve
• Consider the impact of compassion and kindness in practice
• Think about practical strategies for working compassionately, treating themselves with kindness and compassion and advocating for cultural change within their workplace
• Experience compassionate practices and approaches that they can apply in their work

Evidence shows that LEWs have a positive impact on the recovery of people who are experiencing mental health issues. As well as the many benefits to consumers and carers such as offering hope, role-modelling recovery and providing an environment for people to become empowered, we know that LEWs can have a positive impact on organisations, programs and services, including culture and the perspectives and service delivery of other professionals within the workplace.

Bradstreet and Pratt 2010, Walker and Bryant 2013 in Health Workforce Australia [2014]: Mental Health Peer Workforce Study p13 state “Staff may become more aware of their use of language, and more reflective regarding recovery-oriented practice.” LEWs are able to achieve this in a way that is unique to this skill set. A mental health nurse comments “I just stand back and watch him [peer worker] work his magic. Not just with the patients who come in here so frightened and hopeless, but with staff too. He can help them see things in a completely different way...” (Shepherd 2013 in Health Workforce Australia [2014]: Mental Health Peer Workforce Study p13).

Research indicates that professionals in health services who practice compassion, are more effective in delivering quality care as they encourage service users to feel more comfortable in openly disclosing their concerns, behaviours and symptoms they are experiencing (Larson & Yao, 2005 in Compassion in care: ten things you can do to make a difference p2 © 2015 The Royal College of Psychiatrists). Research also shows that where health professionals do not experience compassion or are treated unkindly they are more likely to make mistakes, misinterpret information and deliver poorer standards of care (Riskin et., al., 2015 The Impact of Rudeness on Medical Team Performance: A Randomized Trial).

Peer Work is built on compassion. Through lived experience of services and organisations as a service user (consumer or carer), LEWs have first-hand knowledge of what a helpful, supportive service looks like. They are able to use this expertise to walk with others, advocating for/support self-advocacy for cultural and systemic change. “My life experience is an asset, not a liability. It is required! It really informs my work every day and it has personally helped me transform a lot of pain into meaning and fuels my passion to make the mental health system a kinder, gentler place.” (Maline, quoted in Bluebird in Health Workforce Australia [2014]: Mental Health Peer Workforce Study p12).
The workshop will be chaired by Belinda Brown, Senior Project Officer of the Mental Health Coalition of SA’s Lived Experience Workforce Project (LEWP) and will be facilitated by a highly experienced LE leader, who has been involved in the implementation, professional development and growth of the LEW in SA for many years. The workshop structure will be:
• 5 minutes: Chair introduces the session and facilitator
• 30 minutes: Facilitator presents - Thinking Kind: The Three C’s of Mental Health
  - Context
  - Courage
  - Compassion
• 45 minutes: Interactive workshop:
  - What have you learned about compassion and kindness through your own LE?
  - How do you or could you translate this into practice - for others (work practice), for self and within your organisation/service?
  - What gets in the way and how do we work around these? (Challenges and take-away strategies)
• 10 minutes: Sharing key ideas from workshop and closing remarks from Chair

Learning Objectives

Learning Objective (1):
• Greater understanding of compassion and kindness as strengths and essential components of the LE skill set
• The opportunity to listen to and interact with other LEWs, share ideas, consider the impact of compassion and kindness on work practice
• A forum to formulate and experience practical strategies for working more compassionately and with kindness, in self-care and self-management, work with others and advocating for cultural and systemic change within mental health services

Learning Objective (2):
• The Fourth National Mental Health Plan (Commonwealth of Australia, 2009) included the employment of people with LE and development of a supporting workforce strategy, as a priority
• NDIS is an opportunity to grow this specialist LEW, which continues to form an integral part of our national and state strategic direction through Fifth National Mental Health and Suicide Prevention Plan and SA Mental Health Strategic Plan
  - Evidence shows that LEWs, through LE expertise which includes compassion, have a positive impact on the recovery of service recipients and workplace culture, including perspectives and attitudes
  - Working compassionately in mental health care enriches relationships, saves time and money, prevents burn out and stress, enhances wellbeing and recovery (Youngson, Dr R, 2012 Time to Care)

References

Health Workforce Australia (2014) Mental Health Peer Workforce Study  

The Royal College of Psychiatrists, England, Wales and Scotland (2015) Compassion in care: ten things you can do to make a difference  
https://www.rcpsych.ac.uk/pdf/FR-GAP-02_Compassionate-care.pdf

ps.psychiatryonline.org April 2014 Vol. 65 No. 4  
https://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201300244


Youngson, Dr R (2012) Time to Care https://heartsinhealthcare.com/
Holistic Care: Building Health and Wellbeing through Integration

Kathryn Buxton, Kate Verghese

1 Merri Health, Melbourne, Australia

Biography:
Kathryn Buxton is the Team Leader of the Healthy Mind Hub at Merri Health and has worked in the Mental Health sector for over 15 years. She is passionate about delivering services that support the health and wellbeing of consumers.

Kate Verghese has over 15 years experience in the community Mental Health sector and is passionate about improving the health and wellbeing outcomes for consumers. She has a strong history in group facilitation and has lead many of the healthy lifestyle programs offered by Merri Health's Healthy Mind Hub.

Delivering services that provide holistic care to consumers underpins the work of Merri Health’s Mental Health programs. Whereas traditional Mental Health services may have focused purely on an individual's mental health presentation it has become increasingly important to look beyond this and provide services and programs that address broader health and wellbeing needs.

The link between mental health and poor physical health has been well established. In order to address this significant health inequity, our programs provide groups and services that tackle this issue in a creative, supportive and integrated manner. This presentation will explore some of the innovative programs that we deliver to improve the overall health and wellbeing of consumers. One key program is Healthy Steps which incorporates health education, cooking and exercise into one group, and is run in conjunction with Allied Health professionals and our local Area Mental Health service. We will cover program development, the importance of strong partnerships and the outcomes and health benefits for consumers. The introduction of Mindfulness and yoga based programs will also be discussed as another example of providing holistic care to consumers.

The presentation will provide an integrated service model that addresses the intersecting health needs of consumers.

Learning Objectives

Learning Objective (1): The audience will gain an understanding of the impact of broader health issues on the wellbeing of mental health consumers, as well as strategies to implement a holistic care model that tackles these intersecting health needs.

Learning Objective (2): This topic is relevant to other Mental Health services as it will demonstrate practical ways that services can design and implement programs that address broader health and wellbeing issues in an integrated manner.

References


Professional Self-Care: Who is the expert?

**Belinda Brown¹, Matthew Halpin²**

¹Mental Health Coalition Of South Australia, Unley, Australia, ²Office of the Chief Psychiatrist, SA Health, Adelaide, Australia

**Biography:**

Belinda’s expertise in Education was invaluable in developing SA’s first Peer Work training and pilot Certificate IV in Mental Health Peer Work. 12 years on, Belinda continues to support the growth of this workforce, as Senior Project Officer for the Mental Health Coalition of SA’s NGO Lived Experience Workforce Project.

Matthew Halpin is the Consumer Consultant in the Office of the Chief Psychiatrist, SA Health. Matthew’s expertise includes Lived Experience Workforce development, recovery based practice and consumer engagement. Matthew is an Adjunct Lecturer within the School of Nursing at UniSA and regularly publishes research in the area of Mental Health.

Evidence shows that Lived Experience Workers (LEWs) have a positive impact on the recovery of people who are experiencing mental health issues. But mental illness does not just affect those we deliver services to. We know that almost half of the population of Australia will be impacted in their lifetime, meaning that many of our colleagues and managers are also dealing with their own mental health issues. (Health Workforce Australia, National Survey of Mental Health and Wellbeing, 2007).

The support provided by Peer Workers (PWs) differs from traditional support as it is mutual, reciprocal and based on equality and can enhance a person’s understanding or self-awareness of what they are experiencing while promoting hope and self-responsibility (Davidson et al, 2012). Effective LEWs have gained – and continue to gain – valuable learning from their experience. We have a finely tuned understanding of our own wellbeing, including things that are detrimental to it and strategies that support it. With appropriate professional development and training, LEWs have developed the ability to translate this learning into practical skills and strategies (Health Workforce Australia, 2014).

One of the core Lived Experience (LE) skills is self-management around self-care. LEWs practice this day in and day out, as a key responsibility to our loved ones, our community, our organisation and most importantly, ourselves. This responsibility on the PWs can lead to increased stress and at times may impact on the individual’s health. To address this, effective support structures and training needs to be in place (Repper & Carter, 2011; Bradstreet & Pratt, 2010).

We know that management and staff in many mental health organisations do not fully understand LE as a skill set. Far beyond service delivery, the boundaries of the role and simply ticking the box of ‘must have lived experience of mental illness and recovery’, organisations have an incredible opportunity to explore this skill set and the strengths in LE, and develop strategies for effectively utilising these to support the entire organisation. Effective training and development for the PWs themselves as well as non-peer staff and leaders is a key priority supporting the growth and development with the Peer workforce (Repper & Carter, 2011; Bradsheet & Pratt, 2010, Gallagher and Halpin, 2014; Davidson et al, 2012).

In South Australia, a training and development partnership between the Lived Experience Workforce Project (LEWP) run by the Mental Health Coalition of South Australian (MHCSA), Central Adelaide Local Health Network (CALHN) Lived Experience Workforce LEW and the Office of the Chief Psychiatrist (OCP), has worked to more effectively meet the training and development needs of both the LEWs and their leaders.

This workshop will provide an example of the training developed by this project and will provide LEWs from across Australia with an opportunity to:

- Think about the strengths and skills they have developed with regards to self-care, through their lived experience
- Consider ways in which they currently apply this expertise in practice and how it could benefit their workplace
- Think about strategies for working with their leaders to achieve this

The workshop will be chaired by Shandy Arlidge, Project Manager of the LEWP and facilitated by two experienced LEW leaders, who have been involved in the implementation, professional development and growth of the NGO and Government LEW in SA for many years. Despite operating in different contexts, the presenters collaborate regularly and effectively, leading a Working Group of LEWs and Leaders from both sectors, who co-produce professional development
opportunities. This initiative has been developed in response to the specific needs identified members of the LEW and their Leaders from both sectors, and is effective in promoting cross sector collaboration.

The workshop structure will be:

- 5 minutes: Chair introduces the session and facilitators
- 30 minutes: Facilitators present:
  - Learnings from LE: strengths in self-responsibility, self-management and self-care
  - LE expertise and strengths in supporting the wider workforce within the organisation
- 45 minutes: Interactive workshop:
  - Self-care reflection: what have you learned through your own LE?
  - How do you use this in your work practice?
  - Do you share this with your organisation/service?
  - How could you advocate for the utilisation of this skill within your organisation/service?
- 10 minutes: Sharing key ideas from workshop and closing remarks from Chair

Learning Objectives

Learning Objective (1):
- Greater understanding of a key element of LE skill set (self-management) and benefits LEW expertise in self-care can have for the workplace
- Opportunity to consider strategies for greater recognition of strengths in LE and more effective utilisation of these within the workplace

Learning Objective (2):
- The Fourth National Mental Health Plan (Commonwealth of Australia, 2009) included employment of people with lived experience and development of a supporting workforce strategy, as a priority
- NDIS is an opportunity to grow this specialist workforce, which continues to form an integral part of our national and state strategic direction through the Fifth National Mental Health and Suicide Prevention Plan and the SA Mental Health Strategic Plan
- 2015 LEWP Training Needs Analysis identified that LE skill set is not clearly understood by leaders of LEW and colleagues, and that professional development around the LE skill set is vital for effective employment and leadership of LEW
- Training and development for LEWs and their leaders is a priority for continued LEW development across CALHN’s Mental Health Services: Lived Experience Workforce in South Australian public mental health service: what we have learned, what we have achieved and future directions. (Gallagher & Halpin, 2014)

References


The Voices of Young People in Mental Health – All in the Family

Leanne Galpin¹, Mario Corena¹, Tiffany Marchant³
¹Child Adolescent Mental Health Services, Women’s & Children’s Health Network, Adelaide, Australia

Biography:
According to the last Census, Leanne Galpin is the ‘typical’ Australian - a 38 year-old female, born in Australia, married with two children and completed Year 12. OK, she lied about her age. Leanne works part time, and volunteers where possible as her journey travels through mental health, education and autism.

Mario Corena is a 57 year old born in Italy but lived 56 of them in Australia. He has been active for the past 20 years on community/charity work for various Not for Profit organisations. He is passionate about health issues and especially Mental Health. He also is an advocate of strong support for those in need from a family, friend or service.

There are approximately 10 times more stay-at-home dads today than there were a decade ago. Dads can sometimes have a quiet voice in a field dominated by women. Within the child and youth mental health system, the vast majority of consumer representation has traditionally been made up of women. Where are the men in formalised advocacy? Is this a problem?

Men can bring a different point of view and a different approach to consumer engagement and advocacy. Are we getting the full picture?

How can we make it easier for men to participate?
What needs to be considered when building a team of men and women?

At this roundtable discussion we will explore the barriers to and benefits of recruiting, retaining and hearing the voices of fathers of young people with mental health issues.

Members from ELECT (CAMHS Energetic Lived Experience Consultancy Team) will share their observations of changes that have occurred during the team’s evolution from a “support group” to an active and authentic advisory service.

Learning Objectives
Learning Objective (1): The benefits of and barriers to engaging fathers as consumer representatives on behalf of their child with mental health issues.
Learning Objective (2): Children and adolescents in the mental health system need to have a voice – and sometimes that voice will sound like a parent or carer.
Relections on the impact of peer workers' involvement as co-leaders in smoking cessation programs provided in clinical mental health settings.

Narelle Mancer1, Shane Sweeney1
1Northwestern Mental Health, Parkville, Australia

Biography:
Narelle Mancer is currently employed as a 0.4 EFT Quit Victoria funded peer support worker position at SUMITT. She is also employed 28-day readmission peer support worker at Sunshine Hospital Inpatient Unit. She is also studying for a Bachelor of Ministry.

Shane Sweeney, Program Manager, SUMITT (NWMH) is a social worker with over 30 years’ experience in clinical mental health and alcohol and other drug services. He is particularly interested in organisational change and service improvement initiatives. He is passionate about involving people with lived experience in the planning and execution of projects.

People with severe mental disorders on average tend to die earlier than the general population, premature mortality. There is a 10-25 year life expectancy reduction in patients with severe mental disorders. Smoking is a major contributor to premature mortality.

The role entails working across 3 different sites and each team is radically different from one another. At the Epping site the worker works within a community team where consumers come a go for appointments. At Broadmeadows the worker is based at the CCU and works residential consumers. At Sunshine, the worker works in more of an inpatient unit environment, where the consumers are generally more chronically unwell and have longer lengths of stay. The varying context and team structure at each site has been challenging.

Biggest challenges has been staff resistance, e.g. "not having enough time" and/or "concern about asking consumers to stop smoking will lead to aggression". More recently there has been a positive shift in staff attitudes.

Enablers have included high level of support from program leader at one site by involving smoking cessation in tem meetings. Lived experience as being extremely helpful in terms of connecting.

Learning Objectives

Learning Objective (1): Participants will learn the functions, challenges and enablers from reflections of Quit-funded peer support worker at 3 adult and 1 youth mental health services at NorthWestern Mental Health.

Learning Objective (2): Tobacco use is a significant contributor to the early mortality and morbidity of people with serious mental health issues. Despite the availability of smoking cessation clinical guidelines and increased attention to physical health, embedding smoking cessation support into routine care is challenging for the mental health sector. This presentation will demonstrate a new innovative approach.

References

Peer Learning Advisors – An Innovative Form of Peer Support.

**Vicki Katsifis, Alise Blayney**

1SES LHD Recovery College, Sydney, Australia

**Biography:**

Vicki has worked in peer work and education for over twenty years. She has worked in multicultural mental health, inpatient, community settings and non-government organisations. She works at the South East Sydney Recovery College as a Senior Peer Learning Advisor/Educator. She is passionate about supporting people on their recovery journeys.

Alise Blayney has been a Consumer Peer Support Worker with South Eastern Sydney Local Health District for 5 years. She has worked across Inpatient, Intensive Care and Rehabilitation Units and is currently based in Community Mental Health settings. She has worked with the Recovery College as a Peer Learning Advisor and Educator for 3 years and finds it rewarding learning alongside students who are on a path of self-discovery towards directing their own recovery journey.

Peer support is a growing discipline in mental health and is diversifying into many specialties. One example of innovation in delivering quality services to people with a lived experience is providing peer support through education. This presentation will highlight an important part of the South-Eastern Sydney Recovery College which is the Student Learning Plan process and the research that is embedded in the plan. The learning plan aims to support people’s recovery journey through education. A Peer Learning Advisor has a lived experience of mental distress and provides peer support and role modelling to the student to identify their learning goals and support needs to ensure their needs are met and whispers are acknowledged. Emphasis is placed on the student being involved at the heart of any decision making. Having a peer conduct the learning plan is integral to the process as they can share their lived experience on their educational journey and also how to overcome barriers in the education process. The student learning plans also form part of research and evaluation informing practice. A partnership with the University of Technology Sydney provides research where measurements are taken on self-perception of health, social inclusion and the Recovery College experience.

**Learning Objectives**

Learning Objective (1): By attending this presentation the audience will learn about a new specialised form of mental health peer support that focuses on supporting a student with mental distress in education. They will also learn about a research and evaluation process that has been effective in the South East Sydney recovery college.

Learning Objective (2): This issue is relevant to mental health services and mental health issues as mental health peer support is growing as a discipline branching out into many specialised forms of peer support of which educational peer support is an innovative example. This also presents research and evaluation embedded in the peer support process. More research and evaluation is required to form an evidence base for peer support work.

**References**

Advocating for Influence: The Unique Value(s) of Lived Experience We Need to Amplify and Ground Ourselves Within.

Ellie Hodges

Ellie Hodges, Littlehampton, Australia

Biography:
Ellie is a Lived Experience Counsellor and Consultant with more than 18 years of experience working in the community and mental health sectors as a practitioner, manager, educator, advisor, advocate and consultant. Most recently she has been a Lived Experience Advisor to the South Australian Mental Health Commission. At the heart of all of Ellie’s work is her commitment to innovation, social justice and leading together.

Advocating and activating change as a person with lived experience can be challenging. The people and systems we seek to influence can hold reductionist viewpoints and not see that we are more than our lived experience. Structural oppression and unsafe environments can crush the passion and enthusiasm we have for reform and speaking up. It can be lonely too, where do people with lived experience belong?

This paper will set out the key value, and values, of lived experience that strengthen our advocacy position. They are the key to our withstanding and influence and they are key education points for the people, services and systems that we interact with.

Having a seat at the table and raising our voice is one thing, speaking with our own authority and being influential is another. And it is the latter that we need and it is time for.

Themes covered will be: the nuanced wisdom of lived experience; the experience of lived experience and where focus should be for involvement; how we call-in practices and mindsets that nurture lived experience (rather than maintaining focus on call-out’s and division); lived experience leadership and solidarity; spiritual pain; structuring safety; sharing power; and more.

Learning Objectives

Learning Objective (1): People will reflect on the unique value and values of lived experience to be able to incorporate this into their own advocacy efforts and become more influential in their approach.

Learning Objective (2): Increasingly people with lived experience are being involved in mental health services and reforms and it is important that people with lived experience remain grounded in the unique perspective - and strength - of lived experience so that their involvement remains authentic.

References


Empowering People to Empower People - Redefining Professional Development in the Workplace.

Lynnette Parkin¹, Turaukawa Bartlett¹
¹Careerforce, Wellington, New Zealand

Biography:
Between them, Lynnette and Turaukawa have a comprehensive background in mental health & addiction, aged care, community support and youth work. Their mutual passion for ensuring our most vulnerable New Zealanders receive the best possible support and services is ignited by their personal journeys within Mental Health & Addiction. Their current joint portfolios bring together work with key influencers and stakeholders in the sector with a focus on ensuring the voice of the person being supported and the person providing support is heard in the work Careerforce does.

As the needs of whaïora (people experiencing mental health issues) continue to evolve, so does the face of the mental health workforce needed to support these needs. This evolution has created the need to develop and empower a new wave of holistically competent mental health workers that are able to engage, connect, understand and most importantly enhance whaïora wellbeing. This presentation will illustrate how Careerforce – te toi pukenga* have successfully met this need by redefining the way people learn and enter the mental health sector with an innovative work based apprenticeship programme targeting lived experience mental health workers. This ground-breaking initiative looks to remove the barriers that have historically limited the professional development opportunities for lived experience workers, and challenge the stigma and discourses associated to mental health and addiction support. This employer led approach founded on validating life experiences, prioritising cultural competency and on the job learning empowers mental health workers to achieve a nationally recognised qualification and supports a natural progression towards sector leadership – Empowering people to empower people.

*Careerforce – te toi pukenga is the Industry Training Organisation (ITO) for New Zealand’s Health and Wellbeing sectors

Learning Objectives
Learning Objective (1): People in the audience will learn how life experience can be validated and fostered within workplace based learning to support a generation of future sector leaders.
Learning Objective (2): There is overwhelming support to shift wellbeing enhancement away from a clinical health weighted perspective to a more holistic approach. This initiative directly supports and validates the expertise and role of a lived experience mental health worker and their abilities in supporting wellbeing - Our people want people they can relate to.

References

Whose journey is it anyway?: Consumers & Carers joining forces to navigate the NDIS and better support each other in their recovery journey.

Suzi Tsopanas\textsuperscript{1}, Jasmine Corbo\textsuperscript{1}
\textsuperscript{1}Wellways, Melbourne, Australia

\textit{Biography:}
Suzi Tsopanas holds an Honours Degree in Psychology from Monash University with post graduate qualifications in Community Management.
Suzi has been working in the community mental health sector for 20 years and currently manages the Family Services and Community & Peer Education Programs in the East & North West at Wellways. Suzi continues to be committed to family inclusive practise and education.

Jasmine Corbo currently manages the Inner East Partners in Recovery Team within Wellways, with a strong background in mental health, homelessness and asylum seeker and refugee issues. Jasmine is a Masters qualified Social Worker, with a particular interest in trauma informed recovery practice, policy development and program innovation.

Research demonstrates that better outcomes are achieved for consumers, when carers and families are also engaged in the recovery process (Price-Robertson et al. 2016). This ethos of relational recovery informed our decision to create an integrated program for both consumers and carers to work alongside each other in preparing for the National Disability Insurance Scheme (NDIS).

Wellways Partners in Recovery and Family Services programs worked together to co-design an innovative course combining education and interactive activities for consumers and carers. Driven by the need to respond to the changes in Commonwealth funding and the subsequent shift in focus for both programs; we sought to develop a course that would have a broad reach and utilise our peer workforce in the co-design and implementation of the program.

This presentation will explore the benefits in creating a space for consumers and carers to come together and draw on their collective experience and wisdom. We sought to create an environment in which they were able to support each other in this new landscape of the NDIS by fostering hope and personal responsibility, drawing on key elements of advocacy, education and peer support as highlighted by Mead and Copeland (2000).

\textbf{Learning Objectives}

\textbf{Learning Objective (1)}:
• Creative ideas in addressing funding changes and constraints
• Ways to foster relational recovery for both carers and consumers
• How to listen, respond and integrate the experiences of both consumers and carers in navigating the NDIS system, into a peer support and education model

\textbf{Learning Objective (2)}:
• Addresses the significant service gap for carers in the NDIS scheme, with the end of existing Commonwealth funding for family support services.
• Addresses the emerging direction in Mental Health towards relational recovery and removing barriers to engagement and traditional silos between carers and consumers

\textbf{References}
• Rhys Price-Robertson, Angela Obradovic & Brad Morgan (2016) Relational recovery: beyond individualism in the recovery approach, Advances in Mental Health, 15:2, 108-120, DOI: 10.1080/18387357.2016.1243014
Survival Sex in the context of Family Domestic Violence were pre-existing mental health are present.

Karla Reardon
Department of Child Safety, Youth and Women, Queensland, Australia

Biography:
Karla Reardon has been involved with Child Protection for over 27 years and across her lifespan has seen the impact of adverse childhood experiences first hand and understands the difficulties many of our parents find themselves in. In particular is her interest of the emotional health and safety of young people involved in sexual exploitation and self harming behaviours.

“We must continue to discover ways of making the unspeakable 'safely' speakable, thus promoting healing and prevention”. Jennifer Freyd,2010.

For this abstract, it is important to note that the focus is not on women who are in an FDV relationship where sex working for financial gain is a component. My objective is to create a different method of how we view and understand ‘survival’ in a FDV relationship and the impact on an individual’s social and emotional wellbeing. It explores how individuals who due to early childhood experiences of sexual abuse have entrenched ‘mind sets’ regarding how they function in adulthood. The Mandel framework (Safe and Together) underpins engagement with FDV families who are known to Child Safety in Queensland. The ‘victim mapping’ can identified past or current issues impacting on emotional safety and how we can work with mental health to prevent further deteriorate. It is hearing the whispers of these individuals.

The Safe and Together framework shifts practice from ‘victim blaming’ and ‘non believable’ to that of support and encouragement -shifting the language of what we do and invites both survivors and perpetrators to participate. Difficult conversations need to occur and in the context of FDV no one survivor/victim is the same as another. This paper explores recent themes that have appeared within discussions with FDV survivors/victims in the frontline child protection context.

The concept of Survival Sex which has been typically linked to women who ‘sex work’ or women residing ‘within refugee camps’ is intertwined within the concept of attaining basic needs for ‘food, water and shelter’. The focus is on sexual abuse, marital sex and sexual violence (Intimate Partner Sexual Violence) and the impact on survivors in relation to their participation in specialist counselling.

“I survived my relationship by initiating the sex before the violence started and I am told by Sexual Assault and Domestic Violence services that this was still him being abusive….but this was my time to take control and change the situation and how can that be called wrong”. This parent had a history of Complex PTSD.

“If I talk to Child Safety about this then I get told that I need to attend Domestic Violence counselling/mental health counselling and Sexual Abuse counselling in order to move forward when really what I really want is life counselling. If I don’t go then I am told I am resistant and not meeting the caseplan goals/expectations of the department. They think I don’t fully understand my relationship but I live it”. Bipolar and Complex PTSD with self-harming a recurrent theme.

The aim of the abstract is to invite workshop discussion around the significant benefits of applying the Mandel model to work with survivors of sexual abuse and DFV to ensure their emotional safety.

Learning Objectives

Learning Objective (1): The audience will take away a different perspective to home child safety is working with survivors in a FDV situation and how safeguarding the emotional safety and wellbeing of all involved is paramount.

Learning Objective (2): The issue is relevant as it highlights the need for collaborative practice across all services and that in many instances the priority is stabilising a parent's mental health and how behaviours such as survival sex is the parent's way of re-enacting their earlier trauma.

References

van der Kolk, B (2014) Trauma, Re-enactment, Revictimisation and Masochism. Harvard Medical School: Boston USA
‘Let’s talk’ - Helping families communicate. A Narrative and Systemic SST family approach that includes the introduction of communication skills. Illustrated by our work with a family where the young person had depression and cutting.

Tess McGrane¹, Ron Findlay

¹Headspace/Alfred Child And Youth Mental Health Service, Elsternwick, Australia

Biography:
Tess McGrane co-founded the Single Session Family therapy service at headspace Elsternwick several years ago and currently coordinates the service. She has worked for many years in child and youth mental health, SST, and systemic family therapy. She has presented nationally and internationally on SST family work.

Dr Ron Findlay is a practitioner and lecturer (post-grad) of narrative therapy. He has worked in private practice and in community mental health for many years.

Our Single Session Therapy (SST) service for families is at Headspace Elsternwick Melbourne (Alfred Health). It operates within a traditionally individually focused youth service (age 12 to 25). It reaches a segment of the community needing, but often not receiving, service from other Tier 3 services in our catchment area.
Consistently, families tell us they want to find better, different, less conflictual ways to communicate and relate to each other.
Getting our Narrative and Systemic skills working together we then help the families do the same.
The diverse communication techniques we impart are gleaned from many sources including Diamond, Gottman, PET, Ekman and Rogers amongst others.
Especially we find that coaching families to practise new ways to communicate while in the therapy session offers a high level of satisfaction with the service.
A case example of a family where the young person had depression (including suicidal thoughts) and cutting will be used to illustrate the approach.

Learning Objectives
Learning Objective (1): Increased skills at helping families to better communicate when a member has mental illness.
Increased skills at helping families with a young person with depression to better manage the condition.
Learning Objective (2): Mental health staff and carers and clients all want skills to better manage mental health conditions. They want skills that augment and add to (not subtract from) other treatments such as medication. This presentation is relevant as it helps provide these skills.

References
Conversations around suicide risk assessment - moving away from the "management of suicide" towards a compassionate approach and collaborative "safety-planning".

Jane Ellis, Emily Blackman

Office Of The Chief Psychiatrist, SA Health, Adelaide, Australia, UniSA, School of Nursing and Midwifery, Mental Health and Suicide Prevention Research Group, Adelaide, Australia

Biography:
Emily is a Mental Health Triage Clinician and has previously worked in acute inpatient settings and community mental health. She has a Masters in Social Work and was the recipient of a 2017 full time stipend PhD scholarship jointly funded by Mental Health and UniSA.

Jane is a Carer Consultant, Senior Project Officer in the Office of the Chief Psychiatrist SA and Adjunct Mental Health lecturer at UniSA. Jane has a background in peer work and support work in crisis respite as well as Lived Experience representation on a local and Statewide Level.

The Connecting with People (CwP) education and training program is established on the premise that suicide is preventable. This is a move away from risk assessments that focus solely on risk factors, with scales of low, medium or high risk. This approach is a paradigm shift in how we think about and respond to a person in suicidal distress where a clinician and a person in distress work together to develop a comprehensive safety plan to mitigate suicidal distress and the associated risks with a series of evidence-based and peer-reviewed clinical tools (SAFETool). It supports clinicians to work collaboratively with a person to identify their own risk factors, triggers, needs and strengths, imparting hope and encouraging connection to personal and social resources and where helpful connection to supports provided by the community sector and health system. This is a significant move away from the traditional approach to risk assessment, reliant on a combination of three broad approaches: clinical, actuarial and structured professional judgement (Cole-King et al. 2013 & Bouch & Marshall. 2005).

Lived experience has been involved in the creation of ‘Connecting with People’ Suicide and Self Harm Mitigation and Prevention Training which was developed in the UK in consultation with clinicians, academics, consumers and carers. Under the auspice of the Office of the Chief Psychiatrist SA, 26 people have completed the ‘Connecting with People’ train the trainer course, including those with lived experience.

Learning Objectives

Learning Objective (1): A lived experience and healthcare professional perspective on standard ‘risk assessment’ and the ‘management of suicide’ compared with a compassionate approach to understanding ‘suicide-related distress’ that involves co-producing a safety plan.

Learning Objective (2): A compassionate approach that includes a comprehensive assessment and the co-production of a safety plan is paramount in suicide prevention.

References
Cole-King, A, Parker, V, Williams, H & Platt, S 2013, Suicide prevention: are we doing enough?, Advances in psychiatric treatment, 19, pp. 284-291
Working It Out: Vocational Support in Mental Health

Catherine Gayed¹²
¹Headspace Youth Early Psychosis Program, Melbourne, Australia, ²Alfred Health, Melbourne, Australia

Biography:
Catherine Gayed is a vocational worker with over ten years experience working and volunteering within the private sector as well as not-for-profit organisations. Catherine is passionate about working alongside people experiencing challenges and barriers to gaining employment, and combines her legal and vocational knowledge to advocate for their needs.

All community members have the right to work in suitable conditions, which reflect equity, security, human dignity and respect. Employment is an aspect of life that provides economic security, valued personal roles, social identity and opportunities for individuals to contribute meaningfully. Young people with mental health conditions often miss out on these important opportunities. This can be particularly disruptive for them at a time when their peers are beginning to establish their work and career trajectories and important connections, fundamental skills and dispositions are established.

Vocational support, however, is rare in mental health services. From the outset the South East Melbourne headspace Youth Early Psychosis Program has implemented a vocational program within the Recovery team to promote meaningful and sustainable employment and education pathways for young people. The vocational program within hYEPP is informed by the Individual Placement and Support model which is an evidenced-based approach, supporting young people to identify and achieve employment opportunities in the competitive market.

The Vocational worker supports clients by exploring their interests, strengths and preferences for career and educational pathways in addition to providing assistance with resume writing, interview training as well as on the job support for both the young person and their future employer.

This paper will report on the implementation of the vocational program within hYEPP and the strong and positive results that have been consistently achieved, by the integration of this service within a community mental health setting.

Learning Objectives

Learning Objective (1): The audience will gain a greater understanding of the vocational role particularly the level of expertise and level of support that is provided to young person navigating the employment sector.

Learning Objective (2): This topic is relevant to mental health services as meaningful employment is key contributor to a one's sense of self purpose and

References


Youth Hospital in the Home, a pioneer in youth mental health service. Provides an alternate to inpatient treatment for youths aged between 16-24 in the North Metropolitan Region of Perth, WA.

Christopher Ward, Brooke Seebohm
Youth Mental Health Services, Perth, Australia

Biography:
Chris is Registered Mental Health Nurse, with a Bachelor of Mental Health Nursing from the University of Robert Gordon, Aberdeen (Scotland). Upon completion of training he worked in Scotland for two years in acute mental health, before moving to Western Australia in 2011. Since relocating to Australia Chris has continued to work in acute mental health care in a number of settings and roles around the Perth Metropolitan area.

Brooke is a Registered Nurse, Graduating with a Bachelor of Science in Nursing from Edith Cowan University, Perth WA. Experienced was gained in the Private mental health inpatient arena. After 2 years, Brooke moved to the Public health system, gaining experience in ED departments, Acute Mental Health Observation Wards and Hospital in the Home. During this time Brooke completed her Masters in Mental Health Nursing with the University of Newcastle and now joins the Youth Hospital in the Home team.

Youth Hospital in the Home (YHITH) is a pioneer in youth mental health treatment and support. The Western Australian Government service provides daily mental health care in the patient’s home or usual place of residence that would otherwise be delivered within a hospital as an admitted patient.

YHITH provides clinical services equal to the standard provided in hospital and actively facilitates access to additional community services, if required. These extra supports can help the individual with their day-to-day activities, thus minimising the impact on carers and families.

YHITH clinicians work in partnership with the individual and their families or carers for around 14 days to provide intensive support, education and guidance for all parties.

YHITH provides patient focused service delivery, and the development of a comprehensive youth stream with a range of services that improve access and coordination between inpatient and community services. Trauma Informed Care and the National Framework for Recovery Orientated Mental Health Services, 2013 acknowledge that hospital admission is often disruptive and a traumatic experience for patients. Service evaluation has shown a significant improvement in patient health care when YHITH admission occurs. Carers have expressed high satisfaction with the quality of care through service feedback.

Learning Objectives

Learning Objective (1): Audience members will be introduced to the YHITH model of care and service delivery. Providing an overview on how acute care can be provided in the community, minimising disruption to the patient, families and carers. Participants will learn of service outcomes from evaluation data from stakeholders, patient and carer feedback.


References

4. Mental Health Coordinating Council (MHCC) 2013, Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group, Authors: Bateman, J & Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA)
Why Mental Illness Is Good For You

Louise Pascale

*Mental Health Coalition Of South Australia, Unley, Australia*

**Biography:**
Louise Pascale is the Media and Communications Coordinator for the Mental Health Coalition of SA (MHCSA). Louise has extensive experience in Media, Journalism and Producing.

Kristy Stengert is the Mental Health Promotions Officer for the MHCSA and has experience in health promotion and is the key coordinator for Mental Health Week.

*Louise and Kristy now work to de-stigmatise mental illness through their work and will be presenting together on Why Mental Illness Is Good For You.*

Reducing the stigma of mental illness through mental health promotions needs an holistic approach. A catchphrase and catalogue of positive images is no longer enough, it’s now about what we do.

This presentation provides a case study of de-stigmatising mental illness by;
- engaging people with lived experience as creators of media as well as the story,
- engaging family, friends and colleagues to share experiences of supporting a loved one, acknowledging them as experts being stringent regarding what we endorse

For 14 years the MHCSA has been charged with the promotion and coordination of SA’s Mental Health Week. Over that time many lessons were learnt and we’ve evolved to a place where lived experience is front and centre in all we do.

Mental Health Week 2017 was launched with a panel discussion where the expert was those living with mental illness. Their story was not focused on trauma, illness or psychosis but their recovery. They were accompanied by a loved one who supported them. They were not there to hold their hand but share what they learnt about their own mental health through this experience. Here the audience learnt that mental illness can make you a better person and relationships strengthened.

**Learning Objectives**

Learning Objective (1): The audience will gain a fresh insight into the complexities of de-stigmatising mental illness through mental health promotions

Learning Objective (2): This topic and approach puts those with lived experience as the expert.

**References**


“LETSS Talk Co-Design”. Case example of the co-design process in service design, and what we learned from the experience.

Shandy Arlidge¹,², Damon Fenech²,³, Keryn Robelin⁴,³, Lyn Whiteway²,³, Jules Davis²,³
¹Mental Health Coalition SA, Unley, Australia, ²Adelaide PHN, Mile End, Australia, ³LETSS Co-Design Group, Mile End, Australia, ⁴Uniting SA, Port Adelaide, Australia

Biography:
Shandy Arlidge
Shandy is the Project Manager for the Lived Experience Workforce Project. With 13 years’ experience in the mental health sector she is a passionate advocate for Lived Experience Workforce, having seen again and again the benefit this skilled workforce brings to the lives of people living with mental health challenges.

Damon Fenech
Damon works jointly across state and commonwealth health services in strategic development and implementation of integrated mental health services. Bringing 32 years of mental health nursing, management and innovative service change, he is truly committed to self-determination and the value of lived experience being in the driving seat of service improvement.

Kez Robelin
Kez is the Consumer Consultant for UnitingSA, a Peer Support Worker and currently leads a predominately LE team. Driven by opportunity for change and education alongside those who have a MH story, she has represented the voice of her peers in the co-design process with view to a better tomorrow.

Lyn Whiteway
Lyn, 72, has experienced three definitive episodes of severe mental illness earlier in her life. Her passion for this project was fueled by her belief in the benefits of utilising peer workers - and the knowledge that you need help when you have a flare up. Not the next day.

Jules Davis
With 25 years of her own Lived Experience, Jules is also the mother of 2 teenagers living with mental illness and substance misuse. She believes there are many Peers in our community with knowledge and experience that could be well utilised in LETSS and across the mental health system.

This symposium will showcase a successful consumer and carer service co-design process, highlight the benefits that a paid peer workforce can bring to mental health service, and to talk about what we learned along the way.

“The Lived Experience Telephone Support Service (LETSS) is a mental health support service staffed by paid Lived Experience Peer Workers and Team Leader that is designed to provide support and guidance for someone who -
• is seeking general mental health advice;
• is seeking to navigate and access available mental health services;
• is in crisis seeking help and support;
• is living with a severe and complex mental illness and needs some help with implementation of care plan strategies
• is in need of someone to talk to, to relieve isolation and loneliness;
• may need a welfare check following hospital admission or Emergency Department attendance;
(MHCSA 2018)"

Current research and literature recognises the efficacy of peer work as an evidenced based model of accessible and effective mental health support, both nationally and internationally (Mowbray et al., 1997; Campbell, 2005: Cleary,
The Mental Health Coalition SA Lived Experience Workforce Project (LEWP) has been working with the NGO mental health sector for three years to build the Lived Experience (LE) workforce. Co-design and co-production are critical to the success of the project, utilising a Lived Experience Reference Group. All elements of the project are co-designed and co-produced; decisions are made in collaboration with the Reference Group. Research undertaken through the MHCSA and Don Dunstan Foundation recommended investment in the LE workforce, and increasing consumer and carer voice in service design and delivery (MacKay and Goodwin-Smith, 2016). Additionally, the MHCSA commissioned an analysis of mental health services available in SA with recommendations for the future. That future could include improved access to links for community members to appropriate supports and services (MHCSA, 2017).

The Adelaide Primary Health Network (APHN) Story
Following an intensive and wide-ranging assessment process by the APHN during 2015/2016 (APHN 2016), a number of service gaps were identified by consumers, carers, stakeholders and the wider community. One option to help address service gaps was the possible provision of an after-hours telephone support service staffed solely by Lived experience personnel.

Co-design
Currently a Lived Experience led telephone support service does not exist in the Metro Adelaide area. There are several similar services inter-state, however these are volunteer worker based and supervised by clinical personnel. This is additionally true of nationally based helplines that have volunteer lived experience personnel, with paid clinicians who may have lived experience but who are not employed on that basis.

People with experiences of mental illness and recovery, working as Lived Experience (Peer) Workers make a unique contribution to the responsiveness and effectiveness of mental health service delivery. Growth and development of a mental health Lived Experience Workforce is a priority in Australia and internationally.

Building on the assessment and evidence base, the APHN and MHCSA began a co-design process based on clear programme logic developed from the University of Wisconsin-Extension Programme Development and Establishment Logic Models.

An expression of interest to stakeholders from Local Health Networks (LHN’s), NGO’s, Primary Mental Health Care Service providers, consumer and carers was circulated and received a response from 24 interested people consisting of 80% consumer carer representation.

A series of meetings resulted in a program logic that APHN was willing to tender out as a new service – tenders closed on 28th February 2018. This was the point where co-design met with established policies and procedures and we began learning about the changes needed to move to co-production.

The symposium presenters will talk about their experience of being part of the process, the learnings as we worked within existing policy and procedural structures. What did we learn? What would we like to see for the future?

Symposium Structure
- Symposium will be co-chaired by Damon Fenech (APHN) and Shandy Arlidge (MHCSA)
- Co-Chairs introduces topic and presenters (5 minutes)
- MHCSA story – context (5 minutes)
- Adelaide PHN story - context (5 minutes)
- The co-design process – (5 minutes – MHCSA and APHN together)
- Participating in the process (LE participants – 5 minutes each x 3)
- What did we learn? Comments across the panel (10 minutes)
- What is our vision for the future of LETSS? (5 minutes)
- What could the future look like for co-design? How do we move to co-production? Comments across the panel (10 minutes)
Learning Objectives

Learning Objective (1): The audience will gain an appreciation of co-design as a process that when undertaken genuinely can produce a service that not only meets the needs of health service provision but meets the real needs of consumers, carers and the community. They will also learn that no process is perfect and that there are learnings for the future if we are willing to take them on.

Learning Objective (2): This topic is relevant for two main reasons – investment of time in a genuine co-design with people with Lived Experience leads to a better service. The case example demonstrates the value of the Lived Experience Workforce in the design, development and implementation of a service that has the potential to meet the needs of consumers and carers.

References


My Mind, My Body, Me: Implementing a 12 week physical health program in a youth mental health setting.

Nancy Pepper¹ ²
¹Headspace Youth Early Psychosis Program, Melbourne, Australia, ²Alfred Health, Melbourne, Australia

Biography:
Nancy Pepper is an Exercise Physiologist passionate about using exercise and physical activity as medicine to improve quality of life and enhance overall health and well-being. She is passionate about facilitating group programs and educating young people about the benefits of being physically active to better the mental and physical health.

Weight gain and increased cardio-metabolic risk are common side effects of several psychotropic medications, adding to the potential challenges experienced when living with early psychosis, however the inclusion of Exercise Physiologists within youth mental health settings is unusual. Evidence suggests that supervised exercise interventions can be effective at reducing unwanted weight gain. Exercise Physiology services were therefore implemented within the recovery program at the headspace Youth Early Psychosis Program (hYEPP) in South Eastern Melbourne from the outset.

hYEPP considers mental health and physical health as fundamentally connected. We take a holistic approach when supporting young people with their individual recovery journey, to improve their quality of life as well as physical and mental health outcomes.

An exclusive 12 week Program titled My Body, My Mind, Me (MMMBM) has recently been created to improve young peoples’ overall health profile and prevent/manage the development of metabolic and cardiovascular disease, specifically targeting those at high risk. Physical health screening of all young people entering the hYEPP program is helping to identify those at most risk of poor physical health outcomes. This paper reports on the work involved in creating and tailoring the MMMBM program specifically to meet the needs of these young people.

Learning Objectives
Learning Objective (1): The audience will take away an awareness of the importance of establishing and implementing routine physical health screenings and exercise programs in mental health care, and hopefully a strong incentive to integrate programs such as these in their own mental health settings.
Learning Objective (2): This topic is highly relevant to mental health services and its relevance to mental health is only beginning to be recognised and valued. Physical health and mental health, largely, are still treated in isolation and not seen as being inextricably connected to the holistic wellbeing of an individual.

References

Equally Well: Improving the physical health of people living with mental illness.

Russell Roberts1, Helen Lockett2, Alexis Mohay3, Elida Meadows4
1Charles Sturt University, Bathurst, Australia, 2The Wise Group, , New Zealand, 3Department of Health, Canberra, , 4National Mental Health Consumer and Carer Forum, Canberra, Australia

Biography:
Russell Roberts is an Associate Professor in Leadership at Charles Sturt University, Chair of the Australian Rural and Remote Mental Health Symposium and Co-Chair of the national Equally Well Implementation Committee.

Helen Lockett is the leader of Equally Well New Zealand, and senior consultant for the Wise Group New Zealand.

Alexis Mohay leading the implementation of the Fifth National Mental Health and Suicide Prevention Plan on behalf of the Commonwealth.

Elida Medadows is the Chair of the National Mental Health Consumer and Carers Forum and Co-Chair of the national Equally Well Implementation Committee.

People living with mental illness die on average, 20 years earlier than the general population (Thornicroft, 2013). People living with severe mental illness are 6 times more likely to die of cardiovascular disease, 4 times more likely to die of respiratory disease and 5 times more likely to smoke (National Mental Health Commission, 2016). Two-thirds of this premature mortality is due to preventable and treatable physical illness (Cunningham, Peterson, Sarfati, Stanley, & Collings, 2014). The reasons behind this are complex and interrelated. They include factors such as the effects of medication, smoking, obesity, lack of exercise, diagnostic overshadowing and the role of the healthcare system in exacerbating this disparity (Blanner Kristiansen et al., 2015).

This presentation will update and outline the current status and approaches to implementation of EquallyWell, Australia and EquallyWell, New Zealand. More than 100 organisations in each of these countries have committed to action in their spheres of influence. The presentation will overview the similarities, differences and collaboration between the two countries. It will also detail the role of consumers and carers in design and implementation. Finally, it will review the status of physical health initiatives associated with EquallyWell in the implementation of the Fifth National Mental Health and Suicide Prevention Plan.

Learning Objectives

Learning Objective (1): “What will people in the audience gain or learn from attending this presentation?”
Participants will gain an awareness of the things they can do in their sphere of influence to improve the physical health of people living with mental illness.

Learning Objective (2): “How is this topic/issue relevant to mental health services and mental health issues?”
For every one person living with mental illness who dies prematurely due to suicide, 14 die early due to cardiovascular and respiratory disease. This is a priority area for mental health services in the Fifth National Mental Health and Suicide Prevention Plan (Department of Health, 2017).

References

Being Bi+: Mental Health Issues for Non Binary Sexualities

Ruby Mountford¹, Mx Mellem Rose¹, Jessica Olivo¹, Anthony Lekkas¹
¹Melbourne Bisexual Network, Melbourne, Australia

Biography:
Anthony Lekkas is a counselor and psychotherapist at Essendon Counselling Solutions, and a family violence and men’s behaviour specialist at the Victorian Aids Council. His career spans over 13 years in the not-for-profit community sector and in private practice. He is the founder and president of the Melbourne Bisexual Network.

Ruby Mountford is a passionate advocate for the Bi+ community and Neurodiversity, and Vice President of the Melbourne Bisexual Network. She hosts a community radio program on Bisexuality, has been featured on ABC radio speaking about Bisexuality and Autism Spectrum Disorder, and was nominated for the 2016 GLOBE Community Award.

Mellem Rose is the Secretary of Bi-Alliance Victoria, Committee Member of Transgender Victoria, and Education Coordinator of Melbourne Bisexual Network. Mellem’s passion for community advocacy and activism in Intersectionality specifically disability, neurodiversity, and mental illness spurred them to create Spectrum Intersections the LGBTIQA+ Neurodiverse Group.

Jessica Marie Olivo is a mental health professional working in the community health sector. She aims to promote better health outcomes and tackle stigma against psychosocial factors and those impacted, particularly pertaining to disadvantaged groups and the LGBTIQA+ community. She is a official committee member of the Melbourne Bisexual Network.

Comprised of health professionals and LGBTIQA+ community advocates who identify as bisexual and/or multi-gender attracted, the Melbourne Bisexual Network was founded to improve health and wellbeing outcomes for multi-gender attracted people by raising awareness and insight into the unique challenges experienced by Bisexual people through discourse, education and consultation.

While awareness around the mental health concerns of the gay and lesbian communities has been improving rapidly in recent years, research continues to show that Bisexual people suffer from significantly poorer mental and physical health outcomes than both the heterosexual and homosexual communities.

Australian research in 2012 found bisexual men and women were more likely to report experiencing psychological distress, and were significantly less likely to be open about their sexuality to friends and family, and less likely to be involved in the LGBTIQA+ community or to regularly see friends who identified as LGBT. Bisexual identifying people of both sexes were more likely to report a psychiatric disability than straight or gay men and women.

Research from the UK, US and Australia suggest that bisexual people often face discrimination, distrust and rejection from both the heterosexual community and LGBTIQA+ community, and as a result experience high levels of social isolation, as well as difficulties accessing resources and services that confirm and validate their sexual identity. There is also research that finds bisexual women are at higher risk of developing eating disorders and non-suicidal self-harm behaviours, and that bisexual people are at a higher risk of suicidality.

There is a lack of education around multi-gender attraction within the mental health sector, which can lead to misunderstandings and invalidation, which may compound feelings of isolation and loneliness, and can impede future help-seeking behaviours.
The MBN will facilitate a workshop that aims to collectively determine strategies to improve and promote Bisexual inclusivity in both mainstream health services and LGBTIQA+ services by focusing on three key areas:
- Promoting new research
- Informing practices
- Community consultation

During the workshop, our committee members will share research outcomes, professional knowledge and anecdotal experience whilst facilitating discussion about the barriers Bisexual people face when accessing health services. We will discuss strategies to counter these impacting factors and include case studies to allow participants to apply new information in a practical manner.

Learning Objectives

Learning Objective (1): People in the audience will learn about the mental health risks bisexual people face as a result of social isolation and “double discrimination” from both the heterosexual and LGBTIQA+ community, and the current barriers for bisexual people accessing mental health services. The audience will gain an understanding of how this information can be practically applied to the delivery of services.

Learning Objective (2): These issues are relevant to mental health services and mental health issues as bi+ people are at exceptionally high risk of poor mental health outcomes and permanent psychiatric issue, as well as being at a high risk of encountering traumas that can impact on mental health. The lack of education and understanding of the risk factors for bisexual people within specialist and general mental health services can lead to miseducation, misrepresentation, and outright discrimination which may compound mental health issues.

References


“Setting Standards for the Lived Experience Workforce”. One organisation's experience of implementing Standards and Guidelines for their Lived Experience Workforce.

Shandy Arlidge¹, Phil Jones², Keryn Robelin²
¹Mental Health Coalition SA, Unley, Australia, ²UnitingSA, Port Adelaide, Australia

Biography:
Shandy Arlidge is the Project Manager for the Lived Experience Workforce Project. With 13 years’ experience in the mental health sector she is a passionate advocate for Lived Experience Workforce, having seen again and again the benefit this skilled workforce brings to the lives of people living with mental health challenges.

With 22 years in the mental health sector, Phil Jones diverted from his first career as a boiler maker welder to become a registered general nurse and mental health nurse. He is committed to seeing holistic mental health services delivered in the community and the expansion of the Lived Experience workforce.

Kez Robelin is the Consumer Consultant/Peer Worker for UnitingSA, leading a LE team within MHS. She is driven by opportunity for change and education, alongside people lived experience and those who deliver supports when needed. Kez works from the understanding of recovery as a daily practice of "welling".

The support provided by Lived Experience (Peer) Workers differs from traditional support as it is mutual, reciprocal and based on equality and can enhance a person’s understanding or self-awareness of what they are experiencing while promoting hope and self-responsibility (Davidson et al, 2012)

“While there are a number of state and territory based initiatives aimed at supporting and developing the mental health consumer and carer identified workforce...many of these workers have been employed without regard to the tensions inherent in their role and with little support to address these.” (National Consumer and Carer Forum, 2010)

That quote was from 2010 and we are still in process to create a work environment where Lived Experience (LE) workers thrive. The Lived Experience (Peer) workforce has been developing in SA since 1998 and it has, over time has matured to be a skilled and specialised workforce. The Certificate 4 in Mental Health Peer Work has been refined and is a valuable professional qualification for the LE workforce. Yet in many instances, the work environment has lagged behind.

The Lived Experience Workforce Project (LEWP) was funded in late 2014 by the SA State Government to deliver, amongst other outcomes, a set of Standards and Guidelines for the Community Managed Mental Health sector (CMMH) to support the effective recruitment, retention, leadership and growth of their Lived Experience Workforce. These best practice Standards and Guidelines were co-produced by the LEWP Reference Group (Lived Experience Workers and Leaders of Lived Experience Workforce from the CMMH sector) and will be shared with the Government sector to support their Lived Experience Workforce. Lived Experience members of the LGBTIQ, Aboriginal and CALD communities have filtered the Standards and Guidelines to ensure they meet more than the dominant culture across the CMMH sector.

The Standards and Guidelines, developed as a self-assessment tool are now in pilot across several organisations. UnitingSA in Adelaide has fully embraced both the Standards and Guidelines, and the review and implementation process. Led by their Lived Experience Consumer Consultant, a project team have reviewed their organisation from the top down and developed an action plan to ensure the Standards and Guidelines are implemented within the context of their organisation.
With an intended audience across the spectrum of the mental health system, this workshop will be Chaired by Paul Creedon, UnitingSA Manager, Community Mental Health.

The workshop structure is:
• (5 minutes): Chair introduces the session and presenters
• (30 minutes): Presentations:
  - Describe the Standards and Guidelines and the process to development them.
  - Describe why and how UnitingSA decided to audit their organisation for the Standards and Guidelines,
  - Hear from Lived Experience participants in the process, and
• (45 minutes): Interactive workshop (small groups/talking circles):
  - How are the Standards and Guidelines relevant to their organisation?
  - What opportunities could be created by adopting the Standards and Guidelines?
  - What challenges could participants foresee and how could they be overcome?
• (10 minutes): Sharing key ideas from workshop (large group) and closing remarks from Chair

Learning Objectives

Learning Objective (1): The audience will gain an appreciation that recruitment, retention, leadership and development of the Lived Experience Workforce starts at strategy and ends at the front line, and encompasses everyone in the organisation. Implementing Standards and Guidelines provides a structured and shared approach.

Learning Objective (2): This topic is relevant in today’s changing mental health environment. For example, the NDIS is an amazing opportunity to grow and develop this specialist workforce, which continues to form an integral part of our national and state mental health strategic direction through the Fifth National Mental Health and Suicide Prevention Plan and the SA Mental Health Strategic Plan

References


My Treatment, My Directive

Hannah Harbinson, Shannon Calvert

Biography:
Hannah Harbinson worked as a Mental Health Advocate working across VIC for the Victorian Mental Illness Awareness Council (VMIAC) and the Independent Mental Health Advocacy Service (imha). Moving to WA employed as Mental Health Team Facilitator and Recovery Peer Support Worker, Project Officer, Sector Development and Events and Training Officer.

Shannon Calvert is a consumer in recovery of 30 years with a severe and enduring Eating Disorder. Shannon was diagnosed with depression, anxiety and PTSD. Shannon’s interests are directed in Mental Health peer support with priority in consumer advocacy to support the respect, rights and appropriate choice of treatment.

Methods:
Focusing on key aims with opportunity to upskill all key stakeholders to expand their capabilities in service delivery and implementation. Adopting a narrative approach of personal experience by exploring the journey of Lived Experience and Lived Experience Workforce involvement, while providing a channel for advocacy.

Aims to demonstrate:
• Where interventions can be supportive vs. detrimental in treatment.
• Where practices are deemed necessary, application must be in context of supportive intervention, ensuring consumers are central to their care, not as coercive or threatening forms of treatment.
• Safeguarding the consumer voice and help facilitate best practice using National and International models (United Kingdom, Ireland, Scotland, Germany, Belgium, Canada, New Zealand, India and Australia
• The need for Advance Health Care directives as an alternative voice.
• Exploration of three complementary aspects of a directive; these being, consumer autonomy, co-designed therapeutic alliances and integration of holistic care.
• The importance of treatment teams being aware of empathy, compassion and open, honest communication with the individual.

Content:
If a person is required to have compulsory mental health treatment, an Advance Directive is a way to record their treatment preferences, opinions and wishes in a way that all key stakeholders can access and understand. Presenters will discuss aspects of treatment history with an eating disorder, which involved restrictive practices and could have been negated with an Advance Health Care Directive. Following with a Consumer Mental Health Advocates account of the benefits of an Advance Health Care Directive in action. Presenters will outline the environment and culture that can exist in a mental health unit, posing clinical issues and how an Advance Care Directive can help to alleviate these issues by offering an innovative and quality method of supported decision making. Presenters will explore the clear tension that can exist between consumer autonomy and right to treatment which underpin many concerns (Atkinson, Garner, and Gilmour, 2004) by utilising a real-world example and providing a human connection behind abstract clinical concepts. An interview that will explore the executed, steps that must be taken to ensure compliance, including adequate dissemination to providers, and to ensure that proxy decisions are consistent with the person’s treatment preferences. Audience members will then work with the presenters using the information provided to create and examine a person-centered living Advance Health Care Directive. Presenters and audience members will then have a
round table discussion on what can be added to enhance these documents. Brainstorming potential barriers and outcomes that could exist.

Conclusion:
Intervention is sometimes crucial and necessary in treatment. When necessary, so is equal importance of compassion and dignity towards the individual. Ensuring that a person’s voice is the greatest road to recovery. Hear their whisper before it becomes a roar.

Workshop Format:
- Introduction: (20 minutes)
  - Brief introduce the topic and key points (5 minutes)
  - Explanation of workshop, aim and the inclusion of lived experience workforce perspectives (5 minutes)
  - Summarisation of the literature on lived experience contribution to clinical decision making (5 minutes)
  - A historical lived experience account and the benefits that an Advance Health Care directive could have provided (5 minutes)
- Interview conversation between presenters: (10 minutes)
- Presenter role play demonstrating the formulation of an Advance Health Care Directive (5 minutes)
- Audience members creation of a living Advance Health Care Directive, using flowcharts, checklists and tips provided by presenters (10 minutes)
- Question and Conversation Time- Open to the floor (10 minutes)
- Summary and Close (5 minutes)

Learning Objectives

Learning Objective (1): Audience members will learn practical tools to implement and use Advance Health Care Directives and help embed supported decision making, as a recovery-orientated practice by assisting people with a diagnosis of mental ill health and emotional distress to participate and be an active citizen in decisions about their treatment, care and recovery. This workshop will show a new pathway to care and include tips, checklists and flowcharts to ensure that the Care Directives are being fully utilised. Presenters will engage in an interview style discussion; dynamic role play and interactive question and answer. Participants will be asked to help create a living document that showcases the benefits of an Advance

Learning Objective (2): Currently, Advance Health Care Directives in psychiatric settings are an underutilised practice in Australia, and this workshop aims to introduce it as an emerging practice. With an increasing emphasis on the inclusion, participation, engagement and leadership of lived experience in services and person-centred treatment this interactive and participative workshop explores the use of Advance Directives in clinical mental health settings as a medium for the consumer voice. and helps to facilitate co-design practices into everyday clinical treatments.

References


Images of Recovery: Young people tell their stories.

Jennifer Griffiths

Youth Mental Health Program, North Metropolitan Health Service - Mental Health, Health Department of Western Australia, Perth, Australia

Biography:
This presentation was developed by young people who are members of the Youth Reference Group (YRG) of the Youth Mental Health Program, Health Department of WA. The YRG engages consumers in activities including skills development, consultation to organisations, and creative projects with a focus on mental health.

Jennifer Griffiths is a Consultant Clinical Psychologist, and Acting Co-Director of YouthLink. She has worked in youth mental health for over 20 years, and has a strong interest in finding creative ways to support consumer engagement and participation. She collaborated as clinician facilitator with YRG members to develop this presentation.

The Youth Mental Health Program comprises four specialist mental health services operating across the Perth Metropolitan area:
> YouthAxis
> YouthLink
> YouthReach South
> Youth Hospital in the Home.

The Youth Mental Health Program aims to reduce the incidence, prevalence and impact of mental health and psychosocial problems on young people, in consultation and collaboration with other services providers and the broader communities in which young people reside and find themselves connected. These services are trauma-informed, welcoming and inclusive of diversity, client-centred and flexible.

This presentation features a "Pecha Kucha" slide show, with photographs, artwork, spoken text, and music, developed by members of the Youth Reference Group. The Pecha Kucha describes aspects of the mental health journey of the young people, highlighting components of service delivery within Youth Mental Health Program which have supported their recovery journeys. Following the Pecha Kucha, individual young people will speak briefly about their own experiences of mental health problems, with reference to some of the practices and environments within services that can enhance access and responsiveness to young people with barriers to accessing mainstream services, including homelessness and transience, trauma histories, diverse gender and sexuality, and cultural barriers for Aboriginal young people.

Learning Objectives

Learning Objective (1): The audience will gain an increased understanding of the lived experience and mental health recovery journeys of marginalised young people, and the service delivery characteristics which they perceive as the most helpful. They will also see the outcome of a creative process undertaken by young people as part of their engagement with the service’s Youth Reference Group.

Learning Objective (2): While there is an increasing recognition of the importance and value of engaging mental health consumers in service development, delivery and evaluation, there is much to be gained by harnessing the existing skills and creativity of service users in creative and original ways. The benefits can be to both the service, though enhancing the capacity to engage clients, and the consumers who gain connection with others, skills development and a valuable reflection of the their achievements. These benefits can serve as a positive adjunct to their mental health therapy and treatment, and support the consumer to develop greater awareness of their own strengths and capabilities.
Family Violence and Mental Health Services - Changing Policy and Practice.

Sabin Fernbacher

Department of Health and Human Services, Melbourne, Australia

Biography:
Sabin Fernbacher has worked in the area of sexual assault, family violence, homelessness and mental health for over 30 years. She is passionate about working collaboratively on systemic change to increase gender sensitivity/safety and trauma-informed care. To do this, she works across sectors, in service and policy development, research and workforce development. She currently works in the Mental Health Branch/Department of Health and Human Services. She is responsible for the implementation of key recommendations of the Royal Commission into Family Violence that relate in particular to the mental health service system.

The Victorian Royal Commission into Family Violence identified the need to improve Victoria’s response to family violence, including that of mental health services. The Commission highlighted the unique position of health and mental health services, and the role clinicians have in identification and early intervention. The Chief Psychiatrist Guideline on Family Violence provides direction about family violence practice for clinical mental health services in Victoria. It clarifies expectations of management and clinicians regarding their roles in responding to family violence.

Current literature, an analysis of current practice in mental health services regarding family violence and Project Advisory Group members provided the backdrop to the guideline development. What has shaped the guideline most of all was hearing what people with lived experience have told us about the need for better service responses when it comes to family violence.

This presentation will provide an overview of the major findings of the literature and the situational analysis. Focus groups with clinicians and people with lived experience provided rich information about gaps, needs and insight into current practice and potential solutions. An outline of the guideline and its application to practice will be discussed.

Learning Objectives

Learning Objective (1): The audience will increase its understanding:
- of family violence in the context of mental health service provision
- the roles and responsibilities of mental health services &
- the background to the development of the guideline

Learning Objective (2): Many people who access mental health services have experienced family violence. The Victorian Royal Commission into Family Violence identified a need to increase services’ capacity to respond to family violence. The guideline is one way to support change in mental health services

References


Bridging lived experience and evidence based practice with spiritual care values.

Jennifer Greenham

Spiritual Health Victoria, Melbourne, Australia

Biography:
Jennifer is a passionate advocate for true person centred care which allows one to feel seen and heard at their essence. With over 30 years’ experience in the mental health sector, her role at Spiritual Health Victoria brings together all the elements that she believes truly supports people to heal and move on in their lives. Jennifer’s work is supported by an Interfaith Ministry Ordination and units in Clinical Pastoral Education. Complementing this role Jennifer supports people to authentically express themselves at important times in their lives in her work as a Celebrant.

Relationships are not the vehicle through which we deliver treatment; relationships are the treatment. (Prof Mike Slade) It is in relationship that we have the capacity to hear the whisper long before it becomes a roar. It is through relationship that trust is built, confidence gained and the ‘what is possible’ comes into view. Reflection on what it means to live as a human being draws us beyond the confines of science based view of people, towards an understanding of our human existence that is multidimensional and frequently deeply spiritual. People live their lives in a constant process of exploration, wonder and awe, where issues of love, hope, meaning and transcendence are fundamental. These aspects of life may not be on the agenda of many mental health professionals, however they are often central to the lived experience of people with mental health issues. If we are going to offer mental health care that reflects and respects the fullness of human experience, it is necessary to expand the scientific worldview to include forms of evidence that may be different to what we consider the norm. Lived experience is the evidence so listening deeply becomes the tool that informs our practice.

Learning Objectives

Learning Objective (1): Members of the audience will take away a contemporary understanding of what spiritual care is and how it supports people to nominate their experiences and gain support that is respectful and person centred at its essence. Participants will leave feeling that a topic long held as taboo in psychiatry has been demystified and made accessible.

Learning Objective (2): We are consistently hitting our heads against the wall searching for new ways to engage and support people who are increasingly disconnected and feeling alienated in the world. Spiritual values remind us of a place from where we can commence. They provide a sound framework to begin our true person centred work, work that is always endorsed by those we seek to engage with and support.

References

Pain Behind the Poker Face: Development and Evaluation of Mental Health First Aid for Gambling Problems.

Louise Kelly
Mental Health First Aid Australia, Melbourne, Australia

Biography:
Louise Kelly is the Manager of Specialised Programs at Mental Health First Aid Australia. She is the author of the MHFA for Gambling Problems Course. Louise is a passionate advocate for mental health literacy and models that promote early intervention. She has Masters of Education and postgraduate qualifications in psychology.

Many Australian's lives are impacted directly and indirectly as a result of problem gambling. Those with gambling problems are at increased risk of suicide and likely to experience mental health problems including depression, anxiety and substance use problems.

Mental Health First Aid for Gambling Problems is a new 4-hour course for community members that was developed by Mental Health First Aid Australia. Curriculum content is based on expert consensus guidelines developed with the Delphi method using both professional and consumer experts from English speaking developed countries. Learning outcomes of the course include: helping community members identify risk factors and warning signs; knowing the first aid guidelines of how to help when someone is experiencing gambling problems; and practicing these skills in a safe environment.

This presentation will focus on how this course was developed to give participants a comprehensive understanding of the early warning signs of gambling problems, encouraging participants to listen to the whisper, not the roar. The presentation will also present initial results from an uncontrolled trial of the course across Australia. Knowledge, attitudes, behaviours and confidence in providing assistance to a person experiencing gambling problems is being assessed before the course, immediately after and at a six month follow up.

Learning Objectives

Learning Objective (1): Attendees will gain an understanding of how this course assists community members to identify early warning signs and uses evidence to inform the curriculum.

Learning Objective (2): Attendees will learn about preliminary findings from the evaluation which they can use to inform any community-based education programs which they may be engaged in.

References


Mental Health First Aid Australia. Helping someone with gambling problems: mental health first aid guidelines. Melbourne: Mental Health First Aid Australia; 2015.
Uniting our sector through communication - a national Charter to guide the way we talk about mental health and suicide prevention with each other and the community.

Amanda McAtamney¹, Marc Bryant¹
¹Everymind, Newcastle, Australia

Biography:
Amanda McAtamney is a Project Lead on the suicide prevention team at Everymind, with a current focus on national leadership in the areas of media and communication about suicide. She has a Masters in Policy and Applied Social Research (Macquarie University) and has contributed to a range of national and state mental health and suicide prevention programs.

Marc Bryant is the Program Manager for Everymind’s Suicide Prevention team. He is a qualified journalist and communication professional, having completed the National Council for the Training Journalists pre-entry course (UK) and a Bachelor of Communication (Honours). He has 11 years’ experience working in the mental health sector.

The National Mental Health and Suicide Prevention Communications Charter is a resource and uniting document designed to guide the way organisations talk. The Charter encourages sector commitment to working together and developing better structures and processes for collaboration.

This presentation aims to raise awareness of the Charter, outlining its key components and the outcomes of its redraft and operationalisation. This includes an updated structure, principles and key messages and the establishment of new support and dissemination strategies, such as a Champions Group and training resources.

People working in the mental health sector as well as government, businesses and community groups will be encouraged to sign up to Charter and align with its principles and keys messages. In implementing the Charter, individuals and organisations will communicate in ways that actively work to increase help-seeking behaviour and reduce stigma, and collaborate with each other and the community to maximise efforts and resources and minimise duplication across the sector.

Learning Objectives

Learning Objective (1): The primary learning objective is for the audience to understand that the mental health sector can strengthen their collective voice in bringing attention to the issues of mental health and suicide prevention in Australia. The audience will gain in-depth knowledge of how to communicate about mental health and suicide in a safe way that aligns with the evidence base, as well as the importance of common goals and working together under the guidance of this Charter.

Learning Objective (2): The Charter provides principles and key messages to guide how individuals and organisations in the mental health sector work together to keep mental health and suicide prevention prominent in the national conversation, including strategic communication, advocacy and awareness-raising. The redevelopment of the Charter has included the creation of resources that can be used by organisations across the mental health and suicide prevention sectors. Rather than solely being a static document that sits on a website, the Charter is now a ‘living’ document with practical guidelines for its uptake and implementation.
Life in Mind - Suicide Prevention Through Collaboration

Mr Marc Bryant¹, Amanda McAtamney¹
¹Everymind, Newcastle, Australia

Biography:
Marc is the Program Manager for Everymind’s Suicide Prevention team. He is a qualified journalist and communication professional, having completed the National Council for the Training Journalists pre-entry course (UK) and a Bachelor of Communication (Honours). He has 11 years’ experience working in the mental health sector.

Amanda McAtamney is a project lead on the suicide prevention team at Everymind, with a current focus on national leadership in the areas of media and communication about suicide. She has a Masters in Policy and Applied Social Research (Macquarie University) and has contributed to a range of national and state mental health and suicide prevention programs.

Life in Mind is a national initiative that connects Australian suicide prevention services and programs to each other and the community. It provides an online platform for knowledge exchange surrounding suicide prevention and sector leadership through collaboration and engagement. The presentation will include an interactive tour through the Life in Mind online portal, outlining value and usability of content for both community, government and sector.

Life in Mind has been developed following national consultation with key agencies and organisations working within suicide prevention and mental health including representation from lived experience, culturally and linguistically diverse communities, LGBTI peoples and Aboriginal and Torres Strait Islander peoples. The Life in Mind portal is a new approach to connecting suicide prevention and mental health sectors and community with renewed accessibility of resources and tools, national and state policy and strategy, gatekeeper training courses and communications guidelines. Life in Mind hosts specific suicide prevention information for priority populations, linking users to specialised organisations and resources. Acknowledgement of diversity and lived experience is present throughout the content of the Life in Mind portal, and focuses on strengths based approach to suicide prevention.

Learning Objectives

Learning Objective (1) answers the question: “What will people in the audience gain or learn from attending this presentation?”

Audience members will gain awareness of the new online portal (Life in Mind) and its features. The audience will learn how Life in Mind improves access to suicide prevention resources, programs and services that are inclusive for both sector and community, as well as policy, research, and directories for suicide prevention organisations and networks.

Learning Objective (2) answers the question: “How is this topic/issue relevant to mental health services and mental health issues?”

The role of suicide prevention within mental health is important in preventing suicide deaths, with individuals experiencing mental illness identified as having an increased risk of suicide. The communication guidelines, national and state policy, resources and research hosted within the Life in Mind portal is valuable for mental health professionals and community services.
The physical health of older persons living with mental illness: Implementing Equally Well.

Russell Roberts1, Kate Jackson2

1Charles Sturt University, Bathurst, Australia, 2NSW Health, Mental Health Branch, Sydney, Australia

Biography:
Russell Roberts is an Associate Professor in leadership at Charles Sturt University. He is Chair of the Australian Rural and Remote Mental Health Symposium and Co-Chair of the national Equally Well Implementation Committee.

Kate Jackson is Director, Older Persons Mental Health Policy Unit, NSW Health. She has led the development of the NSW Older Persons Mental Health Service Plan, (2006, 2017) and the development of the Community Model of Mental Health Care for Older Persons. She has been a leader in older persons mental health in Australia for over a decade.

Almost 80 percent of people living with mental illness have a mortality-related chronic physical illness (Australian Institute of Health and Welfare, 2012). Cardiovascular disease, respiratory disease and cancer are the main causes of early death in older persons living with mental illness (Australian Bureau of Statistics, 2017). Whilst the antecedents of this early death often exist decades prior (Erlangsen et al., 2017), chronic disease and associated premature death rises dramatically as people age.

The physical health of people living with mental illness is referenced as Priority 5 in the Fifth National Mental Health and Suicide Prevention Plan. In addition, over 100 organisations have committed to the Equally Well National Consensus Statement (National Mental Health Commission, 2016) to make improving the physical health of people living with mental illness a priority. This paper overviews current national policy, research and examples of the innovative practice in Australia to improve the health of older people living with mental illness in Australia. This presentation outlines the major causes of early death and the physical conditions of highest risk, and the research into managing and preventing the early death of people living with mental illness. This presentation will help equip participants to address the physical health needs of older people living with mental illness.

Learning Objectives

Learning Objective (1): “What will people in the audience gain or learn from attending this presentation?”
Participants will gain an understanding of the major risks of early death in people living with mental illness, examples of best practice and clinical guidelines to improve the physical health of older people living with mental illness.

Learning Objective (2): “How is this topic/issue relevant to mental health services and mental health issues?”
The premature death of and poor physical health of people living with mental illness is a recognised priority action area in Australian mental health.

References


Just Listening – a community response as a strengths based approach to mental distress.

Matthew Ball¹, Annabelle Lockwood, Jasmin Edwards
¹Humane Clinic, Adelaide, Australia

Biography:
Matt is a mental health nurse practitioner who has lived experience of psychosis. He engages in human-to-human relationships to find meaning in extreme or altered states. He is developing a non-clinical community alternative for people in crisis.

This presentation will discuss and describe how the project evolved and specifically focus on the development of the key members of the ‘Just Listening’ development group, with a special focus on the role of the Occupational Therapy Students and the value they have brought to the project as an unlikely, but invaluable resource. Just listening will provide an environment of community develop, led and delivered alternative for individuals who are experiencing distress and isolation. Just Listening principles and values are drawn from Open Dialogue, Soteria and Rogarian concepts. Community members will be trained and supported to listen and remain in relationship as peers in the community are supported to move through distress without having to approach mental health emergency services. This presentation will discuss how the novel project evolved, a project that may lead to a change in the way communities can respond, embrace through the strengths of the community. The collaboration between community members, the local children’s centre and the unlikely but invaluable resource of two Occupational Therapy final year students, has brought invaluable time, energy and perspective in bringing the Just Listening project to reality.

The likely outcomes are a significant reduction in contact with emergency mental health services by people in distress and broader understanding with the community itself, both of people’s needs and the communities’ ability to respond.

Learning Objectives

Learning Objective (1): Understanding how communities can realise resources that already exist in supporting people in distress.
Learning Objective (2): Recognise the value of resources available in our communities when responding to distress in a strength based approach.

References

Family Whispers

Jacob Kuklych, Lindy Chaleyer

Biography:
Jacinta is a Carer Consultant and Family Program Manager at Alfred Child and Youth Mental Health Services and at headspace Youth Early Psychosis Program. Jacinta’s ‘lived experience’ and involvement with services has informed the development of the family peer workforce.

Lindy is the senior family peer worker at headspace. Lindy's experience in providing support to families is extensive and multifaceted. Lindy's lived experience enables our families to be supported in an empathetic and empowering manner.

Since implementing ‘open dialogue’ families’ whispers have been able to be heard and not develop into the full blown roar! The ‘open dialogue’ type of model at headspace youth early psychosis program has given a voice to families where previously they have felt unheard. It has also become a forum where clinicians can share their thoughts openly with the family and young person’s network.

Families having the regular opportunity to have their voice heard in a network meeting have been less inclined to have to resort to a massive roar to be heard. Open dialogue network meetings have demonstrated and empowered families to be comfortable to express themselves knowing that they will be heard.

Learning Objectives

Learning Objective (1): Hearing about the open dialogue network experience will validate how intentionally listening with opportunity to respond can add to improved family and young person communication. This can often deflect from the often necessary compulsion families have to “roar” their displeasure or concerns.

References

Mental Health Education - integration of knowledge into contemporary clinical practice.

**Lisa Wong**¹, **Patrick Livermore**², **Juliette Cox**³, **Michelle Leahy**³

¹Health Education And Training Institute - Higher Education, NSW Health, North Parramatta, Australia, ²Specialist Mental Health Services for Older People (SMHSOP), Central Coast Local Health District, Central Coast, Australia, ³Prince of Wales Hospital, South Eastern Sydney Local Health District, Randwick, Australia

**Biography:**
Lisa Wong is the Course Coordinator (Older Persons Mental Health) at the Health Education and Training Institute (HETI) – Higher Education of NSW Health. Lisa is a mental health nurse for 35 years. She has the passion to provide high quality mental health education for the benefit of those with lived experience.

Patrick Livermore is a social worker and Coordinator, Promotion / Prevention, Specialist Mental Health Services for Older People (SMHSOP), Central Coast Local Health District and Secretary of the NSW Elderly Suicide Prevention Network (ESPN). Patrick research interests include peer work, group programs, elder abuse and suicide in later life.

Julietta and Michelle both work at an older persons mental health inpatient unit at South Eastern Sydney Local Health District. They are enthusiastic to offer recovery-oriented person-centred care to elderly people with lived experience. They are passionate to conduct health promotion programs in their inpatient unit.

**Introduction:** The report ‘Living Well in Later Life’ (Mental Health Commission of NSW, 2017) supports the enhancement of wellbeing in older people via health promotion strategies.

**Aim:** To assist students studying for the unit on ‘Recovery-oriented Mental Health Care with Older People’ as part of the Postgraduate course in Applied Mental Health Studies to design a health promotion activity for older people in their clinical area.

**Method:** An assignment task is set up with the aim to facilitate students to develop an evidence-based health promotion activity for older people focusing on positive ageing in their area of practice.

**Results:** Evidence-based recovery-oriented health promotion activities for older people were developed with input from the Facilitator in Application to Practice Tutorial and Unit Coordinator. Students were able to assess the needs, plan and evaluate their health promotion activity in collaboration with their team. Two students had carried out their ‘Emotional Recovery Program’ and ‘Exercise for the Mind Program’ for elderly people in their mental health inpatient unit. Both programs had achieved positive outcomes with improved wellbeing in their client group.

**Conclusion:** It is important for mental health education to provide opportunity for students to integrate newly acquired knowledge into contemporary clinical practice.

**Learning Objectives**

Learning Objective (1): After attending this presentation, people in the audience will gain knowledge that recovery, including the hope, is essential later in life. As such, the audience will come to understand that it is important to support positive mental health and wellbeing for all older people via health promotion activities not only in the community, but in acute inpatient units as well. Finally, the audience will gain a better understanding how mental health education can help to supervise health care professionals to develop health promotion program which can enhance wellbeing in older people.

Learning Objective (2): Mental health education at HETI – Higher Education, NSW Health aims to educate the mental health workforce using best practice for mental health service development. It is important for mental health education to maintain strong connections with the reality of clinical field to understand the needs of people with lived experience. There is a need to ensure that services are appropriate and effective in meeting the mental health needs and promoting positive ageing in older people. Mental health education should be working towards helping people to live well in later life by promoting a positive attitude and support for our older people who continue to contribute in our society.

**References**

Increasing the responsiveness to LGBTIQA+ needs across an adult mental health service.

Catherine Harrison¹, Michelle Bullivant¹
¹St Vincent’s Mental Health, Melbourne, Australia

Biography:
Catherine Harrison (BHSc.OT)
Grade 2 Occupational Therapist/ mental health clinician
St Vincent’s Hospital
After working for the NHS, London- Catherine decided to experience life in Melbourne. Prior to her current role at St Vincent’s, Catherine developed valuable experience in trauma informed practice. Catherine is committed to client centered, innovative approaches.

Staff from across St Vincent’s mental health service implemented strategies and training to develop the work force in order to address the needs of those who identify as LGBTIQA+. This staff group included a consumer consultant, mental health nurse, social worker, occupational therapist, medical staff and lived experience. The group consisted of the LGBTIQA+ steering committee and members of the Victorian mental health interprofessional leadership network who worked collaboratively to promote a safe, supportive and welcoming environment for staff and consumers who identify as LGBTIQA+.

This presentation aims to explore the journey of the team in developing the workforce in Gender and Sexual Diversity Inclusive Practice in Mental Health. It will include the limitations and strengths of the project including liaison with external agencies, key stake holders within the service, inclusion of lived experience and dynamics within the project team. It will also include some outcomes from training delivered as well as specific examples from the training that other services can use in developing their workforce in LGBTIQA+ responsiveness.

Learning Objectives

Learning Objective (1): “What will people in the audience gain or learn from attending this presentation?”
People in the audience will gain insight into the limitations and strengths in developing the workforce in order to increase responsiveness to LGBTIQA+ needs. Through the exploration of this journey they will take away tips and ideas for increasing responsiveness to LGBTIQA+ needs within their mental health service.

Learning Objective (2): “How is this topic/issue relevant to mental health services and mental health issues?”
This topic is relevant to mental health services as it has been shown that the prevalence of mental health disorders and suicide attempts is higher in those who identify as LGBTIQA+ and it is unclear how consistent mental health services are in responding to these needs. It is important to note that the higher instance of mental illness in those who identify as LGBTIQA+ is a result of social pressure, stigma, rejection, poor access to inclusive healthcare, not only due to identifying as LGBTIQA+.

References


PTSD UnMasked

Simon Gillard
Simon Gillard, Sydney, Australia

Biography:
Simon Gillard was a NSW police officer for more than fifteen years, before being invalided out of the force with PTSD. His first book, a bestseller called Life Sentence: A Police Officers Battle with PTSD, was released by Penguin Random House in May 2017.

As soon as he finished high school he joined the Police Force. He climbed the ranks from probationary constable, and as his experience grew so did the number of cases he worked on. Working in stations around Sydney, he was tasked with investigating suicides, high-profile murders, paedophile rings and much more.

Simon never spoke to anyone about the traumatic things he’d seen and had to do; not colleagues, friends, professionals or even his wife. It reached the point where he couldn’t close his eyes without images flashing through his mind: unsolved murder cases he couldn’t let go, bodies he had seen over the years, and schoolboys, not much older than his own son, whose lives had been destroyed. He began to suffer panic attacks and nightmares. As the cases mounted, so did the pressure, and over time Simon made an attempt on his life.

The pressure didn’t ease once he was formally discharged from the Police Force in 2012. Simon had lost his career and identity and was hounded and harassed by insurance companies who thought he wasn’t genuinely ill. Simon was still on a self-destructive path that affected not only him, but his wife and children. He made further attempts on his life during this time.

Simon now speaks about those experiences at conferences, schools and corporate events all over Australia. Simon is now an advocate and wellness educator for others with PTSD, depression, anxiety, identity crisis, suicide prevention and the importance of early intervention. Simon lives in Sydney with his wife and three children.

My presentation is an informative session around PTSD education from a lived experience point of view. As a former NSW Police Detective Sergeant who formed PTSD and depression due to work related trauma and stress, my presentation is applicable to all emergency services, military, mental health professionals and the wider community. I discuss the stages of PTSD formulation and depression and how a sufferer wears a mask, why they wear a mask? and why a sufferer compartmentalises trauma. Due to external circumstances, a PTSD sufferer can be forced to mask their condition due to fear of career loss, stigma attached, poor culture or fear of retribution.

I will also talk about breaking down the barriers for early intervention to be realised. Resilience training, education along with peer support programs are functional methods to a degree to assist in achieving critical early intervention. What I will discuss in more detail, in the case of emergency services, the military, nursing and any ‘Stress and Trauma cocktail profession or lifestyle’ changes that will promote early intervention in a proactive rather than a reactive sense that can save careers, marriages and most importantly lives. I outline the feelings associated with suicide from a lived experience point of view as well as the facts around why suicide seems to be the answer by a sufferer. I will be introducing a suicide prevention resilience model which, I have developed.

Learning Objectives

Learning Objective (1): My audience will have a greater understanding of PTSD, from a lived experience perspective. Suicide prevention via my lived experience will provide the audience to take-away there is always hope and suicide is not the answer even. This will provide a ‘ripple effect’ that can be passed on well after the conference. My audience will learn the signs and symptoms of trauma and depression and their effects, especially within stressful and traumatic occupations. The audience will understand that proactive measures will greatly assist to remove the stigma & culture associated with mental health.
Learning Objective (2): My lived experience has taught me ‘It’s ok, not to be ok’ no matter who you are or what you do. I strongly believe lived experience presentations are as important as any other mental health presentation in the sector. The key to recovery is early intervention and not seeking help early will only allow the mental health condition to fester and can, in time, lead to suicide ideation. Suicide rates are alarming with statistics of approximately 8 Australians per day and 65,000 suicide attempts per year. Having had four attempts I know first hand that PTSD, depression and suicide are critical topics/issues in the mental health sector.

References

National Suicide Prevention Conference 2017:
“You were an inspiration to so many. Those who are willing to share give more than they know to people in need. As I say our pain should be their gain. Leave nothing on the table.”
Conference Lived Experience Mental Health Manager

The Mental Health Services Conference 2017 - Hilton, Sydney:
“Amazing presentation, very open and informative! I enjoyed immensely.”
Psychiatrist RANZCP

International Mental Health Nurses Conference – Tasmania:
“Special commendation to Simon Gillard and his presentation ‘PTSD UnMasked’. The presentation was immensely informative on the urgency to move forward for change to understand that all of our Mental Health Nurses are a human asset and need proactive care within the industry. It was the presentation that gave me tears”.
Head Chancellor - Closing of Conference Speech
Lived Experience Leadership: Sharing, Learning and Developing Together

Matthew Halpin, Ellie Hodges, Matt Ball
SA Health, Adelaide, Australia

Biography:
Matthew Halpin is the Consumer Consultant in the Office of the Chief Psychiatrist at SA Health. Matthew expertise include Lived Experience workforce, recovery based practice and consumer engagement. Matthew is also an Adjunct Lecturer at the University of South Australia and regularly publishes research in the area of Mental Health.

Ellie Hodges is a Lived Experience Counsellor and Consultant with more than 18 years of experience working in the community and mental health sectors as a practitioner, manager, educator, advisor, advocate and consultant. Most recently she has been a Lived Experience Advisor to the South Australian Mental Health Commission. At the heart of all of Ellie’s work is her commitment to innovation, social justice and leading together. She is informed and transformed by her work and knows that everyone has a story to tell... we just need someone to hear it. Ellie integrates her lived, learned and imagined experiences; she knows that they all matter.

Matt Ball is a mental health nurse practitioner who has lived experience of psychosis. He engages in human-to-human relationships to find meaning in extreme or altered states. Matt introduced the Maastricht approach and Talking with Voices to the public mental health system in South Australia and in private practice. He is developing a non-clinical community alternative for people in crisis.

People with lived experience are increasingly being included in mental health services and systems across the government, private and NGO sectors as employees, consultants, advocates and representatives. Whilst this inclusion is welcome and necessary the support of lived experience leadership has been piecemeal, inconsistent, individual-based and often from the perspective of service and system decision-makers who do not themselves have a lived experience.

The emergent area of lived experience leadership – including deciphering the qualities, skills and knowledge required in our leaders – is not a new conversation and is an area for development that needs to happen sooner rather than later. Mary O’Hagan (2009) published an important article exploring this topic and the role that lived experience leaders have in empowerment and ensuring equality. Mary commented that ‘lived experience leadership is underdeveloped at a service and systemic level’ and went on to discuss that ‘lived experience leadership should pervade all leadership across service systems and beyond’.

A more recent article (Bryne et al, 2018) highlights the current window of opportunity that exists to maximise lived experience leadership internationally.

Learning Objectives

Learning Objective (1): After brief presentations of their learning’s and challenges from each facilitator attendee’s at this roundtable will be invited to contribute to a robust discussion on the topic of lived experience leadership.

Learning Objective (2): The aim is for a dialogue focused on collaborating and sharing wisdom while also highlighting in their view opportunities and barriers. It is hoped that this is the start of an ongoing conversation that will continue beyond TheMHS and will contribute to developing lived experience leadership across Australia.

References

The NGO Lived Experience Workforce Project (LEWP) - Lived Experience Leaders Training - A Partnership between SA Health and the Mental Health Coalition of South Australia.

Matthew Halpin¹, Belinda Brown², Mark Loughhead³
¹SA Health, Adelaide, Australia, ²Mental Health Coalition South Australia, Adelaide, Australia, ³University of South Australia, Adelaide, Australia

Biography:
Matthew Halpin is the Consumer Consultant in the Office of the Chief Psychiatrist at SA Health. Matthew expertise include Lived Experience workforce development, recovery based practice and consumer engagement. Matthew is also an Adjunct Lecturer within the School of Nursing at the University of South Australia and regularly publishes research in the area of Mental Health.

Belinda Brown: Joining the NGO sector in 2006, Belinda’s expertise in Adult Education was invaluable in the development of SA’s first Peer Work training and pilot Certificate IV in Mental Health Peer Work. As Senior Project Officer for the Mental Health Coalition of SA’s NGO Lived Experience Workforce Project, Belinda is passionately supporting growth of this incredible workforce.

Mark Loughhead is SA’s first lived experience mental health academic. He has a background in community advocacy and mental health promotion as well as lived experience. He is committed to promoting person centred care in mental health, and encouraging better understanding about lived experience, recovery, cultural identity and consumer engagement.

Integrating the Lived Experience Workforce (LEW) as a fundamental occupational group in mental health services requires a range of strategic supports as well as cultural change (Davidson et al, 2012). In South Australia, education has been an important contributor to, embedding the work of the LEW within the mental health system. Effective training and development for the LEWs themselves as well as and leaders, is a key priority supporting development of the LEW (Repper & Carter, 2011).

Service evaluations across both the government and NGO mental health services found that leadership training was one key development area for leaders. As part of the Lived Experience Workforce Project, a partnership was formed between Central Adelaide Local Health Network LEWP, to explore developing a joint training program offered state-wide to leaders of LE staff across both government and non-government services.

The aim of the leaders’ training program was to improve understanding of the LE skill set, role clarity, retention and assist the growth of the LEW. Through a co-production process involving many partner agencies, specific topics where introduced at each training session building on leaders’ knowledge that could be delivered as solo sessions or side by side.

Learning Objectives

Learning Objective (1): This presentation will provide an overview of the program, key learnings and plans for the future of the LE Leaders training program.

Learning Objective (2): This topic will enhance any services' understanding of the importance of preparing people in leadership positions for their role in supporting and developing the LEW. Attendees will learn about the benefits this has provided, how the gaps were identified and how this training has better equipped leaders in their day to day supporting staff.

References


Peer Work: Self Care in a Capitalist System

Aimee Sinclair, Ella MacNish

Biography:
Ella is a graduate of Curtin University Lived Experience Educators Unit and works in community peer support. Ella’s presentations uniquely blend her knowledge acquired from Community studies with storytelling skills from Creative Writing studies. She is passionate about adding lived experience value to challenging the dominant discourse around mental distress.

Aimee identifies as a mad sociologist. Having worked in the mental health sector for a number of years, she has burnt out many times and has lost count of the number of times she has wanted to hide in her vegetable garden and tend to it for the rest of her life.

Inspired by the conference theme: ‘Hear the Whisper, Not the Roar’, this presentation will explore the increasing ‘whispers’ of burn out amongst peer workers working within the mental health system. Drawing on our own experiences as peer workers, alongside pre-existing research within this area, we will talk about:

• What it feels like to be continually reflexive (or as Ella prefers; ‘to have no brain cells left’)
• Working with others where burn out is the ‘norm’
• Managing microaggressions and the unseen emotional toll
• Juggling part time and ‘consultant’ roles: is it ever really ‘part time’?
• The difficulty of self care within a system that equates ‘work’ with ‘worth’

In our own experiences, we have found there is a tendency for us to feel shame and blame ourselves for ‘not coping’, when we hear the ‘whisper’ of potential burn out. In this presentation we explore an alternative framework: one that recognises flaws that potentially sit within the system rather than within us. We are curious about how best we can, on both an individual and collective level, challenge the systems and practices that lead to burn out for peer support workers, and how other workers within the system may do so also.

Learning Objectives

Learning Objective (1): Audience members will gain an appreciation for some of the systemic reasons for burnout within the peer workforce (unrelated to our ‘madness’!) and ways in which these may be challenged

Learning Objective (2): An appreciation of the systemic reasons for burnout are integral to the sustainability of the mental health peer workforce

References


Training and Supervising Peer Support Workers

Aimee Sinclair, Trish Tran

Biography:
Aimee identifies as a mad sociologist. Having worked in the mental health sector for a number of years, she has burnt out many times and has lost count of the number of times she has wanted to hide in her vegetable garden and tend to it for the rest of her life.

Trish works as a peer support coordinator in a tertiary mental health hospital, where she provides clinical supervision and direction to peer support workers. Aimee has previously facilitated group peer supervision sessions within community mental health and now teaches the Cert IV Mental Health Peer Work qualification. Both have acted as peer tutors within the Lived Experience Educator Unit at Curtin University.

Adopting the format of a reflexive conversation, this presentation will explore the experiences of the authors providing peer 'supervision' and training to peer support workers. Together we will examine our experiences: our challenges and our learnings, to stimulate conversation about ways in which development opportunities for the peer support workforce can remain true to peer values.

We seek to explore such questions as:
• How do we stay true to the values of mutuality and reciprocity within a teaching context?
• How does one facilitate critical reflexivity?
• How might peer supervision differ from other forms of supervision?
• How does one manage peer drift within clinical settings?
• How does one manage clinical staff expectations around the function of peer supervision?
• In which ways does the supervisor’s lived experience act as a barrier in providing effective supervision or education, and how can this be minimised?

The impetus for our presentation comes from our own stumbling facilitating supervision or training for peer support workers. Despite an acknowledgment of the importance of peer supervision and training for peer support workers (Kemp & Henderson 2012, Vandewalle et al 2016), there exists limited literature, stories, guidelines or education to support peer workers when taking on these emerging roles of educating or supervising peers.

Our presentation will highlight some of the complexities involved in facilitating education and supervision from a peer perspective, and the need for further work in this area.

Learning Objectives

Learning Objective (1): Audience members will gain an understanding of some of the challenges, and some of the options, for facilitating training and supervision for the peer support workforce from a peer perspective.

Learning Objective (2): As the peer workforce continues to grow, so does the importance of training and supervision for peer support workers that ensure peer support work is sustainable and remains aligned with its core values and principles.

References


Four Years On – A Peer Worker and a Nurse Practitioner Revisit the Value of Lived Experience in the Mental Health Workforce

Ms Suze Hutchison¹, Mr Matt Ball¹
¹SA Health, Noarlunga Centre, Australia

Biography:
Suze Hutchison is a Consumer Consultant who has several mental health diagnoses related to anxiety, depression, and addiction. Suze is particularly interested in supporting people with co-occurring mental health and alcohol and drug use issues and helping to create compassionate respectful options for people in the community.

Matt Ball is a Mental Health Nurse Practitioner who has lived experience of psychosis. He engages in human-to-human relationships to find meaning in extreme or altered states. Matt introduced the Maastricht approach and Talking with Voices to the public mental health system in South Australia and in private practice.

In a snapshot presentation for TheMHS 2014, Suze Hutchison and Matt Ball examined the parallel experiences of a person with lived experience emerging as a professional, and a mental health professional emerging as a person with lived experience.

Bearing in mind the rhetoric surrounding the value of peer work and the acceptance that clinicians can also find value in their lived experience, this presentation will consider what has been learned since 2014 in a public mental health system in the shared experience of a Peer Support Worker and Mental Health Nurse Practitioner. Four years on key aspects of recovery orientated mental health services are revisited, including hope, innovation, compassion, and empowerment towards best practice for mental health care and service development.

Reflections upon the individuals’ achievements and struggles of the last four years, from the positive - increased opportunities for the lived experience voice, and recognition for best quality and innovative practice, to the negative - lack of recognition of the value of lived experience and innovation at systemic levels, and relapse of severe mental distress, are discussed. The presentation provides discourse on how these experiences impact the individuals and hence their capacities to provide best quality mental health care and support to those in need.

Learning Objectives

Learning Objective (1): Those attending the presentation will have opportunities to reflect upon the roles and value of lived experience in their own lives and the lives of others, and particularly how

Learning Objective (2): The topic is relevant to mental health services and the community as a whole because it discusses ways to review and reform mental health services so as to truly value consumer experiences and honour innovation in mental health service delivery.

References


Imagine having to face your greatest fear, six times a day, everyday!

**Fiona Dale**¹

¹The Road Home, Adelaide, Australia

**Biography:**
Fiona has a 25 year rich and diverse background in working alongside individuals and communities to build resilience. Her passion for advocacy, strengths based approaches, and person centred outcomes provided her with the tools to grow from 'whispering to roaring' to have mental health needs met within the health system.

Imagine having to face your greatest fear, six times a day, every day!
Someone who loves you whispers ‘It’s okay, you can do this’, while a demoralising demon in your head roars ‘Don’t do it or you will die’.
This is the daily struggle for someone with an Eating Disorder!
Eating Disorders are complex neuropsychiatric disorders. They have the highest fatality rates of any psychological disorder, and only 25% of Australians with an eating disorder are known to the health system. The National Agenda for Eating Disorders 2017 to 2022, establishing a Baseline of Evidence-based Care for any Australian with or at risk of an Eating Disorder, Butterfly Foundation for Eating Disorders, page 1.
The purpose of this presentation is to emphasis the crucial role of family and carers in supporting a loved one with an eating disorder diagnosis.
Families and carers play a vital role in treatment and recovery. Without family support, a higher level of intensity of treatment and more frequent episodes of illness will occur.
Through the lens of a lived experience carer who once whispered and now roars, the use of carer’s expertise as co-producers on the road to recovery from eating disorders will be presented.

**Learning Objectives**

Learning Objective (1): Participants will develop an understanding of Anorexia Nervosa and current treatment methodologies.
Learning Objective (2): The inclusion of carers and families in the co-production of responsive mental health and wellbeing services is crucial, they have an expert view of the unique mental health issues the individual is experiencing.

**References**
The National Agenda for Eating Disorders 2017 to 2022, Establishing a Baseline of Evidence-based Care for any Australian with or at risk of an Eating Disorder, Butterfly Foundation for Eating Disorders.
First Time Every Time - check, confirm care. Identifying patients consistently and correctly is a key element in reducing the risk of adverse events and enhancing patient safety. The Consumer Identification Animation - First Time Every Time (CIA) series is an innovative and unique approach that can be utilised for education of staff, consumers, carers and families.

Andrea Taylor\(^1\), Jenny Law\(^1\)
\(^1\)NSLHD, Mental Health Drug & Alcohol, Sydney, Australia

Biography:
Ms Taylor is currently the Director of Mental Health Drug and Alcohol for Northern Sydney Local Health District and was formerly the Director of Mental Health Drug and Alcohol for Northern Sydney Central Coast Area Health Service prior to the implementation of the National Reform Agenda. Ms Taylor is concurrently a Surveyor for the Australian Council of Health Care Standards. Ms Taylor has an extensive history in the delivery of mental health and drug and alcohol services both clinically, operationally and strategically. Ms Taylor has taught at the University of Sydney in Social Work, worked in drug and alcohol services both harm prevention and abstinence, non-government organisations including a Kings Cross Women’s Refuge, a range of aged care facilities including hospitals, hospices, nursing homes and managed private sector non-health services. Ms Taylor has led health service teams in winning NSW Health Awards, NSW Premiers Awards [for Services Working in Partnership in 2010 and again in 2012] and the NSW SiCorp/SunCorp/Treasury Managed Fund Award in 2013 for Risk Management Framework.

Northern Sydney Local Health District (NSLHD), Mental Health Drug Alcohol (MHDA) provides a comprehensive range of mental health and drug and alcohol services. The MHDA Consumer Identification Animation (CIA) and associated resources are an example of incorporating curiosity and creativity to educate and empower consumers, carers, families, staff and the local communities into educated action and autonomy with identification practices across their service. https://www.youtube.com/watch?v=ZcwegFRcGFI Built collaboratively with staff and consumers the CIA was developed with a light hearted approach to a serious issue where the rationale for correct identification using the three C’s (Check, Confirm, Care) is explained.

A feedback survey was responded to by 170 staff, consumers and carers with a high response rate for each question ranging from 80% to 100% participation from those surveyed. YouTube animation has been utilised by other LHDs with very positive feedback. Currently MHDA are partnering with other interested LHDs in developing similar animated series for other types of education.

The MHDA CIA is widely available online publicly and other resources are easily available from NSLHD MHDA upon request.

Learning Objectives

Learning Objective (1): That the people from the conference will gain more confidence in asking consumers difficult questions and be able to explain why it is necessary to have accurate information

Learning Objective (2): Consumer identification is relevant to mental health because it ensures that consumers will receive the correct care, as long as the steps in the process are followed.

References

National Safety Quality Health Standards (second edition) Standard 6 (6.5) - Patient identification was originally addressed in Standard 5
Translating research into practical strategies for improving the provision of employment supports.

**Caitlin McDowell**¹², Ellie Fossey³, Carol Harvey⁴

¹Centre for Youth Mental Health, The University of Melbourne, Melbourne, Australia, ²La Trobe University, Melbourne, Australia, ³Monash University, Melbourne, Australia, ⁴Psychosocial Research Centre, The University of Melbourne, Melbourne, Australia

**Biography:**
Caitlin McDowell is an Associate Lecturer in Youth Mental Health at the Centre for Youth Mental Health, The University of Melbourne and Sessional Tutor in Occupational Therapy at La Trobe University. Caitlin's PhD research relates to employment support for people living with mental illness.

There is a substantial gap between evidence-based vocational services and those that are widely available for people living with mental illness in Australia and internationally (Bonfils, Hansen, Dalum, & Eplov, 2016; Stirling, Higgins, & Petrakis, 2017). This presentation draws on the findings of a grounded theory study of Australian employment specialists’ views and practices related to supporting clients with mental illness. This study found that the employment specialists’ core concern was to help move clients forward toward sustainable employment. Several key themes were identified that contributed to this process. This presentation will focus on translating these findings into practical recommendations to improve the provision of employment supports and to reduce practice tensions for employment specialists. Key recommendations include modifying employment policies and providing training to deliver evidence-based practices that offer a range of vocational services, pathways, and adjunct interventions tailored to clients’ interests, needs, and readiness for change.

**Learning Objectives**

Learning Objective (1): Attendees will gain an understanding of how knowledge about employment specialists’ views and practices may be used to improve supports for clients with mental illness.

Learning Objective (2): Attendees will discover practical strategies to improve employment supports for people living with mental illness.

**References**


Refugee Experiences of Trauma Counselling: Clients’ and Counsellors’ Perspectives on the Facilitators and Barriers to Engagement.

Alicia Gibbs

1ASeTTS, Perth, Australia

Biography:
Alicia Gibbs completed a Bachelor of Social Work (Honours) in 2017. She undertook her Honours research exploring refugee engagement in trauma counselling in collaboration with the Association for Services to Torture and Trauma Survivors (ASeTTS), where she now works as the Monitoring and Evaluation Officer.

Ongoing global conflicts are leading to an ever-increasing number of refugees worldwide. Resettled refugees often experience severe and complex psychological distress, yet utilisation of mental health services by people from refugee backgrounds is relatively low and mental health service providers often face significant challenges maintaining engagement with resettled refugees. This qualitative study explored the facilitators and barriers to refugee clients’ ongoing engagement in trauma counselling in Western Australia through semi-structured interviews and a focus group with refugee counselling clients, counsellors and a client reference group. Thematic analysis of participants’ accounts identified that clients’ perceptions of counselling; the therapeutic relationship between clients, counsellors and interpreters; and clients’ concurrent resettlement challenges and priorities were mediators of ongoing engagement in counselling. Clients’ experiences were varied, multifaceted, and impacted by individual, relational, organisational and structural factors. The aims of this presentation are to highlight the facilitators and barriers to ongoing engagement in counselling identified by clients and counsellors in this study, and to advocate for mental health services to be designed in collaboration with people from refugee backgrounds. Community-based organisations that are responsive and adaptable to changing needs can provide meaningful support to refugee clients experiencing mental distress.

Learning Objectives

Learning Objective (1): Audience members will gain a greater understanding of how to engage clients from refugee and culturally and linguistically diverse backgrounds in mental health services.

Learning Objective (2): This research can be used to inform the design and implementation of mental health services for people from refugee-like backgrounds.

References


Partnering with Communities - Indigenous Mental Health Programs

Anne Williams¹, Suszanne Lang¹
¹Healthwise New England North West, Narrabri, Australia

Biography:
Suszanne Lang is a proud Aboriginal woman with 30 years experience working in both Aboriginal and mainstream positions, bringing a strong background in Health, Mental Health and Education. She has a strong connections with Aboriginal Elders, Homeless Youth, Aboriginal Communities, parents, caregivers, and families as well as expertise in mental health and crisis management. Suszanne brings a passion to her work and her team.

HealthWISE has partnered with local Aboriginal controlled organisations and other NGOs to deliver the Indigenous Mental Health (IMH) Programs.

The aim of the IMH Programs is “to improve access to joined up, integrated, culturally appropriate and safe mental health services that holistically meet the mental health and healing needs of Aboriginal and Torres Strait Islander people.”

The IMH Programs employ Aboriginal people in a range of roles. Staff work across locations and are co-located in Aboriginal Medical Centres and other community facilities. The programs include Care coordination, Peer navigation, Groups programs and Suicide preparedness and Postvention.

The IMH program aims to support Aboriginal people experiencing mild to complex mental illness to support the right level of care at the right time and as close to home as possible. The IMH team supports access to services and works closely with stakeholders in both the health and welfare sectors.

The program is delivered across 10 Local Government Areas and is funded by the Hunter New England Central Coast Primary Health Network.

The ePoster will highlight one case study; Client A had been seeing the MH Clinician (Psychologist) at HealthWISE and was ready to transition on. Joint preparation was undertaken as a partnership between the Clinician, IMH team and client, to move the client over to one of the IMH group programs. The transition went well and the client has reported receiving very good support and being very happy with the group environment. The MH Clinician has been very happy with the outcome and feels the partnership was able to achieve excellence in stepped care through the changeover.

Learning Objectives
Learning Objective (1): An understanding of the benefits of delivering services in partnership with Aboriginal community controlled organisations and other NGOs to enhance inclusion, choice and accessibility for Aboriginal people experiencing mental illness.
Learning Objective (2): An overview of how stepped care can work in rural areas delivering a social and emotional wellbeing approach to care for Aboriginal people experiencing mental illness

References
NATIONAL MENTAL HEALTH COMMISSION SECRETARIAT
Expert advice on specific challenges for Aboriginal and Torres Strait Islander peoples’ mental health. Background paper. (23 OCTOBER 2014)
The Consumer Peer Workforce in NSW: News from Being, the NSW Peak Independent Organisation on current challenges and future directions.

**Irene Gallagher**, **Belinda West**, **Tim Heffernan**, **Travis King**

*Being | Mental Health and Wellbeing Consumer Advisory Group, Sydney, Australia, Peer Work Matters, Sydney, Australia*

**Biography:**
Chairperson: TBA

Presenter: Irene Gallagher
Irene is the CEO of Being, the NSW independent peak organisation for people with lived/living experience of mental health issues. Irene is the Founder of Peer Work Matters, current representative on the National Mental Health Consumer and Carer register, and has been instrumental in developing the peer workforces across NSW.

Presenter: Tim Heffernan
Tim works as Mental Health Peer Coordinator with the South Eastern NSW PHN. Previously he worked as a peer support worker with Illawarra Shoalhaven Local Health District. Tim is a member of the NSW Mental Health Commission’s Community Advisory Council and is Deputy Chair of the Being Board of Trustees.

Presenter: Belinda West
Belinda West has been involved in the peer worker space since 2015, currently working as Peer Practice Leader with Neami, where she is tasked with assisting with the development of the peer workforce across NSW. Belinda is the current Chairperson of the Inaugural NSW Peer Workforce Network Committee with Being.

Presenter: Travis King
Travis has had a lived experience of depression and anxiety for over ten years. He has been volunteering, studying, and working in the NSW mental health sector for nearly seven years. Travis is passionate about developing the Peer Workforce and is currently working as a community peer support worker.

The consumer peer workforce in NSW have grown rapidly over the past twenty years, with more workers being employed across the health sector, including in public, private, and non-profit/community managed organisations. The value of lived experience is now recognised in a range of fields, including peer support, education, academia and research. However, as the workforce continue to grow they face a number of questions and challenges, for example what kind of support and supervision practices should be provided for workers and how should peer workers across the span of organisations work more collaboratively and effectively together.

This symposium will provide an overview of some of the latest research into the experiences of consumer peer workers in NSW. It will outline current practices regarding working conditions, support, supervision and training for peer workers. We will look at some of the current challenges facing the workforce and the visions of peer workers for the future. We will explore the development of a NSW Peer Workforce Network and the NSW peer Workforce Network Committee, an innovative working group set up to develop practices and process to support and enhance the NSW Peer Workforce.

All of the presenters identify as having a lived/living experience of mental health issues and currently work as peer workers.

**Paper 1: Findings of the 2017 Peer Workforce survey, Presented by Being;**
Being is the peak body representing people with a living/lived experience of mental health issues and emotional trauma, and has been involved in advocating for and supporting the peer workforce since its inception. In 2017, Being surveyed
Paper 1: Survey of Peer Workers in NSW, Presented by Peer Work Matters and Being;
Over 170 peer workers across NSW, with the aim of collecting qualitative and quantitative data about the contemporary experiences of being a peer worker in NSW. This survey contained questions about location, role, daily tasks, management, supervision, professional development, training and career progression. This presentation will discuss the findings of this survey, and provide a snapshot of the current experiences of peer workers in NSW, the diversity of roles they undertake and the challenges they face.

Paper 2: Findings of the 2017 Lived Experience Workforce Survey, Presented by Peer Work Matters and Being;
Peer Work Matters is a grassroots organisation setup to support the expansion of the peer workforce in NSW through direct training, mentoring, and peer supervision for the workforce as well as consulting into organisation to assist them to grow the peer workforce.

In 2017, Peer Work Matters received a grant to research the experiences of people who identify as having a lived/living experience and work in mental health workplace settings. Through Collaboration with Being and the NSW Consumer Led Research Network, Peer Work Matters was able to produce their findings on the peoples staff experiences in the workplace, particularly in regards to training, support, supervision, recovery oriented practice in the workplace, inclusion, and mentally healthy workplaces.

Paper 3: Developing a Peer Workforce Network Committee – Presented by the NSW Peer Workforce Network Committee (Being);
The previous papers identified a number of challenges facing the consumer peer workforce in NSW, including a lack of access to training and mentoring, barriers to entering peer work, rates of pay, and collaborative approaches across the span of organisations, and opportunities for supervision and leadership for peer workers. In response to these challenges, Being was responsive to the needs of the consumer peer workforce and set up an initiative to address these issues and build an infrastructure in NSW to support the consumer peer workforce. The formation of the NSW Peer Workforce Network Committee has brought together as a core group of consumer peer workers from across the public, public, Not-for-profit/community managed sector, to collaborate on areas of need such as training and mentoring programs, peer supervision, and careers pathway trajectories. This paper will outline the process of setting up the Peer Workforce Network Committee and their goals and methods as a next step for the future of the consumer peer workforce in NSW.

Group Interaction – Peer Workforce Panel discussion
Time will be allocated for group interactions with a panel of peer workers consisting of the presenters, to open up dialogue of best practice for the consumer peer workforce. We welcome discussion from both consumer and carer peer workers, and other professionals.

Learning Objectives

Learning Objective (1): Participants will gain an understanding of the latest contemporary research into the peer workforce and lived experience workforce in NSW and innovative practices being undertaken to ensure the sustainable growth of these workforces.

Learning Objective (2): The expertise from the lived experience workforce (peer workforce) is increasingly recognised as an important part of best practice mental health services. Participants will better understand how these workforces can grow sustainably, to improve services and outcomes for people with lived experience, and how mental health services can support this process.

References

A Naturalistic Study of Differential Response of Males and Females to Low Intensity Cognitive Behavioural Therapy (LiCBT) for Depression and Anxiety.

**Tony Le¹**, David Smith¹, Sharon Lawn¹

¹Flinders Human Behaviour and Health Research Unit, Department of Psychiatry, College of Medicine and Public Health, Flinders University, Adelaide, Australia

**Biography:**

Tony Le is currently in his 3rd year of postgraduate medicine at Flinders University. He is a registered pharmacist, and has previously completed a Bachelor of Health Sciences (Honours) at the University Adelaide. Tony has a keen interest in the treatment of anxiety and depression.

There has been a paucity of empirical research examining the influence of patient biological sex on the course and outcome of psychotherapy for psychiatric conditions. Cognitive behavioural therapy (CBT) is the most extensively researched psychotherapeutic modality for the treatment of anxiety and depressive disorders. The psychiatric literature has shown mixed results regarding the relative response of males and females to CBT for anxiety and depressive disorders. The lack of uniformity across studies may be partly attributed to methodological weaknesses, limited sample sizes, and a lack of standardized or reliable measures of outcomes. NewAccess is an early intervention program sited in South Australia, Queensland, Australian Capital Territory and New South Wales, which delivers low intensity cognitive behavioural therapy (LiCBT) for anxiety and mild to moderate depression. Modelled on the UK’s highly successful ‘Improving Access to Psychological Therapies’ (IAPT) program, it departs from more traditional models of mental health service delivery by allowing non-graduates to be recruited and trained to practice LiCBT. In the present study, three-year longitudinal data from the NewAccess program was retrospectively analysed for differential response of males and females to LiCBT.

**Learning Objectives**

Learning Objective (1):
- This presentation will introduce audiences to the NewAccess Program, which delivers low intensity cognitive behavioural therapy (LiCBT) in various locations of Australia.
- Audiences will gain an appreciation of client biological sex as an important consideration in the delivery of effective LiCBT.

Learning Objective (2):
- Over the past several decades, an abundance of research has identified fundamental differences between males and females in the aetiological pathways, risk factors and clinical manifestations of anxiety and depressive disorders.
- These fundamental sex-related differences are important considerations in the delivery of low intensity cognitive behavioural therapy (LiCBT).
- National rollout of NewAccess Program in Australia can lead to more readily available and low-cost psychotherapy for sufferers of anxiety and depressive disorders.

**References**


Implementing the Collaborative Recovery Model: Co-production for Organisational Change

Phoebe Williamson¹, Kevin Ong¹, Elizabeth Fraser¹, Margie Nunn¹, Chris Dixon¹
¹Eastern Health Mental Health Program, Melbourne, Australia

Biography:
Phoebe is an occupational therapist who is motivated by food, people and human potential for change. She has worked in acute and community mental health, public and private settings, and is currently the Team Leader for the CRM Workforce Development Team at Eastern Health Mental Health program.

Elizabeth enjoys gardening, yoga, and team work. Her work is informed by principles of person-centred practice and working with individuals and organizations in a way that both empowers people and promotes mental health and wellbeing. She is a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

Kevin is a forensic psychiatrist who enjoys cycling, cooking, campfires and chasing his kids. He is a keen advocate for balancing risk assessment and management within a recovery oriented framework. He is now a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

Margie enjoys working with groups to explore ways to connect, inspire each other and remain resilient. She has worked as a trainer and public speaker in the mental health sector for nearly twenty years and now is a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

Chris is a keen Star Wars fan. He enjoys swimming, reading and watching films. He has a lived experience of mental health for over 18 years. He has worked as a consumer consultant, peer support worker and now is a Collaborative Recovery Model Trainer at Eastern Health Mental Health Program.

CRM is a strengths-based, evidence-informed coaching model and training program that supports individual and family recovery-focused practice, as well as organisation and workforce development. The principle objective is to establish a consistent framework, universality of language, a culture of hope, genuine collaboration, and a learning environment where autonomy is supported. Strengths are embraced as resources for recovery. It signals a move away from a focus on risk and deficits (“the roar”), towards valuing strengths, wellbeing and resilience (“the whisper”).

This interactive symposium will introduce and explore the Collaborative Recovery Model, co-production, and one Service’s ambitious and comprehensive action plan for organisational change. Presenters from clinical, medical and lived experience backgrounds collaboratively reflect on the process of coproducing and implementing the CRM to align the whole of workforce (clinical, medical, leadership and peer workforce; child, youth, adult, aged persons-community and acute services) through training and “coaching”. This symposium is designed to create an opportunity for interactive exploration of the CRM, and is relevant to attendees wishing to apply CRM principles and tools to enhance their own wellbeing, that of their support people and their team, and/or their organisation.

Abstract 1: Mapping the journey of co-production.
Maps the ambitious plan to create a CRM Workforce Development Team, including co-production and contextualising the original licensed package (University of Wollongong; NEAMI), co-facilitating initial 3 day – and booster training by medical, nursing, allied health and lived experience workforce, and developing lived experience stories. Quality improvement processes to support CRM Trainer growth and to embed the model in a tertiary mental health service are also described.

An interactive exploration of the meaning and importance of wellbeing, resilience, having a growth mindset, emotional intelligence, and the all-important righting reflex will conclude this paper and introduce guiding principles.

Abstract 2: The lived experience of co-facilitating CRM Training.
Lived Experience leadership within a tertiary mental health service builds and sustains collaborative recovery, and is not without its challenges. CRM implementation reflects the evolving role of Lived Experience of recovery in mental health workforces. Trainers skilfully tell stories of change, hope and growth to spark practitioners to empower people, their families and support people to approach recovery and wellbeing. The co-facilitation and co-production of CRM attempts to address the power imbalance of “us and them”, creates positivity towards genuine collaboration and true equality, and encourages a growth mindset of hopefulness towards a person’s ability to grow, change, take charge of wellbeing, and lead a meaningful life. CRM Trainers reflect on the trials, tribulations and triumphs of training and “coaching” clinicians and peers who ranged from the sceptical to the enthusiastic. Quotes, anecdotes and filmed stories will be shared to bring to life the lived experiences, and emphasise that the strength of the working alliance is the best predictor of recovery outcomes.

Abstract 3: “Aren’t we doing recovery already?” - Pre/Post Training measures tell their own story. Preliminary findings from Pre/Post training evaluation of staff knowledge, attitudes, skills will be presented, along with a linguistic analysis of the changing language of recovery in this service. Key qualitative feedback is presented from staff doing recovery oriented practice, and from people doing recovery. Strategies to support transfer of training into practice are highlighted, along with future directions in the evolution of recovery implementation.

Abstract 4: Stuck between a rock and a hard place: Risks and recovery can go hand-in-hand. A presentation demonstrating how CRM is utilised to balance recovery principles and the management of complex risk issues. There is a complementary relationship between risk and recovery, rather than one that is diametrically opposed. Mental health services have previously concentrated on the “roar” of obvious risk to self, others and the community. This paper discusses the need to address the unseen harms (“the whisper”) of loss of autonomy, mutuality, responsibility, self-determination and connectedness. The CRM is used to showcase ways to share management of risk, safety, wellbeing and resilience. This presentation will provoke reflection and discussion through use of a clinical vignette told from different perspectives, and will use CRM Life Journey Enhancement Tools (LifeJETs) to explore strengths and protective factors that are mobilised to motivate change, meaningful goal striving, and collaborative action planning and monitoring for positive risk taking. CRM is shown to be a way to create and maintain a strong working alliance whilst promoting safety, self-determination and ownership of wellbeing.

**Learning Objectives**

Learning Objective (1): The audience will hear about one journey of progress from recovery oriented philosophy and theory towards a practice enhancement model with significant practical and clinical utility. Attendees will develop an overview of the Collaborative Recovery Model, resources and strategies for clinical implementation, an appreciation for recovery attitudes of a “growth mindset” and a well-regulated “righting reflex”.

Learning Objective (2): This tertiary mental health service provides an example of implementing a co-produced recovery model that values and celebrates the strengths, achievements and resilience of people with a lived experience of recovery, their families and support people, and the practitioners who partner with them, whilst also complementing concerns about risk management and duty of care.

**References**

Mental Health Support Workers, could we have done things differently in New Zealand?

Julia Hennessy

Auckland Institute Of Studies, Auckland, New Zealand

Biography:
Julia Hennessy PhD, RN: is a clinician and educator having worked in the field of mental health for a number of years. Julia’s PhD focused on the area of mental health support work using an appreciative inquiry methodology. Has written a number of publications in the field of mental health workforce and mental health support work.

Mental health support workers were recognized as part of the mental health workforce in the mid-1990s and especially so as part of the new way of service delivery when mental health services moved to a more community delivery focus.

In 1997 a national qualification was developed that gave mental health support workers a recognised and portable qualification. However nearly twenty years later the potential of this group of workers continues to go unrecognized, why?

Mental health support workers have struggled to be understood for the work they do and they lack the basic criteria that would see this being considered as professional. They work under limited regulations, they do not have a professional body, the educational programmes are not credentialed by any professional groups and as such their role, their contribution and their value are not well understood.

Traditional health professional working in the mental health sector has the opportunity to look at how they could embrace mental health support workers and utilise the scarce resourcing that goes into mental health more efficiently.

This session poses a number of questions related to sector preparedness for the introduction of a new discipline in mental health including both the health and education sectors and questions whether it is professional divisions that are not maximizing the opportunities that mental health support workers bring to the sector.

Learning Objectives

Learning Objective (1): What has been learnt from how mental health support workers were introduced into New Zealand as part of the health workforce.
Learning Objective (2): What needs to be done to better utilise this critical part of our workforce.

References


Reducing Psychosocial Impact on Victims of Workplace Bullying and Their Loved Ones.

Manohar Pawar¹, George Rafael²

¹CSU, Wagga Wagga, Australia

**Biography:**
George Rafael is a candidate for Dr of Social Work course at CSU. He has long experience as a clinical social work - mental health. George’s area of interest focus on clients suffers from depression, self-harm, PTSD as a result of workplace bullying. He is Specialised in Life-Skills Therapy.

This paper aims to explore the mental health issues caused to the victims and their families as a result of workplace bullying and discuss a number of therapeutic solutions to support them. Drawing on the qualitative analysis of practice cases, assessments and interventions, this paper discusses the nature of the psychosocial impact and therapeutic approaches. The negative impact of bullying on employees includes severe depressive symptoms, to the degree of self-harm or suicide, severe anxiety includes social anxiety and Post Traumatic Stress Disorder. Further, it may cause adjustment disorder, relationship malfunction, social isolation and withdrawal, financial strive, emotional dryness (disturbance). Hence, in most cases - psychosomatic disorders such as lack of appetite, insomnia, lack of concentration, heart attacks, panic attacks, high blood pressure, and/or diabetes may be experienced. These damages may require long-term interventions by multidisciplinary professionals. It argues that change in the victims’ cognition (therapeutic technique) lead to enhanced resilience, improvement and a significant recovery from mental health problems. The analysis has implications for changing workplace practices, implementing workplace bullying policies and programs and innovative ways of working with victims of workplace bullying.

**Learning Objectives**

Learning Objective (1): The audience will gain greater awareness of and be able to recognise workplace bullying with a view to act.
Learning Objective (2): Workplace bullying significantly impacts employees’ and their significant others’ mental health, and it is necessary to plan and provide timely mental health services that are easily accessible.

**References**


Developing a Staff Engagement Survey at Richmond Wellbeing

Adrian Munro¹
¹Richmond Wellbeing WA, perth, Australia

Biography:
Adrian initially qualified and worked as a Physiotherapist in hospitals and private practice before managing a region of Anglicare Southern Queensland, which provided community and residential aged care and disability services. Adrian has since been the Executive Manager of Operations of RW for over 5 years, has a post grad in Health Service Administration, is a GAICD and QIP accreditor. Adrian is very passionate about seeing better mental health and wellbeing outcomes for individuals living with a mental illness, especially in minority groups or populations. Adrian sits on the WA Suicide Prevention Network Governance committee.

At RW we set about to conduct our annual staff survey, however, the Aboriginal staff rightly pointed out that their needs as Aboriginal staff has differences to other staff, and therefore they should have a different staff survey.

The Executive listened to this feedback and completely agreed and set out to find an Aboriginal specific staff satisfaction survey. We couldn't find any, nor could we find any research or examples to guide us. So we decided to embark on this process and be guided by the Aboriginal staff and the Elders to co-design an Aboriginal specific staff survey.

We learnt so much along the way and believe that the process we used was culturally safe and appropriate and empowered the Aboriginal staff. It is also led to an excellent outcome where the Aboriginal staff could provide the executive with real and powerful feedback, in a safe and anonymous process.

We believe that every organisation should be completing staff surveys specific to smaller groups of their staff and this process can provide an excellent template for others to learn from.

Learning Objectives

Learning Objective (1): A new way of working with Aboriginal people that is informed by the Aboriginal world view.
Learning Objective (2): This process is an excellent way for services to better engage with Aboriginal people and transform their services as we need to see more Aboriginal employees in our workforce in our sector.

References

To your door: Factors that influence Aboriginal and Torres Strait Islander peoples seeking care Kanyini Qualitative Study Investigators [in alphabetical order]: Deborah Askew1, John Brady1, Alex Brown2*, Alan Cass3, Carol Davy2, Joanne DeVries4, Barry Fewquandie4, Maree Hackett5, Michael Howard2, Suzanne Ingram5, Hueiming Liu5, Ricky Mentha6, David Peiris5, Pamela Simon7, Bernadette Rickards6, Samantha Togni
Engaging with Aboriginal Australia
Health Dept of Australia
Equally Well – improving the physical health needs of people living with mental illness in Australia.

Peggy Brown AO1,2, John Allan1,2, Kim Ryan4,2, Arthur Papakotsias5,2, Lyn English6

1National Mental Health Commission, Sydney, Australia, 2Equally Well Implementation Committee, Sydney, Australia, 3Queensland Health, Brisbane, Australia, 4Australian College of Mental Health Nurses, Deakin West, Australia, 5Neami National, Preston, Australia, 6National Mental Health Consumer and Carer Forum, Adelaide, Australia

Biography:
Dr Peggy Brown, CEO of the National Mental Health Commission has held mental health leadership and advocacy roles for 30 years. She continues to work part time as a psychiatrist and serves on the Pharmaceutical Benefits Advisory Committee and the Agency Management Committee of the Australian Health Practitioner Regulation Agency.

John Allan is Executive Director of the Mental Health Alcohol and other Drugs Branch in Queensland Health and President Elect of the Royal Australian and New Zealand College of Psychiatrists. He has previously been Chief Psychiatrist in both Queensland and New South Wales.

Kim Ryan is the CEO of the Australian College of Mental Health Nurses. She is passionate about mental health and mental health nursing holding a more prominent position on health agendas and believes this can only be achieved with a strong, united, professional voice. In 2016 Kim was awarded the inaugural Australian Mental Health Prize.

Lyn English is a Board Member of the Mental Health Coalition of South Australia and member of the Expert Reference Panel for the Fifth National Mental Health and Suicide Prevention Plan, Deputy Co-Chair of the National Mental Health Consumer and Carer Forum, and member of the Primary Health Network Advisory Panel on Mental Health.

Arthur Papakotsias is CEO of Neami National. Arthur sits as Chair of Housing Choices Australia and Chair of Mental Health Australia’s Finance audit and Risk Management Committee. Arthur has completed a Graduate Diploma of Business (Health Services Management) from RMIT University and three residential programs at Harvard Business School.

Introduction
Most Australians are unaware of the alarming fact that on average people with a serious mental illness die younger than the general population by between 14 and 23 years. Despite the significant mental health reform in Australia over recent years, the reality for many Australians living with mental illness is that their life journey is compounded by physical conditions that are often undiagnosed and untreated, as their physical health needs are ‘overshadowed’ by their mental health condition.

Purpose
The purpose of this symposium is to highlight the issues pertaining to co-existing mental and physical health conditions and promote ways in which change can be achieved across the health sector and in communities to improve the physical health of people living with mental illness in Australia.

Background
The interaction of mental illness with other chronic diseases is one of the biggest challenges to public health systems in Australia, with four out of every five people living with a mental illness also having a co-existing physical illness.

There is increasing evidence that the deterioration of physical health in people living with mental illness is preventable. People living with mental illness generally have poor quality health care and poor access to services, which can also be compounded by a lack of education, social exclusion, low income, inadequate housing, and experiences of stigma and discrimination.
The National Mental Health Commission (the Commission) led the development of Equally Well – the National Consensus Statement on Improving the physical health and wellbeing of people living with mental illness in Australia (Equally Well) drawing inspiration from our New Zealand colleagues’ work, and the leadership of other voices in Australia who advocated for a health system where the consumer is at the center of everything, in more localised and personalised models of care.

Context
Equally Well identifies six essential elements that describe what best practice looks like, providing guidance to health services, and importantly, to consumers, carers, families and the community. Equally Well serves to inform collaboration to effectively manage co-existing health needs and has been identified as a priority area in the Fifth National Mental Health and Suicide Prevention Plan.

In 2017, the Equally Well Implementation Committee (EWIC) was established as the national leadership group to oversee, lead, and coordinate the implementation of the Equally Well in Australia. EWIC members represent a broad range of stakeholders including General Practitioners, Nurses, Psychiatrists, Aboriginal and Torres Strait Islander Health, Private Health, Consumers and Carers, Primary Health Networks (PHNs), Governments, Community Managed Organisations (CMOs), and Academics.

Plan
This symposium, chaired by the Commission, will run for 90 minutes. Following an initial presentation on the background of Equally Well, three presentations from EWIC members and stakeholders will showcase initiatives being undertaken to put the six essential elements of Equally Well into practice. There will be an opportunity for questions and answers following each presentation, with an additional 20 minutes allocated at the conclusion of the presentations for panel discussion, questions and answers.

- Kim Ryan, CEO, Australian College of Mental Health Nurses (ACMHN) will present on the vital role nurses play in supporting the physical health of people with a mental illness. Kim Ryan will discuss how the ACMHN is undertaking work to upskill nurses to better support both the mental health and physical health care of people.
- John Allan, Executive Director, Queensland Health will address issues relating to the significant disparity in smoking prevalence between the general population and people experiencing mental illness in Australia. John Allan will discuss how the Mental Health Clinical Collaborative in Queensland has used quality improvement payments with considerable success to help people admitted to hospital to enter a pathway for tobacco cessation.
- Arthur Papakotsias, CEO, Neami National will provide an overview of his organisation’s active work prior to the release of the Equally Well consensus statement. Arthur Papakotsias will outline a number of programs, resources and initiatives Neami National has developed and will discuss the role of CMOs in promoting the physical health of people living with mental illness. Lyn English, Deputy Co-Chair, National Mental Health Consumer and Carer Forum will bring a consumer perspective, discussing the role of consumers, carers, and support people in advocating for equal access to health care.

Concluding Statement
The symposium will be a valuable opportunity for participants to see the various ways in which Equally Well is being implemented by organisations and will serve to inspire participants to consider ways in which they may potentially reform policies, services, and programs in their respective areas of work. The consumer story will also highlight the importance of tackling this issue and ensure that people living with mental illness, as well as their carers and support people, are equipped with the knowledge and tools to address their physical health needs.

Learning Objectives
Learning Objective (1): The participants will take away practical examples of how the essential elements and actions of Equally Well can be implemented in different areas of health service provision. This addresses the importance of reforming the physical health supports and services provided to people living with mental illness and how organisations can turn the national consensus statement’s guiding principles into action that bring about real change.
Learning Objective (2): Equally Well identifies six essential elements that describe what best practice looks like, providing guidance to health services, and importantly, to consumers, carers, families and the community. Equally Well serves to inform collaboration to effectively manage co-existing health needs.

References

Improving Mental Wellbeing for Complex Clients within a Short Term Case Management Model

Ben Carter¹, Faishal Mahmud¹
¹Mission Australia, Brisbane, Australia

Biography:
Ben is passionate about advocating for clients with complex needs, and understands the importance of having a stable place to live when reintegrating back into the community. Ben has worked in the homelessness sector for a period of seven years and recently revised and updated the Roma House Service/Case Management Model.

Faishal is working as a Program Manager at Roma House, Mission Australia, Brisbane. Faishal is an experienced Manager with a more than ten years experience in not for profit sector specially in Mental Health and Homelessness support services. Faishal is very passionate about advocating client by providing meaningful support to help the individual to achieve their goal where they can maintain their ongoing personal recovery.

Roma House is a program, an immediate accommodation and support service for adults experiencing homelessness due to Mental Illness, Substance misuse and other complex needs. Roma House recently revised service frameworks and now operates under evidence-based Recovery-Oriented Practice Model. Three core practice approaches to support the recovery model including trauma awareness, client centred, and strengths-based practice. Roma House will not only respond to the immediate crisis of homelessness but will aim to also contribute to the longer-term mental health recovery of these individuals. The Seven Step Case Management Model provides a clear and consistent way we work with complex clients and identifies the key performance indicators (KPI’s) for successful case management to increase client wellbeing and transition into the community. The model identifies specific timeframes on each of the case management steps which helps motivate clients to participate and engage within our program. Although the Service is classified as ‘duration of need’, there is now an expectation that clients will exit the service within three months, unless further service supports have been identified. Our seven steps case management model and service frameworks provide a targeted approach to addressing immediate need and quickly stabilising clients for transition back into community.

Learning Objectives
Learning Objective (1): How the impact of a clearly identified service/case management can improve long-term housing sustainability when transitioning from short-term emergency accommodation into the community.
Learning Objective (2): How mental health well-being of complex clients in a short term residential setting is dependent on a clear Service Model of delivery and Case Management processes.
Reimagining Mindfulness Technique and Practice

Mahlie Jewell¹
²BPD Foundation, Sane Australia, Broadway, Australia

Biography:
Mahlie has lived with severe mental health issues since childhood and spent time homeless and in the care of state mental health services. She is a child abuse, sexual assault and stroke survivor. She has successfully completed a two year DBT program and her advocacy on the experiences of living with borderline personality disorder, bipolar disorder, PTSD and brain injury have been published nationally and she now advocates on the importance of specialised services and lifestyle mindfulness in achieving meaningful recovery. She is active social justice advocate and is currently working with Project Air and the Department of Education concerning teenagers with self harm behaviours. Mahlie Jewell is a qualified counsellor, Intentional Peer Support worker and graphic artist. She has worked in the NFP community services sector for over 10 years and now specialises in design and campaign work for NFP.

My presentation will examine the most common current mindfulness techniques and exercises used in the treatment of Borderline Personality Disorder from a consumer perspective and provide new ways of accessing mindfulness for all treatment participants. Identifying and understanding the ways current mindfulness exercises can interact with people with a diagnosis of BPD and co-existing conditions such as PTSD, Panic Disorder, Anxiety Disorder, Eating Disorder and Brain Injury from personal and shared experience, the presentation will aim to look at innovative mindfulness techniques and exercises that decrease the chance of triggering panic and anxious symptoms. These alternative techniques and exercises are obtained through peer research and consultation and provide diverse and expert opinion from consumers themselves. Not only will the presentation include my personal experience, but also snapshots of the experience of others within this cohort will also be presented. By providing alternatives to the focus on basic "silent meditative" exercises and including other forms of mindfulness such as physical and emotional grounding using connection to nature, artistic expression and practice and neurological cognitive exercises, this presentation gives insight into the alternate ways people with experiences of extreme trauma, hyper-vigilance of self and brain injury, for example, can effectively achieve mindfulness in their often chaotic daily lives without the benefit of quiet environments, excess time and peaceful headspace. The aim of my presentation is to make the benefits of mindfulness practice accessible to everyone, despite their individual situations and challenges.

Learning Objectives

Learning Objective (1): A deeper understanding of how participants in DBT programs experience the program guidelines and expectations.
Learning Objective (2): Many people struggle to understand and work with clients with diagnosis of BPD and this will give insight into ways they can tailor programs to fit clients that are not responding to program guidelines.
Friends for Recovery Program - a community social inclusion program outside of the mental health sector supporting recovery and social inclusiveness for people with severe and persistent mental illness.

Seraphim Jovanov¹
¹Saints Peter and Paul Community Care, Macedonian True Orthodox Diocese For Australia & New Zealand, Adelaide, Australia

Biography:
His Grace Bishop Seraphim, is the Diocesan Bishop of the Macedonian True Orthodox Diocese for Australia & New Zealand. His Grace is very active in the area of community development, mental health, counselling and VET training education. He has developed a number of organisations over the years from a community development approach in community aged care and community services. He qualifications range from counselling, community education, management, mental health to vocational education training. Currently, His Grace Seraphim is completing his Master of Education and leads Saints Peter and Paul Community Care, an agency of the Macedonian True Orthodox Church. He also lecturers in TAFE SA. His Grace Seraphim has keen interest in social inclusion, community support and mental health recovery in a community setting.

The Friends for Recovery is a community social inclusion based program of the Macedonian True Orthodox Diocese for Australia & New Zealand (Macedonian True Orthodox Church) supporting recovery and social inclusion for individuals living with severe and/or persistent mental illness. This program is a unique community social inclusion based program because it situated outside of the traditional clinical and psychosocial rehabilitation mental health sector. The program was developed through a community development approach within the community parish. The program includes individuals who are living with severe and persistent mental illness at different stages of their recovery, also individuals who are community supporters of mental illness in the community. The community based program was an initiative of the church leadership and committed laity aiming to de-stigmatise mental illness and foster recovery by creating a safe and empowering space within their community. The program’s model is based on three main principles. The first principle, recovery is unique personal and collective journey and responsibility. The second principle is that individuals require supportive, trusted relationships and close networks in order to experience recovery. Lastly, the third principle is that recovery occurs in the community, therefore supportive and enabling environments need to be created at both formal and informal levels in the community. Thus, the program has a pool of friends that are trained in mental health literacy and recovery. The friends for program are recruited from the general community network. Furthermore, the label of consumer is removed, therefore irrespective of a person’s mental health status they see each other as friends or supportive individuals. This fosters meaningful engagement and interaction between individuals. These activities are facilitated through conversations, food, shared activities and mutual support. As a result of the program, the person with mental illness experiences level of connectedness and belonging which support their recovery goals. Furthermore, the community supporters/friends experience sense of meaning and higher purpose in life which are indicators of good wellbeing and general mental health.

Learning Objectives

Learning Objective (1): An increased understanding of practices and processes that foster social inclusion and connectedness for individuals living with mental illness

Learning Objective (2): An increased understanding of co-designing programs that aim to increase social inclusion for individuals living with mental illness within the community

References


The Victorian Fixated Threat Assessment Centre: An integrated mental health and police response to improving community safety through early identification and intervention.

Robyn Humphries, Michele Pathé

1DHHS, Melbourne, Australia

Biography:
Robyn Humphries holds a Bachelor of Social Work and a Master of Business Leadership, and has worked in public sector mental health services in Victoria for more than 40 years.

Prior to moving to the Mental Health Branch, Department of Health and Human Services in 2014, Robyn had been the Manager of the Northern Area Mental Health Service for 12 years. In DHHS her responsibilities have included the transition of Mental Health Community Support Services to the NDIS, implementation of Victoria’s 10 year Mental Health Plan, including suicide prevention initiatives, and building relationships with Primary Health Networks to develop collaborative approaches to mental health services in primary care settings, and development and implementation of new approaches to working with children and young people in out of Home Care.

Currently Robyn is the Project Director, Victorian Fixated Threat Assessment Centre (VFTAC). In addition to the establishment of the Centre, services system enhancements in public sector mental health and alcohol and drug services are being implemented to ensure that individuals referred by the VFTAC receive appropriate treatment and support.

Dr Pathé is a Consultant Forensic Psychiatrist and Clinical Lead at the Victorian FTAC. Until November 2017 she was the Principal Forensic Behavioural Consultant with the Intelligence, Counter-Terrorism and Major Events Command of the Queensland Police Service. She is an Adjunct Professor at the Key Centre for Ethics, Law, Justice and Governance at Griffith University. She is a member of the Fixated Research Group, whose studies commissioned by the British Home Office led to the establishment of the world’s first FTAC in the UK in 2006. She was later involved in the establishment of the award winning Queensland FTAC in 2013 and the AFP-led model in Canberra. She has published widely in the field of stalking, threats, public figure fixation and pathological grievances.

Established in early 2018, the Victorian Fixated Threat Assessment Centre (VFTAC) is a joint initiative between Victoria Police and the Department of Health and Human Services (DHHS) that aims to provide a structured and coordinated approach to high risk individuals with complex needs including mental illness. Staffed jointly by senior mental health clinicians and police, VFTAC aims:

• to identify and assess individuals who may have a mental illness and who pose a threat to public safety due to their risk of engaging in behaviours indicative of pathological fixation and grievances with a high potential for violent attack behaviours.

• to facilitate interventions by mental health, police and relevant agencies and, through these measures, prevent these individuals from progressing to violent action.

It is anticipated that VFTAC will have a positive impact on the early identification and intervention of persons with mental illness who are at risk of engaging in serious violence.

The establishment of VFTAC is in line with Australia’s national strategic approach to counter-terrorism, which is a multilayered and collaborative process based on strong relationships between police and mental health services. The first FTAC was established in the United Kingdom in 2006, the culmination of extensive research indicating that fixated persons (those with an obsessive preoccupation with an individual or cause), posed an increased risk of serious harm or death to public figures. Research also found that the rate of mental illness among fixated persons was 40-80%, depending on the type of public figure targeted. Therefore, once detected, mental health intervention has assisted in mitigating the risk posed by these individuals to themselves, public figures and the wider community.
The FTAC model was endorsed by the Council of Australian Governments (COAG) in 2017 and has been adopted, or is in the process of being adopted, by states and territories throughout Australia and in New Zealand. Queensland set up its QFTAC in 2013 and it was the first jurisdiction in Australia to expand the model to respond to the threat posed by persons at risk of engaging in lone actor grievance fuelled violence (LAGFV).

Lone actor grievance fuelled attacks include lone actor terrorism and lone actor apolitical violence (workplace, hate, school and institutional killings, as well as family massacres). It can also include individuals who are fixated on a cause, or quest for justice. The expansion of the FTAC model to include LAGFV is based on contemporary research which, like with fixated persons, identifies substantial rates of mental illness (40%) amongst lone actor terrorists relative to group actor terrorists, and rates of 40% among apolitical mass killers. While LAGFV is multi-determined and mental illness is not necessarily a direct cause of grievance fuelled violence, existing FTACs in Europe and Australia have demonstrated that identifying key warning signs and addressing mental illness at the earliest opportunity can mitigate risk and prevent harmful outcomes. It can also prevent mentally ill individuals who, through co-morbidities and other vulnerabilities, are being drawn into the current security environment.

In addition to funding the establishment of VFTAC, the Victorian Government has funding providing for mental health and alcohol and drug services system enhancements. These enhancements, which will be coordinated through Melbourne Health and Monash Health, will ensure individuals with mental illness who are identified by VFTAC as posing a significant risk to community safety receive treatment and support.

In this symposium, Forensicare mental health clinicians, Victoria Police and DHHS will present the policy and service systems drivers for the establishment of VFTAC, contemporary research and the evidence base for this approach, how VFTAC works, its interface with mainstream service systems, and some learnings and challenges that have been overcome.

Learning Objectives

Learning Objective (1): Attendees will gain an understanding of the two groups of individuals in scope for the Victorian Fixated Threat Assessment Centre (VFTAC): fixated persons and those who pose a threat of Lone Actor Grievance Fuelled Violence.

They will learn about the recently established VFTAC, how mental health clinicians and police officers work together, and the broader services systems enhancements that have been made to support the work of VFTAC. Furthermore, the challenges, sensitivities and systems issues that have been encountered along the way will be discussed.

Learning Objective (2): There is research evidence to suggest that the rate of mental illness among fixated persons is 40-80%, depending on the type of public figure targeted. There is also a growing body of contemporary research evidence which, like with fixated persons, identifies substantial rates of mental illness (40%) amongst lone actor terrorists relative to group actor terrorists.

Therefore, once detected, mental health intervention can assist in mitigating the risk posed by these individuals to themselves, public figures and the wider community, and it is anticipated that VFTAC will have a positive impact on the early identification and intervention of persons with mental illness who are at risk of engaging in serious violence.

References

Biography:
Erandathie is the Team Leader, Consumer and Carer Participation Team at Mind Australia. She has a lived experience of mental ill health and recovery and is passionate about using this experience to inform her work.

Klavdia Vainshtein is the Senior Carer Consultant at Mind Australia and has a lived experience of caring for someone with mental ill-health.

Gabby Harkin is the Carer Consultant at Mind Australia and she has a lived experience of caring for someone with mental ill-health.

Mind Australia is committed to promoting family and carer inclusive practice. Mind sees carers as partners in care for those experiencing mental ill-health; and also carers in their own right as they deal with the impact of mental ill-health on their own wellbeing.

The Carer Champions program is a change initiative that aims to promote family and carer inclusive practice there by creating a ‘care aware’ culture. It establishes a core team of staff that become change agents for cultural change. They become the ‘workplace family and carer voice’ in their teams and geographical areas.

The program is an important part of the implementation of Mind’s approach to working with families and carers. The program consists of a champion in different geographical division who promote family and carer inclusive practice. The presentation will outline the development and implementation of the program; and share reflections of the successes and challenges during the first 12 months of the program.

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation?
People will learn how to:
- Empower staff as agents of change to promote family and carer inclusive practice
- Promote a shared understanding of family and carer inclusive practice within a service delivery context

Learning Objective (2): How is this topic/issue relevant to the mental health services and mental health issues?
“Family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities” (Preamble to the UN Convention on the Rights of Persons with Disabilities 2007)

Carers are seen as partners in care for those experiencing mental ill health; the impact of mental ill health on the well-being of families and carers in their own right is also well recognised. Family centred and inclusive practice is central to modern mental health policy, practice and service delivery. Much is needed to enshrine these practices in service delivery as service providers often face challenges in promoting family and carer inclusive practice. This presentation will discuss the challenges and successes of promoting family and carer inclusive practice within a large mental health service organisation.
ACES High - how the cards you are dealt can affect you throughout your lifetime.

Nicola Palfrey¹ ²

¹Australian Child & Adolescent Trauma, Loss & Grief Network, Garran, Australia, ²Emerging Minds: National Workforce Centre for Child Mental Health, Adelaide, Australia

Biography:
Nicola Palfrey is a Clinical Psychologist and researcher who works clinically with adolescents and adults who have experienced significant adversity and trauma. In her current role as Director of the Australian Child & Adolescent Trauma, Grief & Loss Network at the ANU she is a project lead for Emerging Minds: The National Workforce Centre for Child Mental Health, an initiative to support workforces identify, assess and support children under 12 years who are at risk of experiencing mental illness.

Australia is one of the few OECD countries without a national prevalence study into childhood adversity. International research has shown that adverse childhood experiences (ACEs) are more common than not, often occur in clusters, and negatively affect physical and mental health across the lifespan in a dose-response relationship. As exposure to adversities increases, so does the risk of cancer, COPD, heart disease, premature death, depression, anxiety, schizophrenia, hallucinations, post-traumatic stress disorder, stroke, diabetes, lowered educational attainment, impaired work performance, and increased health-risk behaviours.

Early identification of exposure to ACEs in children and in their caregivers can significantly impact the trajectories of children; by providing services that support family relationships, and foster children's social and emotional wellbeing. Services that understand the reasons behind some children and caregivers’ aggressive, avoidant or resistant behaviours actively work to avoid exacerbating existing stress and trauma. The Australian Child and Adolescent Trauma, Grief and Loss Network (ACATLGN) as part of the National Workforce Centre for Child Mental Health has resources, training and support for workforces to equip them to understand the prevalence and impact of ACEs, and how to work with families to identify, assess and support them in the face or aftermath of trauma and adversity.

Learning Objectives

Learning Objective (1): The audience will take away an understanding and awareness of the effect of early childhood trauma, the associations between early childhood adversity and the numerous negative physical and mental health outcomes, and how you can work with children and families to identify exposure to ACEs in a safe, sensitive and supportive way.

Learning Objective (2): The large majority of children and families that access or would benefit from mental health services and services that are mental health literate have experiences of trauma and adversity. Whilst most practitioners in these services are aware that trauma is prevalent in their consumers, many still feel ill equipped to assess and discuss these experiences.

References


Peer Health Coaching – Partnerships Informing Practice

Elise Whatley\(^1\), Bianca Childs\(^1\)
\(^1\)Mind Australia Limited, Heidelberg, Australia

Biography:
Bianca Childs is both the Peer Practice Coach and the Coordinator of the Centre of Excellence in Peer Support at Mind Australia Limited. Bianca has extensive experience in the mental health lived experience workforce, working in both the clinical and community sector. Bianca has qualifications in Consumer Engagement, Training and Assessment, and Mental Health Peer Work and is studying a Master of Social Change and Development at the University of Newcastle.

Elise Whatley works in the Quality and Practice team at Mind Australia Limited. Elise has extensive experience in the mental health sector as an occupational therapist, community mental health practitioner, family worker, and more recently in quality and practice. Elise is an Occupational Therapist, with additional training in family work.

In 2016/2017, the Take the Challenge Innovation Grants program at Mind Australia Limited (Mind) focused on improving the physical health of consumers who access Mind services. One of the successful initiatives was to pilot Peer Health Coaching. A peer health coach is someone with a lived experience of recovery also experienced in providing peer support, and coaching people to change health behaviours.

The program we used was the Better Health Choices model of peer health coaching, an evidence-based healthy lifestyle intervention. This was developed by Professor Amanda Baker and Associate Professor Peter Kelly and their colleagues from the University of Newcastle and the University of Wollongong. Amanda and Peter delivered training to Mind peer health coaches, as well as providing peer health coaching supervision and project support.

One of the successes of the project was being able to draw on the expertise of people who have been involved in developing research and then translating it into practice. This enabled us to:
• ensure that the pilot and planning future programs was evidence based
• incorporate external expertise into our work

This paper will describe the planning, implementation, training, supervision and project supports and the learnings from piloting peer health coaching at Mind.

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation (what they are going to take away)?
People will learn about:
• The benefits of collaboration when implementing innovations that are based on research or evidence
• How peer health coaching was able to inform the work of the organisation

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues?
Improving the physical health of people with mental ill-health is a national priority due to their poorer health and increased risk of dying from preventable illness. People who experience mental ill-health die up to 30 years earlier than the general population, largely from preventable illnesses usually related to obesity and tobacco smoking. Research in this area suggests that mental health services can do more to include physical health interventions routinely in their work with clients.

References
1. With psychotic disorders, Psychiatry Research, vol. 220, issues 1-2, pp. 63-70. DOI: http://dx.doi.org/10.1016/j.psychres.2014.06.035

TIC Healing Project for Kent AFB 2018

Anna Borg

UTS, Broadway, Australia

Biography:
My name is Anna Felicita Borg and I am a 37 year old whistleblower and qualified Mental Health Nurse (MHN) with post-registration Science degree majoring in Psychology with a minor in Philosophy. I have "lived experience" and live alone in Sydney (Australia) with my two pet cats "Freyja" and "Odin."

Sharing my "Personal Testimony" as a "Public Housing" tenant (11+ years) to advocate for my "Community" and "Privacy" including criminal breaches from "illegal surveillance" and my fight for Justice. I hope this improves societal Mental Health (MH) literacy of "Service Issues" and dangers from "unwanted" Hospital in the Home (HITH) services and programs denied by landlords due to rampant "Public Corruption" in Concord (NSW). Both the final outcome and process applying for a grant from the "Australian Government" through the "Safer Communities Fund" is described including implementing the "Security Infrastructure Upgrades" for the building I live in (protecting "Pet" families too). A review request was made under the banner of the GCCM endorsed by The Holy Father Francis as "Criminal Cartels" including Police are exploiting the NSW Mental Health Act, 2007 (MHA) and "Terrorizing" our neighborhood, profiting from Genocide and Mass Murders ("Organ Harvesting") by qualified Doctors and Nurses operating on "God's People" (GPs). The Falun Dafa Association of Australia "calls us" to help end this crime against humanity and for this I humbly write here thank you to President Xi, Mr Kim, President Jokowi, the "OECD," the "Courage Foundation," and "BEING" and I give "Praise to God."

Learning Objectives
The importance and my motivations for implementing "Trauma-Informed Care and Practice" (TICP) in "Mental Health" and "NSW Corrections" (Prisons) and throughout Australia.

References
The importance and my motivations for requesting and hoping the OECD and Secretary-General, Mr Angel Gurría will consider taking on the oversight role for "Health Data Governance" once I have funding approval for each stage (including Stage I - Safer Communities Funding) of the "TIC Healing Project" (Stage II) - including Stage III - my attendance in person in November this year to attend the "6th OECD World Forum on Statistics, Knowledge and Policy" to be held in Incheon, Korea (2018).
Primary Care - Psychiatry Liaison Service: Developing Psychiatry and Peer worker oriented recovery model within primary care setting. Innovative models of supporting people with persistent and complex mental health needs within Primary Care.

William (Bill) Campos¹, Andy Ang
¹Wentwest Western Sydney PHN, Blacktown, Australia

Biography:
William (Bill) Campos is an experienced Clinical and Child Psychologist. He has worked in various settings including non-government sector, education, correctional services and private practice.

He is presently the senior clinical psychologist and Head of Mental Health team at WentWest – the Western Sydney Medicare Local. The Mental Health team is responsible for the delivery of a number of Mental Health Services and programs with employed clinicians and over 100 contracted mental health clinicians delivering services in the Western Sydney Region.

Many people attending general practices experience coexisting physical and mental health issues and have higher social support needs. General practice is well positioned to address these issues. A strong international evidence base supports the integration of mental health services within the primary care setting. Within Australia there are gaps in clinician understanding of the recovery model and challenges in navigating the available services within the system. Western Sydney is meeting this need through the delivery of an innovative model for the delivery of effective and holistic primary and mental health care, The Primary Care-Psychiatry Liaison Service (PC-PLS). This model co-locates a full-time psychiatrist, peer worker and a support coordinator to support up to ten (10) general practices over 12 months across the WentWest Western Sydney Primary Health Network. This multi-disciplinary team will provide consultant liaison support to GPs and brief intervention to people accessing PC-PLS, increasing access to professional mental health services in the primary care setting. General practice teams and their patients would benefit from improved referral pathways to existing mental health services and readily accessible, on-job mental health education.

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation?
Building capacity and capability within general practice through a multi-disciplinary team-based approach can help to meet community physical, mental and social health needs.

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues?
The psychiatrist will provide consultant liaison support to GPs and brief intervention to people accessing the service, increasing access to professional mental health services in the primary care setting.

References
Kates, N (2011). Integrating Mental Health Services within Primary Care settings, p 174-182
Voices from the Frontline: 80 days of Mutual Help meetings on a Melbourne mental health unit.

Donna Matthews¹
¹Northwestern Mental Health, Melbourne, Australia

**Biography:**
Donna Matthews is the Consumer Advisor at NorthWestern Mental Health, which provides mental health services across the northern and western suburbs of Melbourne. Donna has previously worked as a consumer worker in forensic mental health, community services and inpatient units. Donna also worked as a radiographer for twenty years and now adopts retired greyhounds.

Safewards is a nursing model and set of interventions developed in the UK, with the aim of making mental health units ‘calmer and more pleasant places where people can safely recover, work and visit.’

The Safewards program of ten interventions is to be implemented at all Victorian mental health units by the end of 2018.

One intervention, the Mutual Help Meeting, is a great opportunity to hear the voice of consumers. Unfortunately, many services are not paying heed to the whispers and roars from consumers, and are missing a great opportunity to improve their service and to show a true commitment to consumer empowerment, dignity and respect.

This presentation looks at the rich consumer voice documented from eight months of Mutual Help meetings on a major Melbourne mental health unit. Eight major themes are evident: the environment on the unit, safety, hygiene, community living, meals, group activities, rights and dignity.

The second part of the presentation looks at how services can be more responsive to the consumer voice from Mutual Help meetings, and make real changes and improvements to the service that they provide based on the consumer feedback that they receive.

**Learning Objectives**

Learning Objective (1): People in the audience will learn about the rich information that can be received from consumers by facilitating Mutual Help meetings on mental health units, including major consumer themes from our Melbourne mental health unit and how to action consumer feedback.

Learning Objective (2): This topic is relevant to mental health services as Safewards must be implemented on Victorian mental health units by the end of 2018. However, it should be implemented with integrity, rather than in a tokenistic way. A well-run and actioned mutual help meeting can greatly improve the inpatient experience, and also improve the workplace for staff by reducing tensions and disharmony.

**References**

Safewards Victoria
Community engagement and empowerment for mental health consumers: Four years of PeerZone workshops.

Donna Matthews

Northwestern Mental Health, Melbourne, Australia

Biography:
Donna Matthews is the new Consumer Advisor for NorthWestern Mental Health which provides mental health services across the northern and western suburbs of Melbourne. Donna has also facilitated PeerZone workshops at the Inner West community site for the past three years. Donna also worked as a radiographer for twenty years and now adopts retired greyhounds.

Mental health units in Melbourne are struggling to meet increased demands for their services, with burgeoning population growth, limited funding and limited bed numbers. Consumers are increasingly having shorter hospital stays and are sometimes discharged prematurely.

This presentation examines a different way of providing support to consumers, one that is community-based, voluntary and possibly provides longer term benefits to consumers than short hospital stays.

PeerZone is a series of mental health and addiction workshops for mental health consumers facilitated by consumer peer workers. It was developed in New Zealand by the renowned Mary O’Hagan.

PeerZone supports consumers to increase their self-understanding and self-awareness, improve their resilience and gain practical life skills. Consumers are empowered to deal with stigma, find their voices and take charge of their own Recovery journeys.

This presentation explores the benefits of PeerZone to participants living in the City of Moonee Valley and City of Melbourne, where the workshops have been available for the past four years. We are hoping to gain funding to make PeerZone available at all our community sites.

Learning Objectives

Learning Objective (1): People in the audience will learn about the benefits of community support and educational groups such as PeerZone. Audience members will learn about the topics and structure of PeerZone workshops, the benefits experienced by consumers, and quantitative and qualitative feedback from consumers at our community service in Melbourne.

Learning Objective (2): This topic is relevant to mental health services, as currently the vast majority of mental health funding goes towards expensive mental health inpatient services which react to crisis situations. Community-based support and educational groups, run by facilitators with lived experience, are a much more cost-effective option which empower consumers to drive their own Recovery.

References

http://www.peerzone.info/
Supporting people through the transition to the NDIS.

Daniel Reynolds

Flourish Australia, Sydney, Australia

Biography:
Daniel Reynolds is a Senior Peer Worker at Flourish Australia and uses his lived experience to engage and support people in his everyday work. He has been working in the NDIS environment since its roll out in the NSW Hunter region and is passionate about Flourish Australia’s peer workforce.

The National Disability Insurance Scheme (NDIS) is a major opportunity to support individuals with a disability on their mental health recovery journey. The transition has challenges and opportunities not just for service providers but for people accessing the NDIS. With every transition there are bound to be gaps. Some people find these gaps challenging to overcome and may require support.

The recent Mind The Gap Report's (University of Sydney) solution-based focus seeks to improve the transition for people who identify as having a psychosocial disability accessing the NDIS.

My role as Senior Peer Worker at Flourish Australia enables me to support people through the NDIS application process and ensure they have someone to go to for support. This role has shown me first-hand the gaps in the process, the challenges people face and what is required of them to address those challenges. This Snapshot will describe my direct experience supporting people who have approached Flourish Australia for assistance. It will show how, as a service provider, we can assist people's recovery journeys through supporting them to access the NDIS and through that, to achieve their goals, hopes and dreams, and stay well in the community.

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation? The audience will gain an account of first-hand experience of a Senior Peer Worker's facilitation and support of the NDIS application process and what we as service providers can do to best support people going through this process.

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues? A review of a peer work engagement model designed to assist and support people with a lived experience of mental health issues to navigate the NDIS application process.

References

1. National disability insurance agency, NSW Government (2017), Title: Operational Plan Commitment between the National Disability Insurance Agency (NDIA), New South Wales Government and Commonwealth Government for Transition to Full Implementation of the NDIS.

Voting with your feet: Listening to and supporting a large consumer workforce.

Donna Matthews¹
¹Northwestern Mental Health, Melbourne, Australia

Biography:
Donna Matthews is the newly appointed Consumer Advisor at NorthWestern Mental Health which provides mental health services across the northern and western suburbs of Melbourne. Donna has also worked as a consumer consultant, consumer peer worker, group facilitator and radiographer.

NorthWestern Mental Health employs over twenty consumer workers, all working part-time hours and spread across 6 different regions and 32 different sites. The newly appointed Consumer Advisor has noted that there have been several resignations over the past couple of years which have been ascribed to the consumer worker ‘becoming unwell’ or the work ‘not suiting them’. The Consumer Advisor, however, is listening to the voice of the consumer workforce which she believes are currently ‘voting with their feet.’

This presentation looks at ways that the Consumer Advisor has supported and connected the consumer workforce which:
• is geographically distant
• is working limited hours
• has a variety of philosophical perspectives stretching from the elders in the workforce to the new talent
• is experiencing different workplace expectations of their work

The presentation will include strategies used by the Consumer Advisor, such as gaining critical feedback from the consumer workers; events to promote connection between consumer workers; the provision of timely and regular peer supervision; the sharing of resources across sites; the standardisation of procedures, policies and workplace structures where possible; the standardisation of pay classifications; and the development of appropriate in-house peer training modules to support the work.

Learning Objectives

Learning Objective (1): People in the audience will learn about effective ways to support a disparate consumer workforce to become robust, connected and energised.

Learning Objective (2): This topic is relevant to mental health services who wish to support their consumer workforce to work effectively across sites, while maintaining the well-being of the consumer workforce.
Stories of Men's mental health recovery in a dry and dusty land.

Bruce Jones

Flourish Australia, Sydney, Australia

Biography:
Bruce Jones is a Peer Worker with Flourish Australia. He lives in the "bush", also known as Moree, a small town in North Western NSW. Bruce brings a down to earth approach to his service delivery and enjoys his work.

Living in the bush, growing up on a 4200-acre property in drought, has thrown me lots of challenges. That includes finding myself in a situation where I experienced a serious mental health issue after a separation. It showed me how hard it is to get help out here. We're so often the forgotten part of Australia.

I went off the rails, so to speak, and spent time in a mental health unit in hospital twice. On discharge I became involved with Flourish Australia and my recovery journey has snowballed. So much, that I eventually obtained a job as a Peer Worker.

Working in isolated communities demonstrates the importance of employing local people, who know the local community and who know how to yarn. It’s important to have staff who speak the local lingo and to show them local people have a lived experience.

Men from isolated farming areas are coming in droves to Moree Flourish Australia because they know they can find their people who understand them and know what the isolation they feel is like. This Snapshot will outline how Flourish Australia is responding creatively to support the recovery journey of people in the bush.

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation?
Audience will gain an understanding for the need for effective services in isolated farming areas and how the service delivery challenges in these areas are different from other places.

Learning Objective (2): How is this topic/issue relevant to Mental Health services and mental health issues?
- People will understand the need for ongoing investment in remote and rural mental health.
- Mental health support in isolated areas doesn't fit the same model as in the cities, we have to be creative out here and the relationship with the person is everything.
- Stories will be shared about how Flourish Australia's psychosocial recovery model is positively impacting the isolated farming community of Moree.
- Information will be provided about how Flourish Australia is reducing stigma and discrimination about mental health in Moree.

References

Jones, B., 2018 Flourish Australia
Focus Testing of the Positive Choices Drug and Alcohol Prevention Online Portal: End-user evaluation and impact of the portal.

Cath Chapman1,2, Lexine Stapinski1,2, Lucy Grummitt1,2, Siobhan Lawler1,2, Frances Kay-Lambkin1,3, Maree Teesson1,2, Nicola Newton1,2  
1NHMRC Centre For Research Excellence In Mental Health And Substance Use, Sydney, Australia, 2National Drug and Alcohol Research Centre, UNSW, Sydney, Australia, 3The University of Newcastle, Newcastle, Australia

Biography:
Cath is Program Director at the NHMRC Centre of Research Excellence in Mental Health and Substance Use at the National Drug and Alcohol Research Centre. Cath is a member of the ‘Positive Choices’ team; a Commonwealth Department of Health funded project disseminating evidence-based AOD information to the school community.

Introduction
Research suggests the teenage years are when alcohol and other drug use are first initiated. This highlights the importance of engaging with young people early to prevent drug-related harms. In this, schools and parents play a critical role.

The Positive Choices portal was developed in recognition of a need for easily accessible evidence-based AOD information. To ensure the portal meets the needs of the school community, online focus testing was conducted 2 years post-launch.

Method
Focus testing was conducted with 75 Positive Choices end-users, who rated alternative site versions and images, navigability, content and the impact of the portal. Information was gathered from google analytics to determine the use of Positive Choices since launch.

Key Findings
End-users informed new designs, areas for resource development and indicated plans to change their behaviour since viewing Positive Choices. The portal has had >129,000 users, and is ranked first in google search rankings for drug and alcohol education.

Implications
In online delivery of healthcare, the contribution of end-users is vital. The Positive Choices focus testing is an example of how to engage end-users in the review process. This presentation will interest clinicians and service providers using online approaches to mental health care.

Learning Objectives
Learning Objective (1): The audience will gain:
- knowledge of alcohol and other drug use, and related harms amongst Australian high school students
- knowledge of the development of Positive Choices through in-depth consultation with school staff, parents and students
- knowledge of how Positive Choices aims to help school communities access evidence-based AOD information and resources, and to help students make informed choices about drugs and alcohol
- knowledge of the portal’s recent focus testing by end-users to inform improvements and website reform
- an understanding of the use and impact of Positive Choices, including on school staff and parents’ behavior, since its launch in 2015
- an appreciation of how online approaches like Positive Choices can overcome barriers to accessing evidence-based information and AOD prevention resources
- an appreciation of how end-user evaluation can drive improvement and assist the sustainability of online health promotion.
Learning Objective (2): This presentation is relevant to:
• school counsellors and clinicians working with young people or their parents
• mental health researchers interested in AOD use and harm prevention, particularly through use of an online medium
• policy makers interested in AOD prevention and/or online health dissemination initiatives
Navigating services in regional, rural and remote NSW.

Glenn Botfield¹
¹Flourish Australia, Sydney, Australia

Biography:
Glenn Botfield is Senior Peer Worker with Flourish Australia in the Tamworth/New England area. Having a lived experience of a mental health issue, Glenn has been in a support role since 2006. He endeavours to connect with people the supports they require to pursue their personal recovery aspirations and goals.

In the 1980s, there were few supports or services in the North West and New England areas of NSW. Diagnosed with Schizophrenia in 1986, I found connecting with services very difficult. Wellbeing was something that could only be dreamt of.

Working with my father, I felt fortunate to be part of the workforce. However, employment didn't provide a focus on mental health recovery.

As a member of Billabong Clubhouse in Tamworth, I met staff who also had their own lived experience of a mental health issue and developed my recovery skills. I became employed by as a Support Worker, eventually becoming the Senior Peer Worker. My experience showed the importance of the collaborative effort of family and others in the local community who supported me to pursue my goals, hopes and dreams.

Working as a Senior Peer Worker, I walk alongside people with lived experience and engage with the local community. I assist people to locate, access and navigate services in an area where some years ago people struggled to find support because very little was available. The Tamworth community is a different place to what it was in 1986. I'm proud to represent Tamworth and to share my story.

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation?
- Working toward recovery and wellbeing is not only a personal focus, but a collaborative effort of family and others toward goals, hopes and dreams.
- Representing others and connecting with people with a lived experience can facilitate connection and recovery in communities where little is known about mental ill-health.

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues?
- Building and connecting with services in regional, rural and remote areas is a possibility.
- Peer Work, although a reasonable new concept in country areas, can assist people to realise their own sense of ability and progression toward aspirations and recovery.

References

Botfield, G. 2018 Flourish Australia
Supporting LGBTI people in the workplace.

Peter Farrugia
Flourish Australia, Sydney, Australia

Biography:
Peter Farrugia is Flourish Australia’s Manager Peer Workforce, applying lived experience expertise within his role. Peter also considers influences from his life as a gay man, enabling LGBTI perspective to mental health and wellbeing. "I embrace opportunity to be visible and support other people in the LGBTI community”.

Experiences of bullying, harassment, violence and exclusion against the LGBTI community has long been associated with heightened levels of mental illness, distress and suicide. Pro-activism in recent decades has heralded a revolution of acceptance in Australia but as evidenced during the postal plebiscite for Marriage Equality in Australia during 2017, there remains an undertone of prejudice and discrimination in some parts of the Australian population.

Flourish Australia’s keynote position on diversity and inclusion in the workplace supports a breadth of identity and knowledge, qualifying supports from foundations of lived-experience.

People bring their best when they feel confident, supported and included. Flourish Australia’s Rainbow Network encourages individuals to bring their whole self to work, enabling individuals to celebrate their identity in an environment of openness, trust and worth. It also contributes to Flourish Australia’s submission to the Australian Workplace Equality Index, a national benchmark of diversity and inclusion.

Embracing diversity of lived-experience in the workforce is proving to be of great benefit to people’s journey of recovery of mental wellbeing in not only those who access support, but of staff as well. As a result, people who identify as LGBTI can access mental health support with dignity, self-esteem and pride.

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation?
- Audience will gain insight to the initiatives of Flourish Australia’s diversity policy; understand practical application of the policy across its workforce; hear about the Rainbow Network evolution and other initiatives that support inclusion and reduce stigma and discrimination, with a key focus on the LGBTI community.

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues?
- Flourish Australia's pro-activity in employing mental health lived-experience is renowned, with one of the largest peer workforces in Australia. Supporting diversity within lived-experience workforces brings advantage and opportunity to the breadth of people accessing supports.
- Promoting the Rainbow Network and attracting LGBTI staff reduces stigma and discrimination in the community, strengthens self-esteem, pride, supports strengths-based language and encourages inclusion at all levels.
- Taking a public position on LGBTI inclusion supports a message of anti-discrimination and equality, supporting wellbeing amongst LGBTI people, their family, carers, friends and allies.
- Visibility of LGBTI people in senior leadership roles as presenters supports pride and diversity across mental health services and encourages people to access support without fear of discrimination.

References

Farrugia, P., 2018 Flourish Australia
A systems approach to suicide prevention – what can we learn from health care system reviews into suicide deaths?

Marianne Wyder¹, Kathy Stapley¹, Balaji Motamarri¹, David Crompton¹

¹Metro South Addiction And Mental Health Services, Upper Mount Gravatt, Australia

Biography:
Dr Marianne Wyder is a social worker with a background in sociology. Over the past 20 years she has worked in various research and clinical positions in the Government, Non-Government and University sector. Her research experience spans the health sector and includes expert knowledge on mental health issues, capacity building, inequality, involuntary treatment, family breakdown, gender, drug and/or alcohol abuse and suicidal behaviours. She is currently employed as a Senior Research Fellow in Metro South Addiction and Mental Health services where her role involves conducting and facilitating practice based research and evaluations as well as supporting clinicians in conducting research.

Many of those who die by suicide have had contact with mental healthcare services either as an inpatient or outpatient prior to their death. In Australia such deaths are assessed and where deemed appropriate are reviewed by Human Error and Patient Safety (HEAPS) or Root Cause Analysis (RCA) methodologies. These approaches take a ‘no blame’ approach and focus on system factors that may have contributed to these deaths. In this presentation we will present results from a systematic review of all deaths through suicide who had recorded contact with Metro South Addictions and Mental Health Services between 2014 and 2017 within 30 days of their death. This analysis focused on what occurred during the last contact with the mental health care system, risk assessment and outcomes of these. It will also present an overview of the service recommendations and highlight critical points where issues are more likely to occur.

Learning Objectives

Learning Objective (1): The audience will learn about the critical points within the mental health care system were system errors are more likely to occur.
Learning Objective (2): Suicide is a major concern. A systems approach to suicide prevention has the potential to improve knowledge and understanding of factors that could contribute to suicide prevention.

References


Benefits of Incorporating Lived Experience and Trauma-Informed Care in Emergency Services Organisational Structures and Peer Support Programs

Jason Nelson

1 Sirens Of Silence Charity Inc, City of Wanneroo, Australia

Biography:
Jason Nelson is a Royal Navy veteran and UK Police and WA Police Officer. In 2008 Jason almost became the 63rd police officer to die by suicide between July 2000 and December 2012. His survival and lived experience with complex trauma has gifted him a passion to educate others.

Emergency services regularly face exposure to severe and traumatic experiences, which can have a long-lasting impact on a person’s mental and physical wellbeing, and social and economic participation.

Post-Traumatic Stress Disorder (PTSD) can develop in people who have experienced, witnessed or been exposed to a traumatic event.

It is estimated that approximately 6 per cent of Australians aged 16 to 85 live with PTSD in any one year. Defence forces, emergency services, prison officers and veterans experience higher rates of PTSD and Complex Trauma which is as an alternative to the narrower definition of PTSD which encompasses ‘changes in victims’ attitudes about self, the perpetrator, relationships and belief’.

There is an emerging recognition of Complex Trauma and PTSD across Emergency Services; and their legal and ethical responsibilities to ensure staff safety and mental wellbeing.

However, the system is failing our hero’s. For the best understanding and recovery outcomes, Emergency Service agencies should implement and maintain a Peer Support model that incorporates the Principles of Recovery, Trauma-Informed Care and Lived Experience.

Agencies must educate at all levels, especially senior management as part of an organisational structure and requirement in an understanding treatment framework.

Learning Objectives

Learning Objective (1): The audience will learn that Lived Experience and Trauma-Informed Care can shape organisational strategy.

Learning Objective (2): This topic is relevant as supports the objective of the Fifth National Mental Health Plan (COAG Health Council) and Suicide Prevention 2020-Together we can save lives (Western Australian Government Mental Health Commission)

References


National Coronial Information System – Intentional Self-Harm Fact Sheet: Emergency Services Personnel
Nature Based Therapy: Wellbeing for Mental Health

Kit Kline
*Nature Based Therapy, Torquay, Australia*

*Biography:*
Kit Kline, the founder of Nature Based Therapy, was born in Canada and moved to Australia when she was 10. She is a decedent of the Wampanoag people on her paternal side and is a member of the Sou’West Nova Metis Council. Kit has always felt a strong connection to her Native American ancestry and believes her philosophy on health and wellness derives from this connection.

She has 17 years’ experience working as a Counsellor and Educator in the social and community services sector with both public and private health services specialising in mental health and addictions. She established the modality Nature Based Therapy due to the success she was having with the people she was working with when she incorporated ‘nature’ into her work practice.

Kit is currently completing a Master’s Degree in Indigenous Studies (University of South Australia) and has a Bachelor of Arts in Indigenous Studies (Victoria University). Her post graduate studies include a Diploma in welfare studies, Diploma in alcohol and other drugs, Diploma in holistic healing and a cert IV in training and assessment.

Kit is a recent graduate of the Leaders for Geelong program 2015-2017 and is committed to creating healthy people, families and communities while at the same time protecting our natural resources and environment.

Kit is a mother to three daughters and one son and enjoys coastal life in Torquay, Victoria. In her personal time, she enjoys taking her family on picnics to local forests, bushwalking, mountain bike riding and cooking healthy organic food. She also enjoys long road trips, travelling to new destinations and meeting people from different cultural backgrounds.

If we listen deeply and find some stillness in the natural world we can learn a lot about ourselves and the world around us.

I have been working as a Counsellor in mental health and addictions for 17 years and discovered that I could help my clients better understand their problems and find solutions if I used nature as a metaphor and connected them to the natural world. This led me to develop a modality which is recognized with the International Institute of Complimentary Therapies called Nature Based Therapy.

There is a growing amount of evidence to show that exposure to nature brings substantial mental health benefits. Environmental psychologists have studied the health effects of contact with nature and concluded that humans depend on nature not simply for material requirements but also for emotional, psychological and spiritual needs.

Nature Based Therapy can be practiced either indoors or outdoors, individually in a counselling context or facilitated as a group therapy.

Nature Based Therapy believes that we have a kind of biologically prepared disposition to respond favorably to nature because we evolved in nature.

Mental health issues such as anxiety, stress, depression, loneliness and grief can be relieved by reconnecting to nature.

**Learning Objectives**

Learning Objective (1): What will people in the audience gain or learn from attending this presentation?

The audience will gain knowledge about Nature Based Therapy and learn practical tools to apply both to the people they are working with and to themselves as a self-care strategy. The presentation will allow the audience to reflect on their own experience in nature and their relationship with it. They will gain an awareness about how to bring Nature Based Therapy into their workplace and various ways to take their practice outdoors and work with nature being the therapist.

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues?
Nature Based Therapy is a modality that is recognised with the International Institute of Complimentary Therapists (IICT) that supports people who are experiencing mental health issues and can be incorporated into counselling and group therapy by mental health services. It can also serve as a self-care strategy for workers to avoid 'burnout' and work related stress.

References

1. Townsend, M., Weerasuriya, R. (2010). Faculty of Health, Medicine, Nursing and Behavioural Sciences, Deakin University
Collective Healing in Mental Health and Human Services including NSW Corrections (Prisons) - Creating a Culture of Safety for our Ancient Australia

Anna Borg

ANNA FELICITA BORG, Concord, Australia

Biography:
My name is Anna Felicita Borg and I am a qualified Mental Health Nurse (MHN) with Post-registration Science degree majoring in Psychology with a minor in Psychology. While working as a Psychiatric Emergency Care Centre (PECC) RN I made a Protected Interest Disclosure (PID).

The aim of this paper is to utilise the Paris21 Strategy: 2016-2020 (OECD) for Mental Health (MH) in Australia and embark on an important humanitarian mission to end modern-day slavery in our country. The Healing Foundation is followed to implement Collective Healing (TICP). This is carried out under the banner of the Global Catholic Climate Movement (GCCM) endorsed by The Holy Father Francis to bring LAUDATO SI to life for Climate Justice. Prevention of Corruption and Childhood Sexual Abuse (CSA) must occur for the human species to not become extinct and the need for New South Wales (NSW) to implement the recommendations of the Royal Commission (2017) explained. The theoretical framework is the Kellehear Theory-Practice Integration Model (2011) and complementary Western (bio-psycho-social-spiritual) with its Indigenous (body-soul-spirit (community)) perspectives used for our Ancient country (the land). The author endorses the Makarrata (Uluru statement from the heart) which co-exists with the sovereignty of the Crown. The Commonwealth Attorney-General Department (AGD) and their successful partnership (Justice and Health) and this framework for Business (Harm Reduction) is the Corporate Plan used that will lead to combined savings for Local, State and Commonwealth budgets of at least AU$24 Billion.

Learning Objectives

Learning Objective (1): Spirituality must be included in Mental Health and Atheists respected too as God (Allah) does get bitterly angry and is not always all around us when CSA is proliferating and its terrifying when this happens. The focus by MH on a pure bio-medical approach to the exclusion of all other domains including Psychology and Social as depicted visually in the Kellehear Theory-Practice Integration Model (2011) leads to tunnel vision experienced by people feeling suicidal and homicidal to live in permanent hell on earth.

Learning Objective (2): We must live out the term of our natural life and stay human if we are to go to heaven, even if this means abstaining from activities and actions we enjoy and not coerce other or deceive them into providing consent when they are against the Law and inter-faith harmony and respect is necessary including Privacy and Confidentiality in Mental Health Multi-Disciplinary teams always.

References


Living with Dissociative Identity Disorder - Mapping Identities through art....'see through my eyes'.

Dianne Starick

Biography:
Dianne is a 66 year old female survivor, formerly a nurse, midwife and researcher, wife and mother until DID diagnosis, MVA, divorce, loss of career and identity ended that cycle of life, from the age of 47 years, and began the cycle of artist and personal researcher into life as a survivor of cult abuse.

'Dissociative identity disorder, formerly referred to as multiple personality disorder, is a condition wherein a person's identity is fragmented into two or more distinct personality states. People with this...condition are often victims of severe abuse.' [https://www.psychologytoday.com]. This is my understanding and my experience.

I have used art as the medium to understand the trauma which caused this anomaly, and how to lessen its effect. Drawing the vibrational energy of each identity, has helped to understand how we fit together, skills, roles and access to memories.

Mapping of these connections and how interrelationships occurred and were sustained helped in dealing with the difficulties throughout day-to-day living/surviving.

Slides:
1. Right-handed/left brain identities + Left-handed/right brain connections
2. Recognising each identity-faces
3. Mapping of skills and roles-compilation of drawings
4. Mapping how we work together-conceptually
5. Mapping problems

Combined with the diagnostic and treatment modalities of Psychiatry, Medication, Psychology, Counselling, EMDR, EFT of varied efficacy, art therapy has proven its worth. I have been able to adjust and adapt and survive with the hope that other people with DID could benefit from this lived experience.

Learning Objectives

Learning Objective (1): For the audience to visualize concepts of the use of colour as an identity tool and to 'see through my eyes' how this process has helped.

Learning Objective (2): How the use of identity mapping through art therapy can be used by Mental Health therapists to assist DID clients.

References

https://www.psychologytoday.com]

As this is a lived experience and not an academic perspective, there are no references.
Health Literacy: A neglected intervention in mental health care?

**Philippa Boss**

1University Of Sydney, Sydney, Australia

**Biography:**
Philippa is a health promotion worker guided by a social justice perspective and a desire to promote informed policy and practice. Her professional interests include advocacy and system improvement. She is completing a PhD on health literacy and cardiometabolic health in psychotic disorders at the University of Sydney.

The presentation will briefly outline the literature on health literacy and multi-morbidity in psychotic disorders. The aim of the presentation is to inform and educate people about the Health Education Literacy Program (HELP Intervention). The presentation will highlight the HELP study procedure, aims of the study and an overview of the HELP Intervention results. Education based health literacy interventions have a significant role to play in helping people with a psychotic disorder to access, engage and be empowered to self-manage their health, co-morbidities and recovery journey. Cardio-metabolic health literacy interventions that are multi-layered in design are needed in this population group to make a difference. Future research should focus on the strengths of multi-layered health literacy interventions in this cohort to support patient self-management and improved health literacy and recovery outcomes. Finally, effectively integrating these interventions into routine health care is needed and should be driven by service managers as part of a quality improvement process to demonstrate that health literacy is integrated into the service delivery model to improve individual and organisational health literacy outcomes to improve the continuity of care for patients of the mental health service.

**Learning Objectives**

Learning Objective (1): Overview of the literature on health literacy and multi-morbidity in psychotic disorders. Evaluation results to date on the impact of a health literacy intervention on cardiometabolic health, knowledge and access to medical care, in people living with a psychotic illness: a feasibility study undertaken in three different NSW mental health service settings.

Learning Objective (2): Outline how individual and organisational health literacy knowledge and skills fit within the vital work that is being done across all mental health facilities in NSW from acute settings to community settings and primary health settings.

**References**


Frances Sanders

Department Of Human Services Victoria, Melbourne, Australia

Biography:
Frances Sanders is the Senior Carer Adviser with the Office of the Chief Psychiatrist in Victoria. Prior to this she has worked leading NDIS business development, consumer and carer services and strategy and has held executive roles in the mental health and employment sectors since 1995.

The Victorian Mental Health Act 2014 sought to introduce and strengthen the rights of people with a mental illness. Building on International movements, the inclusion of Advanced Statements and the right to elect a Nominated Person were designed to provide support and protect consumers interests by ensuring people were able to exercise their rights and have their views and preferences about their treatment and recovery taken into account.

The roll out of the Mental Health Act was attenuated by an education strategy to enable service users and service providers to best understand and implement supported decision making, Advance Statements and nominated persons. Clinical services and peak consumer and carer bodies report a low uptake of these mechanisms and the need to evaluate compliance. This project sought to review the uptake and impacts of the provision for an advanced statement, nominated persons, including understanding of the enablers and barriers to implementation. This work is part of a broader suite of projects focused on consumer rights that will inform future actions by the OCP in enabling the Mental Health Act.

Learning Objectives

Learning Objective (1): To provide a platform for information exchange and dialogue between Government, consumers and carers and clinical service staff on perceptions of the implementation of advance statements and their usage of nominated persons including:

• compliance with The MH Act (2014), standards, guidelines and practice directions
• resources, education and training that support and promote advance statements
• share and seek feedback re: factors that influence, encourage or limit take up of advanced statements.
• promote local and international good practice and innovation

Learning Objective (2): This project provides important data and case studies from consumers and carers on the usage and usefulness of advance statements, enablers and impacts on mental health outcomes that can be used to inform human rights frameworks into the future.

References


The challenges and successes of a new Primary Integrated Care Supports (PICS) service in Camperdown, Sydney. Can a Credentialed Mental Health Nurse and a Peer Support Worker really make a difference?

Sophia Vanderwal

One Door, Sydney, Australia

Biography:
My name is Sophia van der Wal. I have been a mental health Nurse for the past 20 years working primarily in acute mental health inpatient units in Sydney’s Eastern Suburbs. I have recently gained invaluable experience in primary health care at the Matthew Talbot Homeless Men’s Hostel clinic. I am Credentialed Mental Health Nurse and have received my Masters’ degree in Mental Health Nursing from the University of Sydney. I am passionate about improving the health outcomes for Sydney’s homeless and mentally ill population.

Funding deficits across mental health services have resulted in chronic shortfalls in service provision. Primary Health Networks have been tasked some of the responsibility of managing service reform. Sydney’s Central and Eastern Sydney Primary Health Network (CESPHN) awarded One Door the Mental Health Nurse Incentive Programme (MHNIP) tender, now Primary Integrated Care Supports (PICS). PICS aims to provide clinical mental health services to people who are experiencing severe mental illness that live and work in the CESPHN. This programme works to improve integration between the client, the mental health services and G.P’s. The PICS service allocates a Credentialed Mental Health Nurse and a Peer Worker to identify individual need, to promote and support self-management with a view of avoiding hospitalisations for this at risk population. This paper wishes to explore the method and implementation, the challenges and successes of this innovative service delivery. The PICS package utilises a multi-pathway to care process. Additionally, this service aims to enhance the client experience by utilising care workers with lived experience of mental illness to supplement this specialty nurse service. The success of the pioneering CESPHN PICS service may result in mental health service reform into the future.

Learning Objectives

Learning Objective (1): The audience will be asked to come on a journey into the working life of a specialist nurse and peer worker to explore successes and failures for this innovative mental health service.

Learning Objective (2): This paper will signpost the outcomes the consumer may experience and how this ground-breaking service might become a blueprint for the future of enhanced integrated service provision.

References

Holistic Support through the Lens of an Early Intervention and Prevention Program: A Systemic Approach Supporting Children & Young People Whilst Recognising the Importance of Investing in our Parents and Community through Mental Health Education.

Allyson Ions¹, Stephanie Rankin¹

¹Baptist Care SA Family Mental Health, Adelaide, Australia

Biography:
Allyson Ions has a 20 year background in human services. She has worked in SA Health, DECD, private practice and in the last 5 years with Baptist Care, as Program Manager for Family Mental Health.

Stefanie Rankin holds a Masters of Psychotherapy and Counselling. Stefanie has been Team Leader of Family Mental Health for two years and still works with a small case load of clients.

Ally and Stef’s passion is working with families and children in the area of Early Intervention and Prevention of Mental Illness and are continually looking to innovate and to improve their practice.

Baptist Care have worked over the last four years with 4100 families and community in the Salisbury and Adelaide Central area through the Family Mental Health Support Program. We provide strength based, education and mental health outcomes for some of the most disadvantaged and vulnerable children, young people, and their families, recognising the importance of a holistic, well-being approach, addressing all the domains of well-being including those that do not fall in the mental health professional’s area of expertise. This emphasises the importance of working in partnership with all sectors to support families where they need it the most. Our programs are evaluated to continually improve and ensure best practice, and as a result have grown to be one of the most sought after services of its kind. We work hard to remove some of the barriers that the families face that prevent them from seeking the support they need, however we have a long way to go. Partnering with other agencies, and educating children and young people as well as their parents to recognise and know the signs that can lead to mental illness as a collaborative effort, creating opportunity to support our children to lead a meaningful life.

Learning Objectives

Learning Objective (1): Learn about how encouraging a holistic well-being approach to Mental Health can significantly improve the outcomes of a child and/or young person and their family through an Early Intervention and Prevention Perspective.

Learning Objective (2):
Q. How can Mental Health service providers improve the future of our children's well-being?
A. Service providers will understand the importance of using collaboration and partnership, to create innovative strategies, that will support an ongoing investment into our parents and the community to achieve the desired outcome.

References

Australian Research Alliance for Children and Young People.

The Mental Health of Young People in Australia, Sawyer et al, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000
Introducing Peer Support Workers as Members of Clinical Service Delivery Teams

Karen McCann¹
¹Metro South Addiction And Mental Health Services, Brisbane, Australia

Biography:
Karen McCann has been a carer for almost 30 years and has worked within mental health for 16 years, currently as Team Leader, Social Inclusion and Recovery, Metro South Addictions and Mental Health Services. Her interest areas include carer and family support, consumer/carer engagement, supervision of the lived experience workforce.

Peer support workers can ensure that a recovery-oriented focus is established and maintained in clinical service delivery teams. Metro South Addiction and Mental Health Services is the largest employer of peer support workers in a publicly funded mental health service in Australasia. The service employs peer support workers across both inpatient and community-based settings to deliver non-clinical care and support to consumers, carers and families. Their unique insights are also valuable to the multidisciplinary teams. In this paper, we will present our learnings about this process, with a focus on recruitment, orientation, training, maintaining a lived experience perspective, supervision and managing un-wellness. We anticipate that this knowledge will be important to other tertiary services that want to embark on a journey of utilising the lived experience of peer support workers to deliver recovery-oriented mental health care.

Learning Objectives
Learning Objective (1): People in the audience will learn that introducing peer support workers in tertiary mental health service delivery teams requires ongoing review and revision by service managers
Learning Objective (2): The issues that this paper raises that are relevant to mental health services include the importance of appropriately considering recruitment processes; operationalising the lived experience in the tertiary clinical care context; the importance of role orientation; supervision as a fundamental support mechanism for workers; managing un-wellness; and developing career support pathways.

References
Perspectives on the Introduction of Peer Support Workers into a Community Based Clinical Outreach Team

Karen McCann¹
¹Metro South Addiction And Mental Health Services, Brisbane, Australia

Biography:
Karen McCann has been a carer for almost 30 years and has worked within mental health for 16 years, currently as Team Leader, Social Inclusion and Recovery, Metro South Addictions and Mental Health Services. Her interest areas include carer and family support, consumer/carer engagement, supervision of the lived experience workforce.

The inclusion of peer support workers in clinical service delivery teams is important to ensuring that a recovery-oriented focus is established and maintained. In 2015 peer support workers were employed within a newly established clinical outreach team - the Logan Beaudesert Wellbeing Team. The service aims to support people experiencing significant mental health issues, as well as their families and carers. They provide intensive care and support in a community and home setting. Clinicians and peer workers from this service were interviewed, exploring two research questions: (1) “How is peer support work constructed in a multi-disciplinary clinical outreach team?” and (2) “How does a multi-disciplinary mental health clinical outreach team respond to the inclusion of peer support workers as team members?”

The research identified three main themes: the ability of peer support workers to navigate a legitimate place within the clinical outreach team; their value to the team once they established a legitimate place; and their ability to traverse the clinical care landscape. Ultimately, successful integration of peer support workers in the multi-disciplinary team was dependent upon the ability of clinical staff to focus on the unique strengths of peer support workers, in addition to their lived experience.

Learning Objectives

Learning Objective (1): People in the audience will learn that there are multiple ways in which peer support workers need to fit with clinical care teams to deliver recovery oriented care.

Learning Objective (2): The issues that this paper raises that are relevant to mental health services include that peer support workers are able to break down barriers by building unprecedented channels of effective communication between clinicians and consumers; and that clinicians must use a strengths-based approach to orient their perspectives and consider the myriad of strengths and possibilities that peer support workers use to enhance mental health care.

References


Views of Peer Workers on the Implementation of Recovery-Oriented Practice in Public Mental Health Service

Janice (Jaz) Chisholm1,2
1Eastern Health, Melbourne, Australia, 2Monash University, Melbourne, Australia

Biography:
Janice (Jaz) Chisholm is a Social Work Clinician in an Area Mental Health Service. She has a Master of Mental Health Science (Research) and is currently a PhD Candidate. Her research is in the area of peer worker and clinician views on the implementation of recovery-oriented practice. Jaz takes on the Recovery portfolio at her work and champions the implementation of recovery-oriented practice in the clinic in which she works. She has a keen interest in the contribution peer workers make to mental health practice and how their lived experience make a difference in the lives of those consumers recovering in their own individual ways. Her PhD research in in it's early stages and will expand to clinician views of the implementation of recovery-oriented practice, and depending on ethics approval, will include the views of consumers. Dr Melissa Petrakis is Ms Jaz Chisholm’s academic supervisor and shares her research time between Monash University and St Vincent Hospital in the area of mental health. She also teaches in the Department of Social Work.

Background
Commonwealth and state policy have mandated the implementation of Recovery-Oriented Practice (ROP). For the purposes of the present research, the implementation of ROP at Eastern Health is of interest because it is in its infancy and is imminent.

Aims
To achieve an understanding of the perspectives of peer workers about ROP prior to the implementation of the Collaborative Recovery Model (CRM) at Eastern Health.

Method
The research design was couched within a narrative approach and was exploratory and social constructivist in nature. A focus group including eight peer workers provided responses to semi-structured questions. The qualitative data was analysed for themes and content.

Results
The results demonstrated that the views of peer workers are potentially valuable in the implementation of ROP. The results showed peer workers add lived experience and can conceivably contribute to clinician uptake and practice of ROP. Some barriers to implementation were identified.

Conclusions
The present study contributes to the growing evidence that supports the inclusion of peer workers in mental health services. It suggests that the role of peer workers in the implementation of ROP is advantageous as their views provide vital indications of how mental health services can successfully implement ROP.

Learning Objectives
Learning Objective (1): The audience will learn, from a peer worker perspective, some of the aspects mental health services need to observe when implementing a recovery-oriented model.

Learning Objective (2): The topic is relevant to current mental health services as it focuses on the implementation of recovery-oriented practice in a public mental health service, which is state and national policy. It also addresses the mental health issue of the role of peer workers in this process.

References
Te Reo Hāpai - The Language of Enrichment

Keri Opai1
1Te Pou, Hamilton, New Zealand

Biography:
Keri Opai
Paeārahi Leadership
Tēnā koutou katoa
My iwi are Te Atiawa, Ngāti Ruanui (Taranaki), Waiohua (Auckland), Ngāti Te Ata (Waikato) and Ngāti Porou (East Coast).
My experience is predominately in education and I have been teaching te reo Māori and tikanga Māori since I was a teenager.
I was taught by elders from a young age and I am a licensed interpreter and have a Master’s Degree in Mātauranga Māori (Māori Knowledge).
My role at Te Pou o te Whakaaro Nui is to facilitate responsiveness to and engagement with Māori. A role I am relishing!
Kia ora tātou

What is the Māori word for autism? What is the Māori word for intergenerational trauma? Or Alzheimer’s or grief stress? Previously, these words didn’t exist in the Māori language.
In contemporary Aotearoa New Zealand there is an appetite for using the indigenous Māori language properly, correctly and with respect. This two year project, ‘Te Reo Hāpai – The Language of Enrichment’ has researched and created over 200 Māori words and terms that adequately and accurately reflect the best use of te reo Māori in the mental health, addiction and disability sectors in 2018 and into the future.
“He mana tō te kupu - words have great power” – my elders would often quote this whakataukī (proverb). Indeed, words have the power to explain, express and define how we understand and experience the world. If our knowledge and use of words is limited, inappropriate, outdated or unclear, this can be inherently conveyed in communicating our understandings and experiences.
Te Reo Hāpai is a ground breaking project creating a new glossary of words and terms of enriching language, contributing ‘words of great power’ in the Māori language from a strengths base and a mana (status, standing, pride, respect) enhancing Māori worldview for the benefit of tāngata whai ora (people seeking well-being). It is a unique indigenous contribution to mental health with approximately 6700 physical copies distributed throughout Aotearoa New Zealand and has had a global impact with approximately 2700 downloads worldwide and my translation ‘takiwātanga’ changing the way people around the world view the concept of autism:

https://www.facebook.com/storiesaboutautism/photos/a.745373108905889.1073741830.692577557518778/1422119797897880/?type=3&theater

The Te Reo Hāpai resource can be viewed and downloaded at:
https://www.tepou.co.nz/initiatives/te-reo-hapai-the-language-of-enrichment/169

Learning Objectives

Learning Objective (1): Presentation participants will come away with an appreciation of selected current Māori interpretations for terms in the mental health, addiction and disability sectors and an understanding of the indigenous creative and constructive process for the strength-based interpretations.
Learning Objective (2): Te Reo Hāpai is relevant to mental health services and mental health issues as it provides and offers for use in the mental health sector an alternative interpretation of words, terms and concepts based within a mana-enhancing, strengths-based Māori indigenous worldview. Many services in Aotearoa New Zealand are now using Te Reo Hāpai to inform their use of te reo Māori.
References

https://www.tepou.co.nz/initiatives/te-reo-hapai-the-language-of-enrichment/169
http://maoridictionary.co.nz/

There were some uncommon words that I have researched and can be found in the Māori dictionary above but the main focus of Te Reo Hāpai is creating new words and terms and therefore does not build on the work of others.
Reflections on the peer workers role - what is special about peer work in clinical mental health services?

Marianne Wyder¹, Karen McCann¹, Gabrielle Vilic¹, Carolyn Ehrlich², Steven Parker¹, David Crompton¹, Frances Dark¹
¹Metro South Addiction And Mental Health Services, Upper Mount Gravatt, Australia, ²The Hopkins Centre, MHIQ, Griffith University, Meadowbrooks, Australia

Biography:
Dr Marianne Wyder is a social worker with a background in sociology. Her research experience spans the health sector and includes expert knowledge on mental health issues, involuntary treatment, family breakdown and suicidal behaviours. She is currently employed as a Senior Research Fellow.

Karen McCann has been a carer for almost 30 years. Karen has worked within mental health for over 16 years and has an interest in the areas of carer and family support, community engagement and partnership, supervision of the lived experience workforce. She is currently employed as the Team Leader of Social Inclusion and Recovery.

A substantial peer workforce was introduced at two new community based residential rehabilitation units, known as Community Care Units (CCUs) in Brisbane, Australia in 2014-2015. The goal of this staffing approach was to allow consumers and the team to benefit from the lived experience of recovery. This project aimed to explore what peer workers believed their role brought to the team. Peer workers were provided with a template to capture significant interactions at the CCU, documenting: a description of the interaction/service provided; reflections on what was helpful (or not); and why they believed it was significant. Completion of these reflections was voluntary and not a requirement of their work. Reflections were analysed using a general inductive approach, leading to derivation of general themes, which were reapplied to the data to generate common case vignettes. This presentation will present these vignettes and highlight what is specific to the role of the peer worker in a clinical setting.

Learning Objectives

Learning Objective (1): People will gain an enhanced understanding of the role of peer workers within mental health rehabilitation settings.
Learning Objective (2): The peer support workers are a growing workforce and findings from this study will have implications for supervision and how best to support this role.

References

The questions we ask – the importance of including consumers voice in the topics we research.

Marianne Wyder¹, Carolyn Ehrlich², Gabrielle Vilic¹, Geoffrey Lau¹, David Crompton¹, Frances Dark¹

¹Metro South Addictions And Mental Health Services, Upper Mount Gravatt, Australia, ²The Hopkins Centre, MHIQ, Griffith University, Meadowbrook, Australia

Biography:
Dr Marianne Wyder is a social worker with a background in sociology. Her research experience spans the health sector and includes expert knowledge on mental health issues, involuntary treatment, family breakdown and suicidal behaviours. She is currently employed as a Senior Research Fellow.

There is a growing momentum towards involving mental health consumers as active members of research teams. In this study, we explored the research interest of peer support workers in comparison with allied health staff. We distributed a survey to all peer and allied health staff of a large metropolitan mental health service. The survey asked them to rate their interest in researching various topics such as causes of mental illness, basic medical research, medications and how health care professionals can best help those living with mental illness. A total of 97 valid responses were returned. Eighty one of these were from the allied health workforce (29%) and 16 from the peer support workforce (34%). Differences between the two workforces were tested with the Kruskal-Wallis test for independent samples. Both groups expressed similar interest levels in researching alternative treatments for mental illness. The peer workforce expressed greater interest in researching the best medications to treat mental illness; programs and services that are best suited to help those living with a mental illness; and, understanding the lived experience of recovery. This study highlights the importance of having the peer workforce actively involved in developing research questions that are relevant to the workforce.

Learning Objectives

Learning Objective (1): To ensure that the right questions are researched it is imperative to have consumer representation at all stages of the research process
Learning Objective (2): Finding better medication to treat mental illness with less side effects remains an important area of research
Good services aim at making themselves redundant.

Fay Jackson¹, Monique Diplock¹
¹Flourish Australia, Sydney, Australia

Biography:
Fay Jackson, General Manager Inclusion, Flourish Australia
Fay Jackson, is also Deputy Commissioner with the NSW Mental Health Commission, a National Consumer member and a Carer Reference Group member. She started work in mental health as a volunteer. Her first paid work was as a Peer Worker in a public mental health system.

Monique Diplock, Lived Experience Expert, Taree
Monique has a Cert IV in Mental Health Peer Work, a Diploma in Mental Health, is enrolled in a Bachelor of Science, Psychology Degree and aims to work in trauma informed care. She is an Expert by Experience, an Emeritus Member of the Flourish Australia Community Advisory Council.

Recovery-focused services support people to reach their full potential and to not be limited by the tyranny of anyone's low expectations. A truly recovery-focused service aims at making itself redundant in the lives of peoples who access their services.

People with lived experience often have poor self-esteem, we can feel embarrassed by our experiences and the way others have treated us. Our whisper can limit our opportunities. In time, this can lead to a low expectation of what might be achieved in our lives. We can become victims to the tyranny of our own low expectations. Services also need to guard against becoming 'uncomfortably comfortable' with the low expectations held by and for people with lived experience.

With the changes and reforms occurring in the mental health sector it is timely to open up a discussion about what it means to be supported to be truly independent - and the role services must play. This paper will open up a discussion about the importance of organisational focus and culture in supporting us to roar! - moving services from supporting people to prioritising becoming redundant in people's lives.

Learning Objectives

Learning Objective (1): People will gain a new philosophical approach to service design and delivery.
Learning Objective (2): This topic is relevant to mental health services because services need to have a considerably improved outlook on how high the bar should be set in delivering services that are focused on recovery in order to ensure that people reach their optimal potential?

References

Australian Government, 2010, 42 Principles of Recovery Oriented Mental Health Practice
National Standards for Mental Health Services 2010
Can the Revival of Indigenous Languages Improve the Mental Health and Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander People?

Alex Brown1, Emma Richards2, Stephen Atkinson2, Ghil’ad Zuckermann3, Seth Westhead1, Graham Gee4, Ngiare Brown1, Alan Rosen5, Michael Wright6, Michael Walsh7, Leda Sivak1

1Wardliparingga, South Australian Health & Medical Research Institute, Adelaide, Australia, 2Barngarla Language Advisory Committee, Port Lincoln/Port Augusta, Australia, 3Department of Linguistics, University of Adelaide, Adelaide, Australia, 4Victorian Aboriginal Health Service, Melbourne, Australia, 5Faculty of Health & Behavioural Sciences, University of Wollongong, Wollongong, Australia, 6School of Occupational Therapy, Social Work and Speech Pathology, Curtin University, Perth, Australia, 7Department of Linguistics, University of Sydney, Sydney, Australia

Biography:
Professor Alex Brown is an Aboriginal medical doctor and the Program Leader of Wardliparingga Aboriginal Research Unit at SAHMRI. He leads projects encompassing epidemiology, psychosocial determinants of chronic disease, mixed methods health services research and randomised controlled trials of pharmacological and non-pharmacological chronic disease interventions, in partnership with Aboriginal communities.

Ms Emma Richards is a Community Research Associate and member of the Barngarla Language Advisory Committee. She also works as an Aboriginal Research and Community Engagement Officer at the Adelaide Rural Clinical School of University of Adelaide, and has a strong interest in supporting the growth and empowerment of Aboriginal youth.

Mr Stephen Atkinson is Chair of the Barngarla Language Advisory Committee and Community Research Associate on the Barngarla Language and Wellbeing Study. His research interests include the history of Aboriginal experiences of early settler encounters. Stephen believes that children are the key to the revival and survival of Barngarla language.

Professor Ghil’ad Zuckermann is a world leader in Linguistics and the ground-breaking development of Revivalistics as an international trans-disciplinary research topic. He has travelled extensively, working with communities of many differing cultures and language traditions, helping Indigenous and other peoples who feel a sense of loss reclaim their linguistic traditions.

Mr Seth Westhead is an Awabakal and Wiradjuri man who works with the Wardliparingga Aboriginal Research Unit at SAHMRI. Seth holds a B.HSc from the University of Adelaide and is currently undertaking his MPH. His research focuses on Health Equity and Social and Cultural determinants of Aboriginal Health and Wellbeing.

Dr Graham Gee is an Aboriginal psychologist who works in clinical practice with vulnerable Koori people in Victoria. His research interests include complex trauma, resilience and recovery from trauma, mental health assessment in Aboriginal people, and Aboriginal social and emotional wellbeing.

The links between language loss and poor mental health have been demonstrated in many settings; however, little research has sought to identify the potential psychological benefits of language reclamation. To date there has been no systematic study of the impact of language revival on mental health and wellbeing. The revival of the Barngarla language on Eyre Peninsula, South Australia offers a unique opportunity to examine whether improvements in mental health and social and emotional wellbeing can occur during and following the language reclamation process.

This symposium begins with Barngarla reflections on their experiences of language loss and revitalisation, followed by an outline of the linguistic program of revival/istics with Barngarla communities. It then presents an overview of the study design, followed by a discussion of how wellbeing might be measured in relation to Indigenous language revival.

Abstract 1
The Barngarla Language Advisory Committee (BLAC) provides governance, cultural advice, conceptual input, community context and practical support (e.g. recruitment of participants) to the Barngarla Language and Wellbeing Study. BLAC
representatives from Port Lincoln and Port Augusta will present the context of language loss within Barngarla communities, with particular reference to the immediate and ongoing impacts of the Stolen Generations on Barngarla families and communities. They will then describe their involvement in Barngarla language reclamation activities including the development of a Barngarla dictionary app and participation in the Barngarla Songs Project, as well as community-based activities such as Welcome to Country, Yarniri Wilya (Barngarla youth movement), NAIDOC activities, community art exhibitions, dual-language community signage and the development of Barngarla language and culture centres. The presenters will then reflect on the individual, family and community impacts of reviving Barngarla language, commenting on changes in language use and observable improvements in social and emotional wellbeing. The presentation will conclude with reflections on Aboriginal involvement and guiding of the study.

Abstract 2
From the point of view of Indigenous empowerment and wellbeing, the presence of a fully fluent community that converses in all semantic domains of life is in many ways a secondary consideration. Essentially, the revival process is as important as the revival goals. Revivalistics is a new trans-disciplinary field that studies the universal constraints and mechanisms of language revival, as well as particular, locally-conditioned and culturally-specific nuances of language reclamation across various sociocultural settings. Revivalistics complements the established field of documentary linguistics, which records endangered languages before they fall asleep. This project revises usual linguistic fields by placing the Barngarla people (rather than the Western linguists) at the centre. Grammars and dictionaries should be written for language reclamation in a user-friendly way, aimed at the needs of community members rather than just for the use of professional linguists. By listening to Barngarla Elders, while learning, mapping and characterising the needs, desires and potentials of the target community, this language reclamation project is being guided by Aboriginal leaders to focus more on basic vocabulary and verbal conjugations than on sounds and word order.

Abstract 3
The Barngarla Language and Wellbeing Study is a five-year National Health and Medical Research Council funded project that aims to systematically assess the mental health and social and emotional wellbeing impacts of language reclamation with Barngarla people in South Australia. It has four objectives:
I. To further develop, deliver and evaluate language reclamation activities with Barngarla;
II. To explore the positive impacts of pilot language activities through semi-structured interviews with prior participants;
III. To review, adapt and/or develop quantitative methods for assessing mental health and social and emotional wellbeing in partnership with community Barngarla language experts; and
IV. To prospectively assess mental health and social and emotional wellbeing of community based language reclamation workshop participants over the course of the project.
This section of the symposium presents the overall study design and key findings from work to date, with particular emphasis on the findings of the semi-structured interviews with pilot participants.

Abstract 4
Following the semi-structured interview phase of the study described above, where the potential and perceived impacts of language reclamation were documented, the team used key themes from the interview findings to identify, review and adapt existing tools to assess mental health and social and emotional wellbeing in the target population and comparator communities. Each of these identified measures were then interrogated by community members for: face validity; cultural appropriateness; understandable response categories; brevity; ability to self-complete; prior use in cross-cultural settings; and robust psychometric properties. The draft assessment tool then proceeded through a facilitated focus group process with BLAC to clarify local idioms of distress, maximise the conceptual coverage, enhance a holistic understanding of the constructs, and ensure the cultural appropriateness of instruments, their items and response categories. This section of the symposium will describe the process and outcomes of this part of the study, with particular emphasis on community involvement in developing, testing, refining and endorsing the assessment tool.

Learning Objectives
Learning Objective (1): Those who attend this symposium will gain an understanding of the relationships between Indigenous languages and wellbeing. In particular, they will better understand: (1) the experiences of a specific Aboriginal language group (Barngarla) with regards to language loss and revival; (2) the ways that involving Aboriginal people in directing and guiding language revival can improve the accessibility of linguistics and the wellbeing of
Aboriginal community members; (3) the potential impacts of language revival from the perspectives of Aboriginal people who have been involved in language reclamation activities; and (4) the value of involving Aboriginal community members in the developing, testing, refining and endorsing of mental health and wellbeing assessment tools.

Learning Objective (2): Culturally appropriate assessment of mental health and social and emotional wellbeing within Aboriginal and Torres Strait Islander populations is of relevance to mental health services and providers alike, and this symposium describes a process for developing an appropriate assessment tool in collaboration with Aboriginal community members. Furthermore, as the potential psychological benefits of Indigenous language reclamation are not well understood, this symposium will provide preliminary results that begin to indicate some of these benefits.

References


Assessing the value of Step-Up Step-Down services in Western Australia.

Keren Wolstencroft\textsuperscript{1}, Hanh Ngo\textsuperscript{2}, Priscilla Ennals\textsuperscript{1}

\textsuperscript{1}Neami National, Preston, Australia, \textsuperscript{2}University of Western Australia, Perth, Australia

Biography:
Dr Ngo has instrumental experience in designing numerous research studies and analyzing and publishing data - the majority of which have a central focus on mental health. Dr Ngo contributed to the overall project design, navigation of health data access and ethics processes, independent data analysis and presenting findings to Neami.

Dr Ennals is the Senior Manager of Research and Evaluation at Neami National.

Ms Wolstencroft is Research Coordinator at Neami National and has responsibility for coordinating Neami’s research and evaluation portfolio. Ms Wolstencroft has been coordinating the project design and research protocol for this study with Dr Ngo since its inception.

In Australia, Step-Up Step-Down residential facilities (otherwise known as Prevention and Recovery Centres or PARC’s) have emerged as an option to meet consumers where they are at, either in terms of prevention thus minimising escalation of illness or need for acute care, or post-hospital support to sustain and strengthen their recovery and minimise potential for re-admission. Nevertheless, in Australia the evidence base for this type of service is currently limited.

In this presentation we share findings from a recent study evaluating the Joondalup Mental Health Step-Up, Step-Down (JMHSS) service in terms of its value to local health service systems and service users’ recovery and wellbeing outcomes. In addition to the use of the service’s internal database, linked administrative health data were also obtained from the Western Australian Data Linkage Branch and analysed for both JMHSS service’ users and their matched controls (who did not receive the service), to optimize the findings’ rigour.

Findings will be presented for (i) consumers’ self-reported measures for general psychological distress, general self-efficacy, work and social adjustment, and satisfaction with service; (ii) linked administrative health record data on patients’ deaths, hospital admissions, and presentations to hospital emergency departments; and (iii) the PARC program’s economic effectiveness.

Learning Objectives

Learning Objective (1): An understanding of the value of the Step-Up Step-Down (or PARC) model in terms of improving prevention and continuity of care options in local mental health service systems.

Learning Objective (2): The Step-Up Step-Down model of service demonstrates potential for strengthening the mental health sector’s ability to proactively address consumer crises, keep consumers out of hospital, and enabling them to lead contributing lives in the community.
Co-design, participatory design, Human Centred design, User Experience design: Exploring the emergent design intersections in mental health services.

**Ellen McNaught**

*Neami National, Preston, Australia*

**Biography:**

Ellen McNaught has worked in the community mental health sector for over 10 years and is currently the Senior Manager, Innovation and Projects at Neami National. In this role, she leads a team to deliver a range of innovations and projects in support of progressing organisational strategic objectives.

We are hearing more and more about social innovation and design. Government departments are engaging social innovation consultants to ‘design’ policies, large banks and retailers employ Service Designers to meet customer need, graphic designers are co-designing, and social innovation companies are designing new services that NGO’s are then adopting.

Mental health service providers also find themselves in a competitive funding environment that presents opportunity to innovate around how services have traditionally been designed and delivered. If liberated from existing constraints, could design thinking and practices offer mental health services something different? Can mental health services be ‘designed’ before they are delivered? Should they be? Could or would this lead to better outcomes?

This presentation aims to highlight and explore ideas, tensions and opportunities related to the intersection of ‘design’ and mental health services. These will be framed/exploried through particular projects and practices including the development of a health app for consumers and new service design for particular population groups.

**Learning Objectives**

- Learning Objective (1): Introduction to design thinking and approaches
- Learning Objective (2): Exploration of tensions and opportunities within the mental health sector relating to design
Collaborative Recovery Model principles to enhance the implementation of Individual Placement and Support (IPS) programs.

Kate Feder¹, Justin Newton Scanlan², Priscilla Ennals¹
¹Neami National, Preston, Australia, ²The University of Sydney, Sydney, Australia

Biography:
Justin Newton Scanlan: PhD, MHM, BOccThy. Justin is an occupational therapist and is Senior Lecturer and Course Director for undergraduate occupational therapy at The University of Sydney.

Kate Feder: MDS, BA (Hons1). As Employment Services Manager at Neami National, Kate developed the WorkWell employment program based on the Individual Placement and Support model, which has been integrated into Neami outreach services across NSW.

Dr Priscilla Ennals: Dr Ennals is the Senior Manager of Research and Evaluation at Neami National. Her research interests include collaborative qualitative research with people with lived experience of mental ill-health and distress.

Individual Placement and Support (IPS) is an evidence-based model of supported employment specifically designed for individuals experiencing severe mental illness who have the desire to work. Despite strong support for IPS in Australia challenges have been encountered in implementing IPS into practice. Neami National commissioned a study with The University of Sydney to evaluate the outcomes achieved by participants engaged with the WorkWell employment program. In addition to following IPS principles, WorkWell is informed by principles of the Collaborative Recovery Model (CRM).

A total of 97 participants were engaged with the program. Almost half of all participants (n=48, 49.5%) gained a competitive employment position in a wide range of roles. Average employment duration was 151 days (21.6 weeks) and average weekly wage was AU$478. These outcomes compare favourably to results reported in the international IPS literature and are higher than outcomes achieved by numerous other IPS programs in Australia. The addition of principles from the CRM appear to have enhanced the ability of job coaches to identify participants’ strengths and desires and assisted in supporting positive outcomes for participants.

Learning Objectives

Learning Objective (1): An understanding of how using a recovery framework can enhance employment outcomes for individuals with severe mental illness.

Learning Objective (2): The WorkWell employment program demonstrates how mental health services in Australia can successfully provide employment support to individuals with severe mental illness who have the desire to work.

References


Community Mental Health Support at the Neighbourhood Justice Centre

Scott Nelson¹
¹Neami National, Melbourne, Australia

Biography:
Employed at Neami for three years, Scott has developed and implemented the Intensive Mental Health Outreach Support Service at the Neighbourhood Justice Centre. Scott has a passion for supporting people who come into contact with the criminal justice system to achieve a meaningful life based on their values.

The Neighbourhood Justice Centre (NJC) in Collingwood, Victoria provides a unique approach to criminal justice in Australia. The centre combines a court with support services and community initiatives designed to prevent and reduce crime, improve safety and increase confidence in and access to the justice system.

Neami National partnered with the Neighbourhood Justice Centre in 2014 to develop the Intensive Mental Health Outreach Support Service (IMHOSS) to provide assistance to people who experience mental or cognitive health issues. IMHOSS offers practical support to consumers to navigate the community and improve access to services, resources and supports. The service seeks to address the underlying factors behind offending by supporting people to improve their health and wellbeing and in so doing also reduce reoffending.

IMHOSS is situated within the NJC’s Client Services Team and compliments the variety of co-located agencies including Berry Street, St Vincent’s, CoHealth, Odyssey House and Launch Housing. IMHOSS works collaboratively with consumers, Magistrates, Community Correctional Services, lawyers and the Client Services Team to provide streamlined and comprehensive support.

This presentation will outline the Neighbourhood Justice Centre model and provide case study examples of how the Intensive Mental Health Outreach Support Service provides assistance to people in this context.

Learning Objectives
Learning Objective (1): Participants will gain an understanding of the Neighbourhood Justice Centre’s approach to criminal justice and the role that community mental health services can play in this environment.
Learning Objective (2): Mental health issues are an underlying factor influencing criminal offending. Community mental health services can play an important role in supporting people to manage their mental health and reduce rates of reoffending.

References
N/A
Improving early engagement of young people at risk of severe mental health concerns: A PHN funded service in Melbourne

Joel Robins¹, Wendy Slinger²
¹Eastern Melbourne Primary Health Network (PHN), Box Hill, Australia, ²Neami National, Preston, Australia

Biography:
Joel Robins is Mental Health Manager – Youth and AOD, Eastern Melbourne Primary Health Network. Joel is a Mental Health Social Worker has a background in managing community mental health and AOD services. Previously managing the Eastern Melbourne PIR program, Joel’s interests are in service design and innovation. Joel’s current role involves planning a commissioning mental health and AOD services for EMPHN.

Wendy Slinger is a Regional Manager at Neami overseeing YFlex, as well as Northern Prevention & Recovery Care Unit in Preston, Wadamba Wilam (Breaking the Cycle) and Me Well (Neami’s NDIS service provision subsidiary).

A service improving early engagement of young people experiencing/at risk of experiencing severe mental health concerns, including early psychosis, was identified as a priority by Eastern Melbourne Primary Health Network. As a result, Neami National was engaged to deliver the YFlex program to young people in this area. The YFlex program us currently supporting a cohort of young people who are experiencing significant anxiety, suicidal ideation or self-harm, and significant rates of disengagement from education. A small proportion of these young people are also experiencing early of emergent psychosis. This presentation will describe the early operation of the service the YFlex service delivered by Neami National. The presentation will focus on the learnings and needs of young people in this area of Melbourne and discuss the successes of using a flexible outreach model to overcome identified barriers to service. Examples of how YFlex staff are flexibly persisting to engage with young people who are unwilling or unable to engage with existing services will be shared. This service is building understanding of the needs and ways of working with this cohort that can be hard to reach, and is successfully connecting with many of them, their families and support networks.

Learning Objectives
Learning Objective (1): An understanding of strategies used to engage young people experiencing/at risk of severe mental health concerns and the outcomes being achieved by young people participating in the service.
Learning Objective (2): The YFlex service demonstrates that flexible outreach models are promising approaches in overcoming identified barriers to service and working to support young people who are unable to engage with existing services.
Kick the Habit: Trialling a new approach to supporting people to reduce or quit smoking

Priscilla Ennals¹, Keren Wolstencroft¹, Francis Mitrou²
¹Neami National, Melbourne, Australia, ²The Telethon Kids Institute, Perth, Australia

Biography:
Dr Ennals is the Senior Manager of Research and Evaluation at Neami National. Her research interests include collaborative qualitative research with people with lived experience of mental ill-health and distress.

Keren is Research Coordinator at Neami National. In this role Keren oversees the implementation of multiple research projects from development through to analysis, report writing, dissemination and making recommendations for translation into practice. Her work revolves around projects that can improve outcomes for people experiencing mental illness through the growth of an evidence base for recovery-oriented psychosocial rehabilitation and wellbeing.

Francis is a Senior Research Fellow with the ARC Centre of Excellence for Children and Families over the Life Course (The Life Course Centre). He has many years’ experience in the conduct and analysis of large scale population surveys, analysis of linked administrative data, Indigenous statistics, and economic evaluation, with a focus on mental health, tobacco addiction, and social inequality and life course trajectories.

There is extensive research demonstrating that smoking contributes to significant health, economic, and social disadvantage. However, despite thirty plus years of increases in tobacco tax levies and public health messaging around tobacco-related harm; smoking rates for people living with mental health illnesses have not been impacted in the same way as for the general Australian population.

In partnership with leading epidemiological researchers from the University of Western Australia, Neami National have been trialling a new approach to support people living with mental illness to reduce or quit smoking. The program combines knowledge about best practice in smoking cessation practice and feedback about the successes and failures from other smoking programs delivered in a mental health service context.

Kick the Habit includes one on one coaching support with consumers to develop and implement an individualized smoking management plan based on a person’s own goals and reasons for reducing or quitting. In addition consumers are supported to use NRT to minimise symptoms associated with nicotine withdrawal and reduce contraindication of mental health symptoms.

This presentation will provide findings from a pilot study exploring the effectiveness of the Kick the Habit approach along with key learnings to improve implementation of smoking cessation programs.

Learning Objectives
Learning Objective (1): The audience will gain an understanding of the key elements of the Kick the Habit approach along with an understanding of the successes and challenges of designing, piloting and implementing a smoking program in mental health services.
Learning Objective (2): Mental health service user feedback demonstrates that there is often a desire to quit or cut down and yet health care services often appear reluctant or ill equipped to prioritise support for tobacco use behavior change. There is a need to strengthen knowledge and practices that can support people living with mental illness to change smoking behaviours.
Pursuing zero homelessness in Adelaide - Street to Home and Adelaide Zero Project.

David Pearson¹, Marion Kennedy²
¹Don Dunstan Foundation, Adelaide, Australia, ²Neami National, Adelaide, Australia

Biography:
David Pearson is the Executive Director of the Don Dunstan Foundation. It is an independent thought leadership organisation working on collaborative projects, such as the Adelaide Zero Project, to inspire action for a fairer world and build on the legacy of Don Dunstan. The Foundation’s current priority areas include Mental Health and Homelessness.

Marion Kennedy is a social worker with a background in mental health in both the government sector and the not for profit sector. More recently Marion has been involved in managing a crisis respite service and currently in the role of manager at Street to Home at Light Square with Neami National.

In 2015/16 52% of people sleeping rough who presented to specialist homelessness services in inner city Adelaide reported they were living with mental health issues. As a specialist mental health service with a long history of working with people with complex needs, Neami National recently commenced the delivery of Adelaide’s Street to Home service. Street to Home provides assertive outreach, case management, primary health services and pathways to assist people who are rough sleeping with housing outcomes. Neami National is a partner of the Adelaide Zero Project which aims to achieve and sustain Functional Zero street homelessness (rough sleeping) in inner city Adelaide by the end of 2020 through core components including by-name data, systems integration and a commitment to housing first. The Project is taking a collective impact approach with Don Dunstan Foundation as the backbone organisation. Through the Project, Adelaide is recognised globally as a Vanguard City by the Institute of Global Homelessness’ A Place to Call Home Initiative. This presentation will share early learnings from Street to Home and Adelaide Zero Project, as well as international learnings and local plans to achieve Functional Zero rough sleeping.

Learning Objectives

Learning Objective (1): International evidence, innovation, collective impact and early local learnings about a functional zero approach to housing people living with mental illness and sleeping rough.
Learning Objective (2): A significant portion of people sleeping rough live with mental illness, dual diagnosis and complex needs requiring assertive, collective and innovative approaches to achieve housing and recovery outcomes.

References

Knotts & Thompson (2017) “Case Study: Bergen County, New Jersey, first community in the US to end chronic homelessness”, Monarch Housing Associates 2016, 2017; Pinto 2017

Steps to Wellbeing - Flexible coaching towards wellbeing for people with depression and anxiety.

Kath Currey¹, Craig Russouw²
¹Neami National, Preston, Australia, ²Eastern Melbourne Primary Health Network (PHN), Box Hill, Australia

Biography:
Kath Currey is the Service Manager of Neami Steps to Wellbeing. Kath has been working in a range of community mental health services for the last 10 years and prior to this role was managing one of Neami’s Mental Health Community Support Services (MHCSS) in the north east. Kath has been involved in the implementation of Steps to Wellbeing from the initial establishment in July 2017.

Craig Russouw is Mental Health Manager - High Prevalence / Low intensity at Eastern Melbourne Primary Health Network (PHN). Over five years, Craig has managed psychological and intake services for Eastern Melbourne PHN and Eastern Melbourne Medicare Local. Previously he worked in private practice as a psychologist and in a number of project and coordinator roles.

Steps to Wellbeing is an innovative approach to delivering low intensity mental health supports to people who are experiencing, or at risk of developing, anxiety and depression. Steps to Wellbeing is an early intervention and prevention service that utilises a coaching approach to improve wellbeing by supporting people to work out what is wrong, develop skills, and move forward with their lives. The service is delivered by Neami National throughout Northern and Eastern Melbourne. It is funded through the Eastern Melbourne Primary Health Network (PHN). The service offers a range of flexible engagement methods including phone coaching, online coaching and after hours sessions. The team of wellbeing coaches includes a lived experience workers that are providing a valued and unique support option.

This presentation will describe the interventions used, strategies for engagement and partnership when implementing the pilot, service utilisation, and the outcomes achieved for people using the service. It will highlight the benefits of utilising digital and flexible engagement methods in service delivery and the role of the peer workforce in this space. Approaches to capacity building and promotion of the service to the general community and priority populations will illustrate both progress and challenges.

Learning Objectives

Learning Objective (1): An understanding and a fresh perspective of delivering low intensity mental health support and ideas on how to engage with the community and PHN partnerships.
Learning Objective (2): The Steps to Wellbeing service demonstrates potential to reduce the burden of mental ill-health in Australia and to provide an innovative and cost-effective approach to supporting people with low-intensity/high-prevalence mental health issues.
The ‘Welcoming In’ Project – developing safe and inclusive service environments.

Katie Larsen\textsuperscript{1}, Tina Grech\textsuperscript{1}
\textsuperscript{1}Neami National, Preston, Australia

Biography:
Katie Larsen is currently the Manager of Innovation and Projects at Neami. She is passionate about supporting service provision that responds to key issues of diversity and inclusion informed by social justice and social impact thinking. Katie holds a Bachelor of Arts (Journalism) and Master of Social Work.

Tina Grech is a Project Officer in the Innovation and Projects Team at Neami National. Tina has worked in the community mental health sector for over six years and has an Occupational Therapy and Psychological Science background. Tina has a strong passion for enabling minority groups to have a stronger voice in the provision of mental health services and in the workplace.

The ‘Welcoming In’ Project is investigating the experiences of marginalised, vulnerable populations in relation to service access, recognising that in mainstream mental health environments their experiences are often assumed, misunderstood or unnoticed.

With a focus on LGBTIQ, Aboriginal and/or Torres Strait Islanders, Culturally and Linguistically Diverse people/communities, people living with disability and/or carers/family, this project aims to support the delivery of consistently inclusive Neami Group services that recognise the unique needs of these priority population groups within an intersectional lens.

This presentation will share findings and developments that raise the profile of the voices of consumers/carers who face a range of barriers to mental health service access. We will demonstrate how we combined human centred design thinking and consultation processes with the culture of reflective practice employed in Neami’s service delivery model to embed values of curiosity, diversity, empathy, self-awareness and learning into service improvement and quality assurance processes. We will share common themes identified through project outcomes, including the value of lived experience workforces and the visibility and naming of diversity of experience. We will conclude with insights from our chosen evaluation method - Most Significant Change – selected to challenge power structures and question assumptions of change.

Learning Objectives

Learning Objective (1): Audiences will gain insight into how design thinking and lived experience perspectives can contribute to new approaches in providing safe, welcoming and accessible services for marginalised people and communities. When identifying what matters most to those who access services, it is crucial to ask questions of people who are most in need of the service.

Learning Objective (2): The topic is critical for the mental health sector as people who identify as LGBTIQ, Aboriginal and/or Torres Strait Islander, CaLD and/or are living with disability continue to face disproportionate rates of psychological distress and reduced wellbeing, yet remain underrepresented in mainstream health services. Increased experiences of inclusion and access to mental health services must be supported by moving beyond ‘treating everyone the same’ to understanding and responding to unique barriers and experiences, with an intersectional lens.
What matters in youth mental health residential settings? Centring the voices of young people.

Carolien VanDijk¹, Philippa Hemus¹, Rebecca Egan¹
¹Neami National, Glen Waverley, Australia

Biography:
Carolien VanDijk is Regional Manager of Southern Victoria, Neami National.
Philippa Hemus and Rebecca Egan are young people who are members of the Steering Committee on this project.

Neami National provides support to 40 young people in 4 therapeutic residential settings in Melbourne. In partnership with Orygen and The National Centre of Excellence in Youth Mental Health, a co-produced, participatory action research process has explored what matters to young people and staff in these settings. A steering group of 3 young people, 2 staff and 2 researchers oversaw the project.

The findings highlight the importance of real relationships as enablers to young people feeling safe, feeling known and feeling that they belong. Real relationships allow young people to exercise agency as experts of themselves as they work out their goals and directions and develop skills required for their future.

The findings provide guidance around meeting the fluctuating needs of young people and tell us that young people experience ‘the work’ of skill development every day, not only in defined therapeutic encounters. The findings have allowed staff to have new insights that have resulted in changes to routines and practice. The learnings underpin the development of outcome measures that measure what matters in order to ensure the individual needs of young people are met. This project demonstrates how embedded participatory action research can positively impact service delivery and consumer outcomes.

Learning Objectives

Learning Objective (1): The audience will understand what matters in youth residential settings from the perspectives of young people who use these services and how services can better deliver on the things that matter.
Learning Objective (2): Youth services are most often designed without considering the views of the young people who use them. This project centres youth voice to ensure the views of young people are understood and that services are (re)designed around what matters.

Raffael Di Batolomeo

1Neami National, Perth, Australia

Biography: Raffael Di Batolomeo is the Manager of the Perth Metropolitan Suicide Prevention Coordination Program delivered by Neami National through the Western Australian Mental Health Commission.

Working with community is at the heart of work in suicide prevention. Since 2016, the Western Australian Mental Health Commission has funded Suicide Prevention Coordinators to address the needs of local communities. Working in suicide prevention with intricate, overlapping communities across a large population requires us to think differently about the construct of ‘community’, to draw on evidence-based and evidence-informed approaches and frameworks while also listening for and harnessing local expertise.

This presentation details the methodology utilised by the Perth Metropolitan Suicide Prevention Coordinator (SPC) Program. It builds on current research and developments by demonstrating how these can be implemented in an urban setting at a grass roots level. It uses the method of Complex Systems Theory that demands we avoid simplistic solutions, and instead look for the complexity, and creatively and collaboratively address inevitable barriers. We have operationalised a framework that acknowledges and values all current stakeholders and their contexts, increasing the level of coordination and collaboration that is possible. Efforts to develop this shared understanding are now paying off in strong collaborations with 34 stakeholder organisations, new partnerships and direct positive action. Some examples of these will be shared.

Learning Objectives

Learning Objective (1): The audience will understand the basics of Complex Systems Theory and how this was operationalised to strengthen coordination and collaboration towards suicide prevention in Perth.

Learning Objective (2): Preventing suicide is a high priority issue in Australia and the range of approaches that are demonstrating positive impact locally require wide dissemination and debate.
Measuring the Impacts of Indigenous Language Reclamation on Aboriginal and Torres Strait Islander Social and Emotional Wellbeing.

Alex Brown, Ghil’ad Zuckermann, Ngiare Brown, Graham Gee, Alan Rosen, Emma Richards, Stephen Atkinson, Michael Wright, Michael Walsh, Leda Sivak, Seth Westhead

1Wardliparingga, South Australian Health & Medical Research Institute, Adelaide, Australia, 2Department of Linguistics, University of Adelaide, Adelaide, Australia, 3Victorian Aboriginal Health Service, Melbourne, Australia, 4Faculty of Health & Behavioural Sciences, University of Wollongong, Wollongong, Australia, 5Department of Linguistics, University of Sydney, Sydney, Australia, 6School of Occupational Therapy, Social Work and Speech Pathology, Curtin University, Perth, Australia, 7Barngarla Language Advisory Committee, Port Lincoln/Port Augusta, Australia

Biography:
Ms Leda Sivak is the Study Coordinator for the Barngarla Language and Wellbeing Study, working within the Wardliparingga Aboriginal Research Unit at SAHMR. Leda holds a BSc in Neuroscience and BAHons, MA in Anthropology from the University of Otago and is presently enrolled in PhD studies at University of Adelaide.

Mr Seth Westhead is an Awabakal and Wiradjuri man who works with the Wardliparingga Aboriginal Research Unit at SAHMRI. Seth holds a B.HSc from the University of Adelaide and is currently undertaking his MPH. His research focuses on Health Equity and Social and Cultural determinants of Aboriginal Health and Wellbeing.

Traditional languages are a core part of Indigenous peoples’ cultural expression, autonomy, identity and spiritual and intellectual sovereignty, and as such, are vital to wellbeing. The links between language loss and poor mental health have been demonstrated in many settings, including Australia, where high levels of acculturative stress have been seen in Aboriginal and Torres Strait Islander children living in regional centres where language loss was occurring. However, little research has sought to identify the potential psychological benefits of language reclamation. To date there has been no systematic study of the impact of language revival on mental health and wellbeing. The Barngarla people of the Eyre Peninsula in South Australia are one example of Aboriginal people suffering the effects of linguicide. In response, Barngarla have been working with a linguist/language revivalist since 2012 to reclaim, re-learn, document and transmit their language to the next generation. This poster presents the study design and preliminary findings of the Barngarla Language and Wellbeing Study, which aims to systematically assess the mental health and social and emotional wellbeing impacts of language reclamation with Barngarla people involved in language reclamation and a comparator group of Aboriginal people residing in Eyre Peninsula, South Australia.

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation? Those who view this poster will gain a better understanding of how to measure the social and emotional wellbeing (SEWB) and mental health impacts of reclaiming Indigenous languages.

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues? Culturally appropriate assessment of mental health and social and emotional wellbeing within Aboriginal and Torres Strait Islander populations is of relevance to mental health services and providers, and this poster provides a study design for developing appropriate methods for measuring the impacts of Indigenous language reclamation on mental health and SEWB.

References


Developing a digital toolkit to enhance mental health and well-being.

Heidi Sturk¹, David Kavanagh¹
¹Queensland University Of Technology, Brisbane, Australia

Biography:
Heidi has a Masters in Organisational Psychology and is the Project Manager of eMHPrac (e-Mental Health in Practice). This federally funded project provides training and support on digital mental health resources to Allied Health Practitioners, General Practitioners and service providers working with Aboriginal and Torres Strait Islander people.

Digital mental health (dMH) comprises services, programs or applications that may be self-driven or guided by a clinician or other support person. dMH interventions are an appropriate option for a) people who have an increased risk of developing mental health issues, or b) who are already experiencing mild to moderate mental health issues. dMH may be used by consumers prior to engaging with mental health professionals, as an adjunct to therapy, or be used by practitioners as a tool to assess, or otherwise engage a client during sessions.

This ‘how-to’ workshop aims to introduce some of these resources in an interactive, hands-on way, so that professionals and consumers can begin to develop their own digital toolkit for good mental health. The session will include group discussion, activities and a web tour. Participants will be encouraged to test out new skills using ipads/notebooks, smartphones or laptops. This workshop also highlights a range of dMH resources developed specifically for use with Aboriginal and Torres Strait Islander people.

Please note: some iPads and laptops will be available, however, participants are encouraged to bring their own iPad/notebook, laptop or smartphone for the ‘discovery’ section of the workshop.

Learning Objectives
Learning Objective (1): Participants will learn how to develop a digital toolkit of relevant mental health resources.
Learning Objective (2): Participants will have a greater awareness of how to utilise digital mental health resources in order to improve mental health for others or for themselves.

References
True co-design starts with one question.

Fay Jackson1, Matthew Salen1, Jade Ryall1, Michael Wren1, Kim Jones1
1Flourish Australia, Sydney, Australia

Biography:
Fay Jackson, General Manager Inclusion, Flourish Australia
Biography: Fay Jackson, General Manager, Inclusion, Flourish Australia, also Deputy Commissioner with the NSW Mental Health Commission and a member of the National Consumer and Carer Reference Group, started work in mental health as a volunteer. Her first paid work was as a Peer Worker in a public mental health system.

Matthew Salen, Cluster Manager Southern NSW, Flourish Australia
Biography: Matthew Salen, Cluster Manager Southern NSW, Flourish Australia commenced his career with Flourish Australia as a Support Work, progressing to Manager and onto his present position. Matthew is extremely dedicated to advocacy and co-design.

Kim Jones, Project Officer, Inclusion, Flourish Australia
Biography: Kim Jones, Project Officer, Inclusion, Flourish Australia and has worked in mental health for more than eleven years. She has worked in disability sectors with extensive experience working with people experiencing Autism. In her current role, Kim uses lived experience to enable her to further contribute to Community led organisations.

Jade Ryall, Manager, Back on Track Health, Flourish Australia
Biography: Jade Ryall manages Flourish Australia's Back on Track Health Program, providing centralised resources for information and coaching around physical health and wellbeing. Jade is an Occupational Therapist, has worked in community based mental health for all her career, commencing at Flourish Australia's centre-based activity programs at Buckingham House, Surry Hills.

Michael Wren, Lived Experience Expert, Emeritus Community Advisory Council Member, Bathurst
Biography: Michael Wren is an Expert by Experience, Lived Experience Systemic advocate. He is an Emeritus member of the Flourish Australia Community Advisory Council and member of the Social Citizenship Think Tank. He holds certificates in IT and is a valuable member of the Flourish Australia community.

In recent years the term co-design has become more prominent in the language used in mental health service design and development. Most services believe they 'do co-design', however when carefully examined it can be 'partial co-design' at best and fall short of including co-design principles at every stage and level of the process. Co-design begins at the very conceptualisation of the issue to be addressed, not part way in. Engaging with respectful, generous co-design from the very beginning of the design process, through all stages of the design, review processes, accountability, feedback and research, services will better ensure the needs of individuals, families, carers and communities involved with those services are met.

Flourish Australia is committed to co-design. In our experience it starts with one fundamental question, "What are the questions we need to ask?". Asking the wrong questions and surmising that 'we' (the service) know what the issues and solutions are, have been major contributing factors to poor service design and outcomes for people accessing those services.

We will share the challenges faced and how we have overcome them, our learning along the way, the unexpected and innovative outcomes of the co-design process.

The workshop comprises of the facilitators and members of the Flourish Australia Social Citizenship Think Tank.
This workshop will explore the co-design principles and practical steps Flourish Australia has undertaken to ensure our Social Citizenship Framework and service delivery model is truly co-designed at every stage and level.

**Learning Objectives**

Learning Objective (1): The delegates will gain a new and deeper understanding of what true co-design is.

Learning Objective (2): This topic/issue relevant to mental health services and mental health issues because it is only through true co-design that services will improve in the way that the people accessing those services need.

**References**

Hagen, P., & Rowland, N., 2011, Enabling Co-design

Flourish Australia, 2016, Strategic Plan 2016-2019

Participatory design - Wikipedia
https://en.wikipedia.org/wiki/Participatory_design
Recognising and Responding to Deterioration in a Person's Mental State

Andrew Moors¹

¹Australian Commission On Safety And Quality In Health Care, Sydney, Australia

**Biography:**
Andrew has worked in the Commission’s mental health program for six years. Prior to this Andrew worked as a mental health nurse in a range of roles in inpatient and community services. Andrew has completed a PhD on how language practices influence people’s experience of mental health care.

The Council of Australian Governments established the Australian Commission on Safety and Quality in Health Care (the Commission) to lead and coordinate national improvements in the safety and quality of health care. The Commission’s work in mental health is embedded in the National Safety and Quality Health Service (NSQHS) Standards (second edition).

There is evidence that many people who experience deterioration in their mental state are further traumatised by interventions delivered by health services, even when these interventions are implemented within existing national and jurisdictional guidelines. The NSQHS Standards include new actions to support health services to deliver safe and effective responses.

The Commission developed a National Consensus Statement: Essential elements for recognising and responding to deterioration in a person’s mental state. This describes the processes a health service can implement so that members of the workforce can work collaboratively with people who experience mental health issues, their families and carers, to recognise the individual’s early signs of deterioration in mental state. They can then collaboratively plan, implement and evaluate a response that is safe and effective, consistent with the principles of person-centred, recovery-oriented and trauma informed care. This approach will contribute to the national aim of eliminating restrictive practices.

**Learning Objectives**

Learning Objectives (1): People in the audience will learn about a proposed approach to the complexity of recognising signs of deterioration in a person’s mental state.

Learning Objectives (2): Collaborating with a person to provide safe and effective response when their mental state deteriorates is a key role for mental health services.

**References**


Emerging Minds, National Workforce Centre for Child Mental Health: Meeting the challenge to support mental health across the life span, starting with infants and children. Building workforce capacity to consider child mental health through promotion, prevention and early intervention.

Helen Francis¹, Ruth Crooke¹

¹Emerging Minds National Workforce Centre for Child Mental Health, Hilton, Australia

Biography:
Helen Francis has background in Homelessness, Child and family, Foster and residential care and Aboriginal services. With extensive experience in child and family mental health, training and development. The last 8 years have focused specifically on workforce development initiatives such as Children of Parents with Mental Illness with Emerging Minds.

Ruth Crooke has worked in child and adult disability services as well as Health Promotion/project officer roles, children and families mental health, the non government sector in South Australia in Child protection and early intervention family support services. With a mix of case work and senior supervisory and manager positions.

Mental health is an integral part of overall health for children, just as it is for adults. Prevention and intervention are vital elements in improving infant and child emotional and social wellbeing, and help to prevent the development of mental illness as they journey into adolescence and adulthood.

There is substantial research documenting the association between adult problems and poor outcomes for children’s mental health. Parental alcohol and substance misuse, mental health problems, family violence and homelessness are commonly described as ‘key risk factors’ for child mental health. However, children’s needs are often ‘invisible’ in many services where these parents may present facing adversity. Identifying the needs of children is central to national policies and guidelines, and highlighted as ‘every professional’s responsibility’ in the National Framework for Protecting Australia’s Children, 2009-2020. This perspective also features in other key documents such including the National Homelessness Strategy, National Mental Health and Suicide Prevention Plan and early childhood frameworks. Effective implementation of evidence-based interventions is of the utmost importance in shifting the workforce practice and culture towards ‘keeping child mental health in mind’ across all service sectors.

Therefore it is important to engage the workforce to influence attitudes and beliefs about child mental health by building an understanding of the correlation between adult problems on parenting, how this in turn has an effect on the parent-child relationship and consequently how this contributes to mental health outcomes for infants and children.

You can help make a difference.

Whether you work with children (0-12 years), with adults who are parents/carers, or with families; you have a crucial role to play in strengthening infant and child emotional and social wellbeing, and improving the capacity to assess, support and identify when a child may be at risk of developing mental health difficulties.

The challenge is to provide the right service at the right time to families with vulnerabilities so that parenting can be supported, the effects of trauma and harm can be reduced, and the social and emotional wellbeing of children is supported.

This workshop will use video case examples to promote practitioner and organisational conversations to ‘keep the mental health of children in mind.’

This engaging interactive workshop will utilise:
• learning activities using video case examples
• a systems approach to supporting implementation, organisational and practice change aimed to improving mental health outcomes for children.

The aim of this workshop will be to engage with practitioners and organisations to promote quality improvement strategies so that parenting practices can be enhanced, infant and child mental health supported and the effects of trauma and harm reduced.

**Learning Objectives**

Learning Objective (1):
Following completion of this workshop, participants should be able to support conversations within organisations exploring:
• the impact of adult issues on children’s wellbeing and development
• understand their role in supporting parenting, the parent-child relationship by ‘keeping child mental health in mind’ to influence outcomes for children and their families

Learning Objective (2):
• Raise awareness about how adult issues can potentially impact on child mental health.
• Extend practitioner’s thinking so that both parenting and child mental health are considered as part of an intervention with adult clients who are parents.
• Understanding how the free eLearning resources of the Emerging Minds, National Workforce Centre for Child Mental Health can be used to support practitioner and organisational change.

**References**

Engaging Parents: Bringing into focus the 'invisible parent and child'.

Angela Obradovic, Derek McCormack, Myfanwy McDonald, Rachel Lovelock

1Emerging Minds, Hilton, Australia, 2Parenting Research Centre, Melbourne, Australia, 3Wellways Australia, Fairfield, Australia

Biography:
Derek McCormack leads key projects at the Parenting Research Centre focusing on the translation of research and best-practice evidence into the day-to-day practices of parents and those who support them. His work includes the co-development of practical resources for policymakers, professionals and parents, including the award-winning Raising Children Network website.

Myfanwy McDonald is a knowledge translation specialist at the Parenting Research Centre. She specializes in developing resources designed to enhance practitioners' and policy-makers' understanding of evidence, taking into account the reality of the practice and policy context, and with a focus upon the health and wellbeing of children and families.

Angela Obradovic is the Adult Mental Health Workforce Development Officer with Emerging Minds. She has a longstanding commitment to systemic change that acknowledges the impact of mental illness on relationships and the interdependent needs of all family members, in particular, parent consumers and their dependent children. She has presented extensively on relationally-oriented mental health practice including the Let's Talk About Children approach.

Rachael Lovelock is a manager, advocate and family/carer leader who draws on her own lived experience and background in community development to lead, design and implement advocacy strategies, community and peer education programs at Wellways Australia. She advocates for platforms that ensure lived experience is heard, rights are upheld, and principles of co-production are at the heart of policy, quality systems and services provision. Rachael has experience in direct service, group facilitation, program coordination, training and project management and her work has contributed to policy development, service design and advocacy.

When a parent experiences mental health challenges, apart from affecting confidence in their parenting role, it can increase the likelihood of their children experiencing poorer developmental, mental health and physical health outcomes. Engaging with adults about their parenting role is a vital part of adult services supporting personal and clinical consumer recovery. This allows practitioners to obtain a holistic picture of what is happening in the life of the adult and the dynamic role of family responsibilities in their recovery, while also bringing into view the child, who may become invisible if not brought into focus.

The Emerging Minds National Workforce Centre for Child Mental Health have developed two eLearning courses which will assist practitioners to be curious about the parent/child relationship from a strengths framework, to open discussion about current challenges and provide opportunities to promote relational recovery.

A national and international evidence base is emerging regarding approaches that adult practitioners can adopt to integrate the parenting role as a routine focus of their practice. These approaches have been demonstrated to enhance parenting, reduce the likelihood of children experiencing difficulties, enhance recovery outcomes for adult clients and significantly improve therapeutic alliance. They also form vital preventative responses that can identify vulnerabilities for children before the development of issues. Partnering with parents, using a non-judgmental, curious approach has been proven to reduce the reluctance of parent consumers to share their hopes regarding their relationships with their children - a major barrier to seeking support and help.

This workshop will include a presentation about the development of two eLearning courses - Engaging Parents and the Building Blocks of Children's Emotional and Social Wellbeing - launched in mid-2018 featuring videoed interviews with practitioners, parents and young people.

Video material will be featured highlighting the voices, reflections and expertise of:
practitioners regarding promising practice, challenges and the areas for development in collaborating with parents

parents who have lived experience of mental ill health or distress and have contributed to these courses

A panel of speakers will discuss their participation in the development and uses of these resources across professional, peer and community practice settings.

This will be followed by an interactive audience discussion regarding prevention and early intervention knowledge and its importance in responding to the challenges of intergenerational aspects of adversity and trauma.

**Learning Objectives**

Learning Objective (1): Attendees will gain exposure to resources outlining promising practice, challenges and the areas for development in collaborating with parent consumers, informed by lived experience and practitioners

Learning Objective (2): Attendees will be encouraged to reflect on broad cross-sector prevention and early intervention knowledge and its importance in responding to the challenges of intergenerational aspects of mental illness and trauma.

**References**


Collaboration is helping to positively shape the way we work.

Joanne Stubbs
Melbourne Health, Hurstbridge, Australia

Biography:
Jo Stubbs has worked as a mental health nurse for the last 15 years. She is currently the Project Manager of the Victorian Mental Health Interprofessional Leadership Network. Jo is passionate about developing a mental health workforce that has many dynamic and forward thinking leaders. She has been very fortunate in the last few years to work with some outstanding leaders and has watched the VMHILN foster new leaders from varied backgrounds, including the lived experience workforce. Jo has specialised in project manager and coordination roles for the last 5 years, she has also been a sessional lecturer at ACU and has a masters in mental health nursing.

In 2013, the Victorian Department of Health & Human Services (DHHS) funded a Statewide Interprofessional Leadership Project. The project aimed to educate and mobilise established and emerging leaders from Victorian Mental Health Services. Teams of four included staff from lived experience, nursing, allied health and medical disciplines.

The participants from the original project have gone on to form the Victorian Mental Health Interprofessional Leadership Network. The Network is an innovative concept, driven by evidence based research that acknowledges the importance of collaborative interprofessional leadership as a key driver for successful change. The Network can also be consider a think tank of experts working in public mental health.

In 2017 the Chief Psychiatrist's audit of inpatient deaths 2011-2014 was released. There were eight actions written into the report. The first was to engage the VMHILN to review and update three of their current clinical guidelines in response to the report.

This presentation will provide an overview of how an interprofessional network of leaders, from across the State of Victoria was able to collaborate with the people currently working within services to develop clinical guidelines that were current, relevant and recovery focused. The presentation will explore the advantages of the interprofessional nature of the Network and the advantages of having representation from metropolitan and rural services.

Learning Objectives

Learning Objective (1): The objective of this presentation is to encourage participants to think about dynamic ways they can utilise their collective skills, knowledge and wisdom to drive practice change.

Learning Objective (2): The objective of this presentation is to encourage participants to consider how they can collaborate effectively with all relevant parties to develop policy and guidelines. The objective is for participants to understand the power of the people.

References


Whisper to Roar: From Glenside to Worldwide, how one Adelaide patient became a global voice on stigma and discrimination/ Co-designing New Zealand's Rākau Roroa initiative, (Tall Trees). The world's first entirely Lived Experience led and supported Mental Health Champions Programme.

**Taimi Allan**1,3, Vanessa Cooper2,3

**Biography:**
Taimi Allan is the CEO of consumer organisation, ‘Changing Minds’, leads Rākau Roroa, and is a strategic advocate for people with lived experience. She featured in M2 Woman Magazine as a global thought-leader, and in ‘MiNDFOOD’ Magazine for creating the world’s first International Mental Health Arts Festival ‘The Big reTHiNK’

Vanessa Cooper is a Senior Advisor with the Health Promotion Agency and the contract manager for Rākau Roroa under Like Minds, Like Mine. She is passionate about reducing stigma and discrimination associated with mental distress—particularly in workplaces—and seeding conversations in communities to challenge myths and stereotypes.

Rākau Roroa (Tall Trees) is New Zealand’s national lived experience leaders’ programme under the banner of Like Minds, Like Mine and the National Depression Initiative (NDI).

Through training and on-going support, Rākau Roroa is growing a network of recognised leaders (Tall Trees), who have personal lived experience of mental distress and recovery and are confident to publicly champion positive messages around the value of these experiences.

In 2001, when Taimi was in Adelaide’s Glenside hospital, admitting your experience was barely whispered … on recovery she decided to turn whispers into a roar, and now dedicates her life to not only acknowledging these experiences but helping others use their own lived wisdom safely, to change minds.

In true partnership with programme funders and people with lived experience, Rākau Roroa was co-designed to do what no other anti-stigma or discrimination Champions programme has ever done; be 100% Lived-Experience and provide ongoing mentorship and support for those using their own story.

Having Lived Experience leaders at every level, Rākau Roroa proves that this workforce is wider than peer support roles. Taimi and Vanessa will walk through the challenges in co-designing a programme rather than a service, and the (perhaps not so surprising) outcome...

**Learning Objectives**

Learning Objective (1): What will people in the audience gain or learn from attending this presentation?
Co-design is a hot topic in Mental Health, but usually used in the context of creating or improving services. This presentation will outline the unique challenges and solutions in co-designing a programme driven entirely by and based on people with lived experience, not bricks and mortar.

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues?
Rākau Roroa provides a template for programmes and services to be entirely driven by the service user at every level, and from inception to delivery. It provides a case study for valuing People with Lived Experience as skilled professionals with knowledge and skills far above and beyond their personal use of mental health services.

**References**


Angela Obradovic1, Rhys Price-Robertson2, Rachel Lovelock3, Louise Salmon1
1Emerging Minds, Hilton, Australia, 2Australian Institute of Family Studies, Melbourne, Australia, 3Wellways Australia, Fairfield, Australia

Biography:
Rhys Price-Robertson is a Workforce Development Officer at the Australian Institute of Family Studies, where he works as part of the Emerging Minds National Workforce Centre for Child Mental Health. He has published widely on topics such as mental health, fathering, family life and social theory.

Angela Obradovic is the Adult Mental Health Workforce Development Officer within the National Workforce Centre for Child Mental Health. She has a longstanding commitment to systemic change that acknowledges the impact of mental illness on relationships and the interdependent needs of all family members, in particular, parent consumers and their dependent children. She has contributed to a number of publications and presented extensively on relationally-oriented mental health practice.

Louise Salmon provides a range of perspectives from lived experience. For some years her mantra has been "You can't draw a ring around individual mental health" believing the site of recovery is not solely within individuals but at the intersection of their relationships; families, communities, workplaces, and everyday acts of living. Louise's professional social work career spans child & family mental health, family law & leadership. She is a Senior Family Consultant with the Australian Family Law Court.

Rachael Lovelock is a manager, advocate and family/carer leader who draws on her own lived experience and background in community development to lead, design and implement advocacy strategies, community and peer educations programs at Wellways Australia. She advocates for platforms that ensure lived experience is heard, rights are upheld, and principles of co-production are at the heart of policy, quality systems and services provision. Rachael has experience in direct service, group facilitation, program coordination, training and project management and her work has contributed to policy development, service design and advocacy.

The recovery approach has influenced mental health policy and practice locally and internationally. The recovery approach centres on personal recovery, which aims at living a meaningful, hopeful, and contributing life, even within on-going limitations caused by mental health problems.

While the recovery approach currently enjoys enormous support, it is not without its critics. The most persistent criticisms have focused on the individualistic worldview underpinning most conceptualisations of recovery. A number of commentators have argued that the recovery approach pays insufficient attention to the social, cultural and structural processes that enable wellbeing, and have called for the development of more relationally-oriented conceptualisations of recovery.

This workshop will focus on the notion of "relational recovery", which suggests that experiences such as hope, empowerment and meaning emerge at the intersections between individuals and the social and cultural milieus in which they are embedded. Such a view in no way invalidates the personal experiences of people with mental ill-health, but simply suggests that the genesis of these experiences is more complex and relationally situated than individualistic interpretations of recovery allow.

Relational recovery emphasises families because they are the most salient relational context for many people living with mental ill-health. Indeed, estimates have indicated that over 50% of people with severe mental ill-health have daily contact with family member/s, and roughly 20% live with dependent children. For many, it is simply not possible to separate their own recovery journey from their roles and responsibilities within their family.
This workshop will highlight theory, practice, policy and lived-experience perspectives on relational recovery, challenging participants to examine the implications of the individualistic underpinning of the recovery approach. The session will include reflections from people with lived experience of mental ill-health and recovery, as well as an interactive group discussion aimed at continuing this dialogue amongst participants’ own personal, peer, professional and organisational networks. Attendees will be encouraged to reflect on how they can place families and relationships at the heart of their efforts at promoting mental health recovery, as well as how they can help to mature and broaden the recovery approach more generally. To maximise the opportunity the session provides, participants are encouraged to read the article by Price-Robertson, Obradovic and Morgan (2016) prior to the workshop (for individuals or non-government organisations without access to the Journal, email info@emergingminds.com.au to request a link to download a copy of the article).

Learning Objectives

Learning Objective (1): Attendees will gain insight into the individualism underpinning the recovery approach, learn about emerging concept of relational recovery and challenged to start a dialogue in their own networks about how the recovery approach can be re-imagined from a more relationally-oriented perspective.

Learning Objective (2): Attendees will be encouraged to reflect on how the concept of relational recovery is relevant to their own practice, communities of identification and lived experience.

References

Homelessness and Mental Health: Principles to Support Positive Health and Housing Outcomes.

Rosie Frankish\(^1\), Beth Fogerty\(^2\), Laura Collister\(^1\)
\(^1\)Wellways Australia Limited, Melbourne, Australia, \(^2\)Wellways Australia Limited, Gippsland, Australia

**Biography:**
Rosie Frankish
Rosie coordinates the Doorway program for Wellways Australia. She has worked in the Doorway Demonstration program prior to her current role. Rosie is passionate about providing evidence based and innovative services to participants that assists them to feel empowered about their life and recovery journey. Rosie has a background in Psychology.

Beth Fogerty
Beth manages the Doorway program at Wellways Australia. Her experience is in working with adults and older adults in acute and community based mental health. She is passionate about supporting consumers and carers in taking an active role in their recovery and in tailoring services that meet their individual needs.

It is acknowledged that homelessness is a complex, multifaceted issue which requires a sophisticated, collaborative approach to not just alleviate, but importantly ‘prevent it’. Its essential services are supported to embed program models that are preventative, innovative, and sustainable to reduce the risk of people becoming homeless in the first instance. Despite this recognition and funding to address this issue, homelessness in Australia is increasing (Witte, 2017). Research suggests factors contributing and perpetuating this complex issue include housing affordability, mental illness, domestic violence, and substance addiction (Australian Institute of Health and Welfare (AIHW), 2017). These community issues also are rising, perpetuating the issue of homelessness and its impact on health and wellbeing.

Whilst homelessness is increasing, the resourcing to provide marginalised groups of individuals with access to safe and secure housing is at capacity, resulting in unmet housing and support needs, particularly those with mental illness (AIHW, 2017). AIHW (2017) reports that individuals with mental illness are one of the fastest growing population groups presenting to specialist homelessness services within Victoria, growing an average of 12% per year since 2013-13, and it’s also identified this cohort of people need ‘more support’ that other population groups experiencing homelessness. This issue is further perpetuated by funding challenges, namely the number of specialist homelessness and mental health service programs that have been defunded, presenting further challenges to effectively support this vulnerable population group.

These issues highlight the need for an expansion in specialised mental health and homelessness support programs to effectively support this population group. It is imperative that these programs are resourced to operate from a prevention and early intervention model through collaboration, community, and tangible housing options to overcome these issues.

This workshop will provide attendees with the opportunity to learn from Doorway, a homelessness and mental health housing and support program delivered by Wellways Australia. This workshop will discuss Doorway’s program model, principles and how these ingredients translate to service delivery. In demonstrating these learnings, the workshop will also provide preliminary outcomes of the program to date and make recommendations about future directions for the program based on these learnings.

**Learning Objectives**
Learning Objective (1): Participants in the session will learn about the principles of the Doorway program. Moreover, participants will learn about Doorway’s program model focused to deliver an integrated service for individuals who experience homelessness and mental health issues. Furthermore, participants will also gain insight to engage real estate agents to support consumers to access private rental as a sustainable housing option.

Learning Objective (2): Access to safe and secure housing for individuals involved in the mental health systems continues to be a significant issue, and often an unmet need that is crucial to consumers recovery. Doorway is a housing and recovery program for individuals who experience mental health issues and are homeless. Doorway is an example of the recovery outcomes individuals can experience when collaborative and integrated service delivery is implemented. Moreover, Doorway embodies a Housing First Approach, therefore providing an early intervention preventative approach to homelessness and mental health.

References


'Work-Strengths’ Social and Emotional Wellbeing Program

Maureen Robertson2, Ashley Bin Omar1, Sohaj Elayodan1

1 Derby Aboriginal Health Service, Derby, Australia, 2 Winun Ngari Aboriginal Corporation, Derby, Australia

Biography:
Maureen Robertson is a Provisional Psychologist and Manager of the SEWB Unit at Derby Aboriginal Heath Service. Maureen is passionate about all aspects of Indigenous social and emotional wellbeing and recognises the benefits to individuals and community of working from a strengths based model in program development.

Ashley Bin Omar is an Indigenous Mental Health Worker at Derby Aboriginal Health Service. His is support author/developer and workshops presenter of the ‘Work-Strengths SEWB Program’. Ash is a strong community leader and spokesperson for his local community.

The term Social and Emotional Wellbeing (SEWB) describes the social, emotional, spiritual, and cultural wellbeing of a person. (Dudgeon, Milroy & Walker, 2013).

This paper describes how a small SEWB team from Derby in Western Australia’s Kimberley, reviewed the literature and research linking Indigenous employment disadvantage to mental health. This team examined the barriers and costs to communities, where capable individuals remain unemployed. Investigations revealed strengths and, it became clear from that Indigenous men and women were keen to gain and maintain employment.

Funding bodies and service providers often appear to lack the ‘big picture’ thinking required to understand the complex cultural responsibilities, and the social and emotional issues faced by Indigenous communities where unemployment for extended periods is the norm.

Specifically, no other employment programs were identified that combined recognition of the strengths, skills and talents of Indigenous Australians, with understanding of the social and emotional wellbeing barriers faced.

This paper describes the development of a ‘Work-Strengths SEWB Program’ that recognises and incorporates the social and emotional resilience communities’ display while living and working in a climate of increasing Indigenous mental health statistics. (Lowry & Moskos, 2007)

Learning Objectives

Learning Objective (1): People in the audience will be informed that development of effective employment support programs for Indigenous Australians must include genuine engagement with the complex social, emotional, spiritual and cultural issues that are an integral part of the living culture of Indigenous Australians.

Learning Objective (2): Additionally, this presentation will support program developers to grasp the importance of applying a strengths based model that recognises the resilience and abilities that already exist in Indigenous communities alongside high levels of unemployment.

References


Psychosis without Destruction

Sarah Reece

Biography:
Sarah is an artist, writer, trainer, and community development consultant who has founded online networks such as The Dissociative Initiative, supporting vulnerable people worldwide. Sarah’s work draws on personal experiences relating to mental health, grief, relationships, and sexuality, with sensitivity and compassion.

The onset of psychosis is frequently a volatile time where people are at high risk for suicide, traumatic interventions, and behaviours such as not eating or sleeping, that can lock them into psychotic spirals. Exposure to narratives of ‘broken’ brains and ‘madness’ often fuels terror, shame, and secrecy, which are highly destructive to identity and relationships. This disruption can make managing psychosis much more difficult. My experience has been that the destruction we associate with psychosis has more to do with our approach than the experience itself. Many creative people like myself have their own understanding of altered states and work with them as part of their arts practice.

Approaching psychosis as a vulnerable but valued and normal human response to a wide range of common circumstances can reduce the risks of harm. We can explore psychosis with gentle curiosity rather than anxiety and a focus on symptom reduction (return to ‘normal’), treating it as a meaningful experience. This context preserves relationships and connections. Normalising and contextualising psychosis allows different stories about it to emerge, at times necessarily conflicting and contradictory. In holding that space, unique opportunities for creative and individual psychosis approaches emerge.

Learning Objectives

Learning Objective (1): Reframing psychosis as a vulnerable rather than dangerous state helps us to engage with different stories, experiences, and types of psychosis to develop the most helpful individual approaches.

Learning Objective (2): First episode psychosis or hospitalisation is the highest risk time for many people for suicide, social, and professional destruction. If our mental health services keep telling the same story about psychosis being a terrifying, destructive, useless state caused by a broken mind we are contributing to that risk.

References


Zine Making Reflective Workshop

Sarah Reece

1SHINE SA, Woodville, Australia

Biography:
Sarah is an artist, writer, trainer, and community development consultant who has founded online networks such as The Dissociative Initiative, supporting vulnerable people worldwide. Sarah’s work draws on personal experiences relating to mental health, grief, relationships, and sexuality, with sensitivity and compassion.

A safely facilitated opportunity to retreat, reflect, and express personal responses to the conference themes and content.
A ‘zine’ is a handmade magazine. It can have quotes, stories, reflections, artwork, poems, comics, doodles, thought-soup, and conversations.
All materials provided, no artistic skills necessary. Sarah is an artist and facilitator, happy to listen, converse, and collaborate, or leave you in peace. Come and write, draw, doodle, talk, think, and process. Conferences can be intense spaces – what’s the whisper you need to hear or want to express?
Submissions will be gathered into a TheMHS 2018 zine and emailed to participants.

Learning Objectives

Learning Objective (1): An opportunity to breathe, reflect, connect, and express. Even if you are not presenting, your ideas and responses are important and valued.
Learning Objective (2): Finding creative ways to help conversations to be two-way dialogues, and to practice opportunities to reflect, digest, and respond facilitates adult learning and change. They are key practices needed in mental health services.
The Alfred CYMHS Mental Health and Intellectual Disability initiative for Youth (MHIDI-Y). The challenges, benefits, lesson learnt and outcomes around implementation and delivery of this new innovative service.

Jennifer Harrison, Eloise Hughes1, Michelle Kehoe1
1Alfred Health, , Australia

Biography:
Dr Harrison is a consultant child, adolescent and family psychiatrist with specialist experience in autism, developmental disorders, intellectual disability, infant mental health and rural child and youth psychiatry. She has run for the past 20 years the Developmental Assessment and Management Program for Alfred CYMHS and since 2007, the Neuropsychiatry Clinic. She is the consultant psychiatrist for the MHIDI-Y program.

Over 400,000 Australians have an intellectual disability and in 2003 a health survey showed that the majority of these individuals have a psychiatric disability. Compared to the general population, people with an intellectual disability experience elevated rates of common physical and mental disorders such as schizophrenia, affective disorders, anxiety disorders and the dementias. Yet research across Australia has shown that people with an intellectual disability have challenges accessing mental health care or receiving appropriate mental health intervention.

The Mental Health and Intellectual Disability Initiative Youth (MHIDI-Y) was established in 2016 to address the crucial service gap that has existed for young people with an intellectual disability and mental health concern. In particular the initiative provides adapted mental health treatment and therapeutic support that meets the cognitive and communicative needs of the young person which can include access to psychiatrists, social workers and occupational therapists.

This presentation will explore the challenges, benefits and lesson learnt around implementation and deliver of the service. It will highlight the reasons for addressing the current gap that exists for young people with an intellectual disability and mental health concern and being afforded the right access to appropriate mental health treatment.

Learning Objectives
Learning Objective (1): The audience will gain an understanding of the special care needs of young people with an intellectual disability and mental health issue.

Learning Objective (2): The presentation will address how innovative new programs can be successfully implemented, how challenges are overcome and the benefits to the young people using a specialist service to address their individual, unique needs since this cohort of young people is under-represented in the mental health care system.

References
NDIS Support Coordination: The Challenges and Opportunities

James McKechnie, Nicholas O'Brien

Flourish Australia, Sydney, Australia

Biography:
James McKechnie, manager at Flourish Australia, leads the Partners in Recovery and the NDIS support coordination teams in Sydney. James brings to the role his experience working in residential mental health services as a support worker and as a manager, and he is completing a masters in social work (qualifying).

Nicholas O'Brien is a Support Coordinator with the Flourish Australia support coordination team in Sydney. Nicholas is a qualified social worker, and he brings to the role his thorough understanding of Chinese medicine, experience working as a personal trainer, and experience running his own business.

People living in State funded group homes and assisted boarding houses have experienced streamlined access to the NDIS. However, once access has been achieved, the experience plan implementation has been challenging. To ensure positive outcomes for people are maximised Flourish Australia Support Co-ordinators have worked hard to identify and overcome barriers to the effective implementation of people's plans. These barriers have included:

- inadequate and inconsistent funding in plans
- participants poor understanding of how the NDIS works
- unclear goals
- participant reluctance to access new services
- a limited marketplace, with little diversity in services

This paper highlights how Flourish Australia Support Coordinators have embraced these challenges and engaged innovative practice in overcoming them, and while maintaining a commitment to recovery orientated practice.

Learning Objectives

- Learning objective 1: "What will people in the audience gain or learn from attending this presentation?" The audience will:
  - Have the opportunity to learn about some of the challenges to implementing NDIS plans with this population;
  - Gain an insight into the innovative practice of Flourish Australia's support coordination team in addressing these challenges;
  - Have the opportunity to learn about how innovative practices have worked in practice; and
  - Will have the opportunity to reflect and discuss themes of the paper with the presenters.

- Learning objective 2: "How is this topic/issue relevant to mental health services and mental health issues?"
  - Psychosocial disability was included in the scheme at a later stage and the result is that people are expected to have their goals supported by a scheme which wasn't designed around unique needs of this population. The responsibility for ensuring that the scheme works for this group of people is on NGOs, organisations and, specifically, support coordinators supporting the implementation of people's plans.
  - A focus on dialogue around the NDIS which is positive and which highlights successes, especially in the context of the well-established challenges.

References

McKechnie, J. 2018 Flourish Australia
Consumer, Carer and Clinician Co-design of Mental Health Intensive Care Training

Julie Anderson¹, Kate Thwaites¹, Frances Sanders¹, Nicole Edwards¹
¹Office Of The Chief Psychiatrist Victoria, Melbourne, Australia

Biography:
Julie Anderson is Senior Consumer Consultant in the Office of the Chief Psychiatrist in Victoria. She is experienced in consulting with people who have a mental illness about services and would say it is the best part of her job. Julie has advised Federal and State Governments on mental health policy.

Kate Thwaites is a mental health nurse working in the Victorian Office of the Chief Psychiatrist which includes nursing leadership projects with the Victorian Chief Mental Health Nurse. My professional vision is a compassionate health care system which provides evidence based care, nurtures, values and develops clinical staff.

Frances Sanders is the Senior Carer Adviser with the Office of the Chief Psychiatrist in Victoria. Prior to this she has worked leading NDIS business development, consumer and carer services and strategy and has held executive roles in the mental health and employment sectors since 1995.

Nicole Edwards is a mental health nurse advisor at the Office of the Chief Mental Health Nurse. Nicole has 24 years’ experience working in a range of mental health settings and is committed to educating the mental health nursing workforce, reducing restrictive practices and improving safety for consumers and staff.

The Office of the Chief Mental Health Nurse is to improve the care experience for consumers and their carers by supporting quality improvement and encouraging uptake of best practice approaches. Mental Health Intensive Care (MHIC) is identified as a specialist care type that can be delivered across settings. Developing training for MHIC follows a state-wide review of current high dependency units; engagement and consultation with key stakeholders, including peak consumer and carer bodies to inform a framework of MHIC. The concurrent project of training nursing staff has been co designed by the Office of the Chief Mental Health Nurse’s senior consumer and carer and senior clinical advisors.

The aim of this paper is to explore how co designing the MHIC Framework has been a mechanism for learning and developing knowledge that will form the basis of culture change in inpatient units in Victoria.

This paper will demonstrate how: “Genuine partnership builds the capacity and harnesses the knowledge and skills of everyone involved – everyone has something to contribute and the exchange of these contributions is enriching for everyone, expertise no longer belongs to the professionals”.

Learning Objectives

Learning Objective (1): People in the audience will gain knowledge how a co design from a consumer, carer and clinical perspective is a mechanism for learning and developing knowledge to form a process of culture change.

Learning Objective (2): This topic is relevant to mental health services as it demonstrates how powerful co design is in system change.

References

Psychosocial Disability and the NDIS: Lessons from Partners In Recovery

James McKechnie\textsuperscript{1}, Zahra Ciardi\textsuperscript{1}
\textsuperscript{1}Flourish Australia, Sydney, Australia

Biography:
James McKechnie, manager at Flourish Australia, leads the Partners in Recovery and the NDIS support coordination teams in Sydney. James brings to the role his experience working in residential mental health services as a support worker and as a manager, and he is completing a masters in social work (qualifying).

Zahra Ciardi is a Support Facilitator with the Inner West Sydney Partners in Recovery team at Flourish Australia. Zahra brings to the role her personal lived experience of mental distress, as well as experience working as a peer worker, qualifications in psychology and a background working in the corporate sector.

The challenges experienced by people with psychosocial disabilities gaining access to the NDIS are well documented. Effectively gathering, collating, presenting and submitting evidence is a challenge. Many people with psychosocial disabilities tell us they find the process and the language used challenging.

Partners in Recovery (PIR) practitioners support participants, professionals and other significant people to learn about the NDIS and the application process. Inner West Sydney PIR has invested significantly in developing the workforce, its understanding of the NDIS, and in funding individuals to access the assessments and reports needed to support their NDIS applications. PIR is able to offer consistent support to a person throughout their NDIS journey. It is important to reflect of PIR’s experience before it comes to an end and for services to learn from it.

This paper highlights the practices and resources which have worked for PIR in supporting individuals through their NDIS journey. It invites the mental health sector to hear the lessons learned over the years with respect to the NDIS and psychosocial disability, in order to inform best practice going forward.

Learning Objectives

Learning Objective (1): “What will people in the audience gain or learn from attending this presentation?” The audience will:
- Have the opportunity to learn about some of the challenges people with psychosocial disabilities experience when applying for the NDIS;
- Gain an insight into the successes experienced by practitioners and participants who are connected with PIR;
- Learn about the practices which have made the difference for participants connected with PIR in their NDIS application processes; and
- Learn about how the difference it has made when participants have had consistent support from a skilled practitioner through the application process, and then also in implementing and coordinating the plan once it has been approved.

Learning Objective (1): “How is this topic/issue relevant to mental health services and mental health issues?”
- The PIR experience of working with the NDIS should be seen as a model of good practice in supporting a person with a psychosocial disability through their NDIS journey.
- The mental health sector in Australia is in need of examples of best practice in supporting a person with a psychosocial disability to fit into a scheme which was not conceptualised with them in mind.

References

McKechnie, J. 2018 Flourish Australia
Hearing the Whispers Within – Acknowledging and working with (your own) inner children.

Judith Drake¹, Flick Grey²
¹Independent, Melbourne, Australia

Biography:
Judith Drake is involved in consumer/community advocacy at local, state and national levels with various organisations covering the mental health, family violence and emergency service sectors. She has particular interests in consumer engagement, Intentional Peer Support, suicidality, research & evaluation, trauma, dissociation, self-care, Hearing Voices and NDIS & psychosocial disability.

Flick Grey is a wandering Mad academic, consultant, trainer, peer support manager and supervisor. She has child parts and takes delight in connecting with rivers, unicorns and enlarged spaces embracing human vulnerability and richer, more complex and nuanced ways of thinking about experiences, beyond the medicalisation of distress.

From the historical “child archetype” of Carl Jung to the voice dialogue work of Hal & Sidra Stone, to the ground-breaking work of trauma therapists like Janina Fischer, there has long been a belief that adults can have fragmented, dissociated or internal parts, or alternate senses of ‘self’ that can include younger, child-like parts. This experience can occur on a continuum from simply wanting to embrace one’s youthfulness right though to adaptive trauma responses like Dissociative Identity Disorder, and everything in between. However our society doesn’t offer us many opportunities to actively and deliberately embrace our younger, child-like parts. Hence we are denied opportunities to explore, embrace, ‘re-parent’, and even enjoy, these parts of ourselves.

This workshop aims to provide a safe place to explore the concept of “Littlies”, give yourself permission to embrace all parts of yourself, and to find healthy ways to include them in your daily life to promote well-being and fun, within a trauma-informed, person-centred framework.

So in amongst all the grown-up conferencing of TheMHS, give yourself permission to take some time out & come play!

Workshop Format:
- Introduction
- Theoretical constructs (e.g. Voice Dialogue, Attachment Theory, Trauma Theory)
- Mental Health perspectives (e.g. dissociation, Hearing Voices Approach, complex trauma, narrative therapies, creative art therapy)
- Why it’s important to acknowledge and recognise ALL parts of ourselves & why they exist
- What happens when we neglect these parts of ourselves
- Grief, shame & trauma
- Ways of including your own inner parts in your everyday life
- Assertiveness and boundaries
- Practical Exercise (optional)
- Brainstorming activity: Things our little parts like to do
- Ways of working with others to encourage them to embrace their “Littlies”
- Potential challenges when working with younger parts and things to be mindful of
- Encouraging use of chill-out spaces/sensory modulation techniques/self-care strategies in mainstream mental health
- Re-grounding and re-orientating - strategies to use

Learning Objectives

Learning Objective (1): People who attend this workshop will learn about different theoretical perspectives to working with inner parts, particularly child-like parts whose needs may not be being met in a fast-paced, grown-up world. We
will look at creative ways to include our inner parts in our daily lives and explore challenges, barriers and enablers to doing this, both for ourselves, and with people we may be supporting. And there will be space to have some fun!

Learning Objective (2): There is a plethora of evidence that people engaging with the mental health system have a high prevalence of trauma, in particular childhood trauma. Even people lucky enough to have had a healthy childhood can still find that there are stages of development they have missed out on. Yet the implications of this are rarely adequately addressed by mainstream mental health services. This workshop aims to allow people to explore this idea, and the concept of having inner child-like parts who may need nurturing, in a safe, supportive, non-judgmental space, both for your own personal benefit and to help inform work you may be doing to support others.

References


How to Improve Mental Toughness to Enhance Wellbeing: Recognising not only the need for resilience to enhance personal wellbeing, but also confidence to embrace challenges with a growth mindset.

Michelle Bakjac\textsuperscript{1}
\textsuperscript{1}Bakjac Consulting, Adelaide, Australia

\textbf{Biography:}
Michelle Bakjac is a highly experienced Psychologist, Trainer/Facilitator and Leadership/Wellbeing Coach with 25 years+ experience. Her expertise ranges from facilitating workplace wellness training and organisation wellbeing strategy, to personal and leadership coaching to organisational development and leadership training. Michelle’s goal is to take individuals and teams from surviving to thriving.

This dynamic interactive workshop provides practical solutions to manage the challenging landscapes we are thrust into and enhance personal wellbeing through the development of mental toughness. Our wellbeing is often linked to our ability to manage challenges which have now become commonplace in our everyday personal and workplace environments. VUCA (Volatility, Uncertainty, Complexity and Ambiguity) has become the new normal. It is no longer enough to simply encourage resilience after adversity. We need to be able to act upon opportunities, build a positive mindset and proactively manage our thinking and behaviour and develop a skill set to drive us toward mastering our own wellbeing and success when exposed to challenges. Mental Toughness has specific importance in the landscape of overall personal wellbeing.

This session will provide a clear definition of the framework of Mental Toughness and its 4 key components (Control, Commitment, Challenge and Confidence) and how it can be both measured and developed in individuals, teams and organisations. As a result of research and direct experience it can be demonstrated that Mental Toughness plays a significant role in achieving aspirations, wellbeing and positive behaviour. The workshop involves participation in interactive exercises to demonstrate the opportunity to improve and enhance Mental Toughness to manage current and future challenges and build a platform for sustainable wellbeing.

\textbf{Learning Objectives}

Learning Objective (1): Individuals will learn how to develop their personal mental toughness to enhance their wellbeing and manage challenges.
Learning Objective (2): This session provides individuals and practitioners tools to enhance wellbeing in support of good mental health.

\textbf{References}


Hearing the whispers of young people supporting a parent, sibling or friend with mental health/psychosocial disability and nurturing the leaders of the future.

Marie Piu¹, Beth Dunlop², Rose Cuff²
¹Tandem, Melbourne, Australia, ²Families where a Parent has a Mental Illness Program (FaPMI), Australia

Biography:
Marie Piu MAPS
Chief Executive Office Tandem Inc.
Marie is an advocate for a compassionate health system responsive to consumers, family and friends to optimise mental health and wellbeing outcomes. Marie has firsthand experience of the disruption to family, confusion and powerlessness experienced by young people providing informal care.

Beth Dunlop is the FaPMI Coordinator at Austin Health who works to reduce the impact of parental mental illness on all family members, especially dependent children. Passionate about Family Focused practice, she specializes in working with people with caring responsibilities, in particular young carers.

Rose Cuff has been the Victorian Statewide FaPMI co-ordinator since 2007, working in child and adult mental health services since 1986. Rose specifically focuses on supporting families where a parent has a mental illness through direct clinical practice, creating peer support and group programs, developing resources and conducting training and research.

Tandem is the Victorian peak body and trusted voice of family and friends supporting people living with mental health/psychosocial disability (known as informal or mental health ‘carers’).
Tandem understands that ‘Carers’, particularly young people in support roles lack information about respite and emotional support and are very often excluded by mental health professionals in treatment, discharge planning and discussions about recovery. In 2017, Diminic et al highlight that the economic value of informal support in Victoria is a staggering $3.3 billion per annum and that 15% is provided by those under 25 years.
We are working in Tandem with the FaPMI Program (Families where a Parent has a Mental Illness) to hear from and nurture the leaders of tomorrow by supporting them to join the Tandem Register. These informal carers can take representative positions, participate in the development of resources and speak at forums and conferences. A recent opportunity was the co-design and development of video resources on accessing the NDIS. This ongoing partnership with FaPMI will ensure the ‘whispers’ of young people will be heard and their potential and strengths recognised.

Learning Objectives

Learning Objective (1): The audience will learn about useful approaches in developing partnerships with agencies and young people with lived experience to ensure the whispers of ‘hard to reach’ groups are heard and resources co-designed to reflect their particular needs, ensuring the resources have maximum impact and are cost effective.
Learning Objective (2): Those providing support to people with mental health issues/psychosocial disability are making an economic contribution of $3.3 Billion PA in Victoria and it would cost $13.2 billion to replace informal mental health care with formal support services throughout Australia. On average these carers provide 36.2 hours of support per week to those they support of which 67% is emotional support. In addition to this carers also report being ‘on call’ or on standby so they can be available quickly if needed. Mental Health Services continue to exclude these informal carers from discussions about treatment, discharge planning and recovery. By routinely including these informal carers in these discussions, and providing them with supports in their own right, the likelihood of carers developing a mental health issue themselves and the relapse and readmission of the person they support would be significantly reduced.

References
Co-producing Recovering: Recovery College course ideas based on findings from a participatory Photo-Voice study with people experiencing mental health issues.

Nastaran Doroud¹, Ellie Fossey²¹, Tracy Fortune¹, Lisa Brophy³, Louise Mountford³
¹School of Allied Health, La Trobe University, Australia, ²Department of Occupational Therapy, Monash University, Australia, ³Mind Australia, Australia

Biography:
Nastaran is currently a PhD candidate at La Trobe University. She has worked as an Occupational Therapist in a variety of mental health services in Tehran, Iran. She is interested in lived-experiences of recovery, community participation, participatory research methods and co-production in recovery-oriented mental health practices.

Co-production is an essential element of Recovery Colleges (Perkins, Repper, Rinaldi, & Brown, 2012). This presentation proposes course ideas for co-production at Recovery Colleges. It shares findings from a participatory Photo-Voice study with people experiencing mental health issues that aimed to understand activities that support recovering. Twenty-one participants from Mind Recovery College and Peer Recovery Communities took part in this study. Data gathering involved series of in-depth individual interviews, Photo-Voice homework assignments and Photo-Voice group discussions (Wang & Burris, 1997). The assignments required participants to take photographs about their everyday experiences that support their recovering. Data was analysed using constant comparative methods. Participants discussed recovering as a journey of living that involves a range of experiences. They identified several strategies to support their recovering. These include strategies for: 1) managing difficult times; 2) taking the first steps; 3) understanding the impacts of mental health issues; and 4) participating in the community. The presentation discusses each of these categories in terms of course ideas for Recovery Colleges that can be co-produced and co-delivered with people experiencing mental health issues. This presentation discusses that people living with mental health issues have valuable lived-experience knowledge that can meaningfully contribute to mental health services.

Learning Objectives

Learning Objective (1): The audience will learn about a range of strategies people identify to support their recovering journey.

Learning Objective (2): Co-producing courses to support recovering inform recovery-oriented mental health services and can enhance collaboration and consumers participation in mental health services.

References

Whispers of Discontent: Lived experiences of mental health carers in the NDIS transition.

Simon Jones

Tandem, Melbourne, Australia

Biography:
Simon is supporting family and friends in the NDIS transition in Victoria. With 12 years’ experience in community mental health in service development and delivery, research, and advocacy, Simon is focused on the wellbeing of carers in the NDIS transition.

The NDIS represents a paradigm shift in the provision of community mental health psychosocial disability services in Australia. An insurance model, the scheme focuses on individual needs and goals, and supports people with significant and permanent disability to live an ‘ordinary’ life with choice and control. However, we know that no person is an island, and there are family, friends and other ‘informal supports’ that contribute to someone’s mental health, wellbeing and recovery.

In the NDIS transition in Victoria, there are whispers of discontent from carers, and some roaring! While the NDIS provides support for NDIS participants, and not carers, how will their informal support be sustainable? What is their lived experience of transition on the ground, and how has the NDIS changed their life?

In Victoria, where Mental Health Community Support Services (MHCSS) and experienced mental health staff are lost, and Carer Respite funding transitions to the NDIS, what support is available for those in an informal caring role—especially if the person they support is unable to access the NDIS? How will we engage with carers, especially hard to reach groups such as rural and remote, and indigenous communities, or young people who may not identify as ‘carers’?

Learning Objectives

Learning Objective (1): We present our experience of engagement, support and advocacy of family, friends and carers throughout Victoria in the NDIS transition. Delegates will learn our engagement strategy, our experience on the ground, and how ongoing support may be provided for carers in the NDIS landscape.

Learning Objective (2): The NDIS is an extraordinary systematic, policy and practice change in community mental health and psychosocial disability services. We share our online information, tip sheets and resources we have designed for engagement with carers, including our young carer NDIS videos created in partnership with FaPMI. What are our key messages for carers, Local Area Coordinators, NDIS Providers, the National Disability Insurance Agency, state and federal government and other NDIS stakeholders?

References

Learnings from the Mental Health Carer Support Fund in Victoria

Anne Finch

1Tandem, Melbourne, Australia

Biography:
Anne Finch has worked at Tandem, supporting family and friends of people with mental health issues since 2015. As manager of the Carer Support Fund, which Tandem administers on behalf of the Victorian State government, Anne has witnessed the impact that the direct transfers can have in this complex environment.

Formulating policy that addresses the adversity faced by family and friends of people engaged with the mental health system is challenging because the situations involved are often so complex. Family and friends usually sustain financial and emotional strain that can jeopardise the most important human relationships.

The Mental Health Carer Support Fund, a $1.5 million fund administered by Tandem on behalf of the Victorian Government, has demonstrated a capacity to in some degree ameliorate the strain of various financial pressures and other needs experienced by carers through a single, simple, efficient mechanism, a result that corresponds to the positive impact that has been documented in direct fund transfers in the field of international development.

The scope of eligible use outlined in the Fund Guidelines is a key component of its effectiveness. It is often a useful tool to avert household stresses which can compound disadvantage. The Fund is a valuable tool for developing therapeutic relationships between families and service personnel, particularly carer workforce at AMHS.

The Carer Support Fund has the potential (if adequately funded) of being a key pillar in developing proactive carer support services, and is therefore worth disseminating among NGO and government policy makers.

Learning Objectives

Learning Objective (1): The audience will develop their understanding of government policy/funding mechanisms that can overcome barriers associated with creating policy that addresses the complex situations of family and friends of those in the mental health sector.

Learning Objective (2): Of relevance to mental health services, valuable insights can be drawn from the decade long implementation of the Victorian Carer Support Fund. How can we make such funds even more valuable in assisting mental health carers.

References

Corsini, E: Cash transfers: an effective tool for international development and humanitarian aid Nesta Challenge Prize Centre 2016.
Diminic, S., Hielscher, E., Lee, Y. Y., Harris, M., Schess, J., Kealton, J., & Whiteford, H. The economic value of informal mental health caring in Australia 2017
Who Cares? Parenting your carers.

Erika Gelzinnis

Open Cage Ensemble, Newcastle, Australia

Biography:
Erika is an inclusive arts practitioner who tackles stigma and injustice through performance, workshop facilitation and public speaking at local, state and national levels. She is the Creative Director of Open Cage Ensemble and a member of the Arts and NDIS Working Party. Her NDIS journey began in 2013.

"When guilt and shame is replaced with reciprocity and openness, it works."

As a single mother of four boys living in rural and regional NSW, Erika found creative ways to manage the dichotomy of "caring" for her "carers". Her family faced poverty, systemic abuse, dysfunction and the complexities of Dissociative Identity Disorder (DID). Despite these challenges, Erika's children have not only managed, they have thrived.

This paper discusses the positive outcomes that the family has achieved through open discussion and collaboration in creative pursuits and daily life. Their advocacy, crisis intervention and daily assistance has enabled Erika to do more than "just survive". Her boys have collaborated on numerous projects and through these experiences, developed their own arts practices as musicians and actors. The family focus on reciprocity, community connection and art as a way of life has retained strong family cohesion. These core values have carried through childhood and remain a foundation to the successful, compassionate and resilient young adults they have become. As she begins a new life with her NDIS funded assistance dog "Gus", Erika reflects on how embracing core values of reciprocity, openness and creativity can enhance any caring relationship, whether formal or informal.

Learning Objectives

Learning Objective (1): They will gain a destigmatised view of psychosocial disability and chronic mental illness and an understanding of the positive outcomes that can come from people working together creatively in reciprocal relationships.

Learning Objective (2): Informal supports need to be valued within mental health and disability service provision. When there is service failure, informal supports fill the gaps. The importance of informal supports and the involvement of all stakeholders needs to be acknowledged. Often young carers, neighbours or other vital supports are left out of discussions. The dynamic that this family used to overcome difficulties around complex mental health issues and psychosocial disability can be directly applied to service failures and successes in the mental health sector. Where there is open dialogue and a reciprocal, collaborative and inclusive relationship, all stakeholders benefit.
Advancing beyond recovery-oriented mechanisms toward equitable and valued social inclusion for people with mental health issues.

Grant MacPhail¹
¹Flourish Australia, Sydney, Australia

Biography:
A long-time advocate for persons with mental health issues and mental health system change, Grant has worked in the sector since 2000. Grant has presented at multiple conferences and has authored peer-reviewed papers. Grants qualifications include B.Arts (Honours) Psychology, B.Arts, B.Bus, and Graduate Certificates in Social Change and Business Research.

The mental-health system and wider-society are gradually moving toward a space where persons with lived-experience of mental health issues are not limited by stigmatised, inequitable, and discriminatory social mechanisms. Although in sight, a glass-ceiling may nevertheless inhibit this movement toward truly equitable human rights. If we wish to overcome a glass-ceiling effect, in-out group attitudes and behaviours must foster and value non-tokenistic and equitable inclusionary spaces of social engagement for persons with mental-health issues.

This presentation discusses the importance of economic, cultural, social, and symbolic capital in further advancing the recovery movement beyond a person-centred/led approach toward non-tokenistic engagement of persons with lived experience of mental health issues into truly inclusive and valued spaces of social inclusion. Economic, cultural, social, and symbolic capital will be further discussed with reference to clinical, psychosocial, and person led support systems, and the agentic mechanisms required to dissolve in-out group boundaries impacting persons experiencing mental health issues, lived experience expertise and leadership, the peer-workforce, family and carers, mental health professionals, service providers, communities, and wider-society. This is a call to action for mental health system stakeholders to bring together previous improvements and further advance how we reform the supports and services we all offer.

Learning Objectives

Learning Objective (1): Audience members will gain a deeper understanding of the practicalities surrounding the inclusion of persons with lived experience of mental health issues in higher-level social systems. In doing so the audience will also gain an appreciation of the importance of fostering economic, cultural, social, and symbolic capital for individuals with a lived experience of mental health issues in further advancing the recovery movement beyond a person-centred/led approach toward non-tokenistic engagement of persons with lived experience of mental health issues into truly inclusive and valued spaces of social inclusion.

Learning Objective (2): This topic is highly relevant to mental health services and the persons who access their services as it explores emerging issues and advancements in the mental health sector and how they apply to the interrelationships between various system stakeholders. This topical area calls for action for mental health system stakeholders to bring together and build upon previous improvements in the way we offer services and further advance the reformation of the supports and services we all offer.

References

Byrne, L., Schoeppe, S. and Bradshaw, J. (2018), Recovery without autonomy: Progress forward or more of the same for mental health service users? International Journal of Mental Health Nursing. doi:10.1111/inm.12446


Maguire, K. and Britten, N. (2017). 'You're there because you are unprofessional': patient and public involvement as liminal knowledge spaces. Sociology of Health and Illness. doi:10.1111/1467-9566.12655
Protecting the Child is also our Business

Latha Nithyanandam

ADFNSW - Kathleen York House, Sydney, Australia

Biography:
Dr. Latha Nithyanandam B.A., M.A., B.Ed., Ph.D. has 35 years of experience as a Psychologist in Australia and India. Her doctoral thesis was on 'Yoga as a Mind Body Approach'. She is the GM of ADFNSW, a residential rehabilitation for women with AOD issues. She is also a Committee Member of the APS Substance Use Interest Group.

Childhood is the foundation on which our entire lives are built. Children of substance abusing parents are widely considered at high risk for a range of biological, developmental and behavioural problems including for developing substance abuse problems of their own. Children whose mothers abuse alcohol or other drugs confront an even higher risk of abuse (Conners et al. 2003). Various studies have shown that growing up in an environment where parents abuse alcohol or drugs and with mental health issues, children experience a daily environment of inconsistency, chaos, fear, abandonment, denial, and real or potential violence. The impact on the child however varies based on various factors including the sex of the child, number of siblings, birth order, age (including if during pregnancy) etc. Similarly their coping behaviours can range from assuming roles such as being a responsible child or an adjusting child or acting out child etc. The general rule that prevails in the family is “don’t trust, don’t feel, don’t talk” (Capretto, N 2007). The premier need of these children is to learn that they are just normal kids who have been trying to cope in an extremely stressful and chaotic environment. Hence if we are to break the transgenerational cycle of addition then, we need to be proactive and ensure supportive services that encompasses interventions not only for the clients but also their children focusing on growth and changes that the children need to make in themselves whilst supporting the client (parent) in his/her recovery.

Learning Objectives
Learning Objective (1): Awareness and Knowledge about the impact of mother's addiction on children and how intervention should also include the children and not restricted to the client (mother)
Learning Objective (2): Most AOD clients have co morbidity that also affects her children. Recognising this and proactively reaching out to them early would act as a preventative measure in breaking the trans generational cycle of addiction and co occurring mental health issues

References

Episodic Mental Illness IS a disability – a consumer’s perspective on how employers, government agencies and service providers can better provide support to our vulnerable populations.

Tanya Blazewicz

SA Health, CALHN, PHN, Adelaide, Australia

Biography:
Tanya Blazewicz is a 30 year old Lived Experience Advocate living in Adelaide, Australia. Co-chair of the CALHN MH CACAG, she also sits on boards/councils for the PHN, OCP and NGOs as a consumer representative.

In Australia within the consumer movement, there has been much discussion as to whether or not we fit within disability politics with the recent introduction of the National Disability Insurance Scheme (NDIS). There continues to be worry that some consumers with an episodic mental illness that fluctuates in severity will miss out on vital services that could potentially prevent future episodes, elongate periods of wellness and ultimately lead to recovery. In some cases these consumers will actually be forced to stop receiving their current services.

This is not a new concern for those of us who advocate within Mental Health. Several years ago, The Royal Australian and New Zealand College of Psychiatrists responded to suggested changes to Centrelink’s Disability Support Pension (DSP) stating that “creating a divide” between people with chronic impairments and those with episodic mental illness would be problematic. Their reasoning? That these people would be left with periods of no employment or income – having a profound affect both on the consumer and their carer.

Episodic disabilities are not limited to mental health of course, and Australia is behind other countries such as Canada who have done a lot of research into the best welfare system, and best practices for employers when it comes to illnesses that are episodic in nature including mental illness, HIV, Multiple Sclerosis and Arthritis.

Learning Objectives

Learning Objective (1): Service Providers, employers, and government workers in the audience will learn through a combination of real life examples and literature review what the challenges are to those with an episodic mental illness and what changes need to be made. Consumers and Carers in the audience will feel validated and empowered to demand more support within the community.

Learning Objective (2): With the NDIS being implemented this year, the topic of whether or not mental illness should be classified as a disability is very real and relevant. As advocates, we need to embrace the title of disability and make sure nobody is left behind in the cracks of the system. As it is, pre-NDIS, the current system is traumatising and isolating for consumers who may feel abandoned between episodes. Consumers with an episodic mental illness need support not only during an episode but between, to help prevent future episodes, and promote recovery. All consumers deserve equal access to the bare minimums - income, housing, medicine, and good nutrition, but should demand more including individual and group therapy, as well as social and sporting groups.

References


How does the conceptualisation and measurement of social inclusion impact on social work practice within a mental health context?

Paul Hickey¹²

¹Metro South Addiction And Mental Health Service, Brisbane, Australia, ²School of Nursing, Midwifery and Social Work, University of Queensland, Brisbane, Australia

Biography:
I have 23 years experience as a mental health social worker and am currently employed as a Social Work Leader at Metro South Addiction and Mental Health Service in Brisbane. I am also a PhD student at the University of Queensland and hold a PA Research Foundation post graduate scholarship.

The literature shows that people with a lived experience of mental illness are amongst the most socially excluded groups in society (Berry, Gerry, Hayward, & Chandler, 2010; Cobigo & Stuart, 2010; Huxley & Thornicroft, 2003) and face exclusion within multiple domains such as employment, housing, education and health and experience ongoing social isolation (Vicserv, 2008). Equally Morgon et al., (2011) found that for people with a lived experience of mental illness issues relating to social inclusion are often a higher priority than treatment of symptoms. This paper will present the findings of two focus groups examining consumer consultant and social worker perceptions towards using a standardised assessment to measure social inclusion and how they understand and apply the concept of social inclusion in their practice as well as their perception of the clinical utility of the Living in the Community Questionnaire.

Learning Objectives

Learning Objective (1): People will learn about the clinical utility of the Living in the Community Questionnaire.
Learning Objective (2): People will learn how social workers and consumer consultants conceptualise social inclusion within their practice.

References


Bridging the Gap: Psychosocial Support for People with Severe Mental Health Conditions.

Tony Stevenson¹, Rohani Mitchell²
¹Mental Illness Fellowship Of Australia, West End, Australia

Biography:
Tony Stevenson is the National CEO for the Mental Illness Fellowship of Australia (MIFA). For more than 35 years, Tony Stevenson has been committed to a viable and proactive health and community services sector which works alongside families and individuals to inspire self-confidence and hope. He has held CEO level positions with some of Australia’s most well-respected not-for-profit organisations as well as executive roles in the Commonwealth and State governments.

The NDIS was originally aimed at a sub-cohort of people with severe and enduring mental health issues. However, many programs with a much broader target were rolled into the NDIS, and as the NDIS is rolling out, a gap is emerging in community-managed mental health services for those who are not eligible for the NDIS.

This presentation will discuss the total cohort of people with severe mental health conditions in Australia, including those with psychosocial disability, and place this in the context of the current mental health system. The paper will explore the original intent of psychosocial disability in the NDIS, the impact of the roll-out of the NDIS on community-managed mental health funding, and make recommendations for future investment, within the framework of the 5th National Mental Health and Suicide Prevention Plan.

The presenter, Tony Stevenson, is the National CEO of the Mental Illness Fellowship of Australia (MIFA). MIFA was established in 1986 to provide a national voice for a federation of community-managed mental health organisations that grew out of consumer and carer advocacy networks. MIFA advocates for positive changes in social and public policy that impact on consumers and carers.

Learning Objectives

Learning Objective (1): What will people in the audience gain or learn from attending this presentation?
Attendees will gain insight into system planning for people with severe and enduring mental health issues, as well as an understanding of current gaps emerging in the service system as the NDIS rolls out.

Learning Objective (2): How is this topic/issue relevant to mental health services and mental health issues?
The NDIS presents a once in a generation system reform. It is essential to retain focus on the broader system design, to ensure that mental health consumers do not fall through the gap. Through understanding the cohort and their needs, we can ensure we are designing a response that is person-centred, and recovery-oriented.

References

Co-Producing Guidelines to Support Consumer Understanding of Medication

Steven Suttie¹, Vicki Langan¹
¹Neami National, Sydney, Australia

Biography:
Steve Suttie is a regional manager based in Sydney for Neami National. Vicki Langan is the NSW Health and Wellbeing Manager for Neami National.

Neami National is a national mental health NGO operating in 5 states providing services to approximately 8000 people annually. In providing supports to people using mental health, housing and homelessness services Neami became aware of an increasing need to support consumers around medication and treatment adherence. We had not developed strong policy or practice guidelines in this area, but were aware of the increasing expectations of funders, clinical partners and people using our services.

This coincided with a National focus on adopting co-design and co-production principles to service planning, design and development so it was this approach that was used to guide our thinking regarding policy development in this area.

In co-producing guidelines in this area a number key points informed our approach:
• For some people medication is a significant part of factor in keeping them well, particularly when it is part of a comprehensive plan including therapy and support.
• Medication compliance issues are a significant factor in psychiatric hospital readmission [2]
• Some staff hold concerns around working in this space with consumers and there was resistance in monitoring medication compliance.
• Working within a compliance and monitoring framework can lead to client disengagement [3]
• The need to align guidelines with the existing strengths based recovery oriented practice approach

This paper will share the guidelines developed and describe the co-production process.

Learning Objectives

Learning Objective (1): people who attend this session will get a sense of a co-design process and how it worked in developing a guideline for a policy gap in Neami. An approach to supporting consumers with medication compliance that supports learning, growth and autonomy as well as the principles of concordance vs compliance will be described. Learning Objective (2): Typically medication monitoring and recovery oriented practice have been seen as mutually exclusive and this has had to shift to respond to the changing landscape. Co-design and co-production provided an effective way to generate guidelines informed by people holding a range of perspectives.

References
Out Together – Delivering Innovative Peer Support Within an NDIS Context

Charles Anderson

Wellways Australia, Burnie, Australia

Biography:
Charlie has a living experience of the intersection of mental health challenges, disability, being a member of the LGBTIQ+ community and peerwork. Charlie is the LGBTIQ+ Peer Project Manager and a Peer Trainer with Wellways. The Out Together Project has brought together professional and personal passions for Charlie.

Wellways were funded in 2017-18 to deliver “Out Together” – a project to develop, pilot and evaluate a new LGBTIQ+ peer workforce model within an NDIS service environment. Goals of the project included improving the capacity of NDIS providers to recruit, train and engage an LGBTIQ+ peer workforce and to provide NDIS participants who identify as LGBTIQ+ with more choice, including access to peer workers and their lived experience expertise. The project also included the development of an LGBTIQ+ peer workforce toolkit.

The workshop is targeted at service providers, peer workers and advocates who are interested in exploring the possibility of delivering peer work under the NDIS.

Workshop Plan
Introduction (20 min)
- Acknowledgement of country (1 min)
- Welcome and introductions (3 min)
- Establish safe space (in line with Intentional Peer Support principles) (7 min)
  • Workshop group “discomfort agreement” on white board – designed to encourage individuals to consider their needs and to create the conditions for people grow in the space outside of their comfort zone
  • Acknowledge impact of dominant heteronormative worldview
- Icebreaker: invite participants to share some personal reflection in small groups (10 min)

Presentation (20 min)
- Exploring the experience of LGBTIQ+ people in a heteronormative world and the impact of a self/societally/service-imposed “Closet” on:
  • Personal identity (sexuality, gender, hiding aspects of self)
  • Assumptions about the self (internalised and externalised stigma)
  • Mental, social and emotional wellbeing
  • Disability and the capacity to access and exercise choice and control (5 min)

- The Out Together project: rationale and structure (5 min)
- Out Together project learnings (10 min):
  • How to support NDIS participants who identify as LGBTIQ+ to engage with NDIA pathways and forums to improve access
  • Creating deeper and wider engagement with LGBTIQ+ stakeholders
  • Creating a space in which LGBTIQ+ staff and participants are valued, safe and invite us in (as opposed to coming out to us)
  • Increasing organisational LGBTIQ+ cultural competency
  • Developing a toolkit for NDIS service providers
  • Influencing and resourcing the NDIA and the mental health service sector

Interactive Workshop (40 min)
- Small group exercise: assess and discuss what your organisation or your role would need to do to establish and support an LGBTIQ+ peer workforce in NDIS operational environment. Components to consider:
  • Supporting a LGBTIQ+ specific workforce within mainstream service
• Building organisational cultural competency
• Recruitment issues - inviting LGBTIQ+ workers and participants
• Addressing specific needs for LGBTIQ+ people
• Training and supervision systems – delivering best practice with limited resources
• Integration with non-peer workforce staff (multidisciplinary team or clinical staff)

-Whole group exercise: working with risk - reflections on possible challenges and needs for LGBTIQ+ peers, including:
  • Accessing LGBTIQ+ spaces such as nightclubs or Sexpo safely – being aware of drugs, alcohol and sex
  • Sharing of lived/living experience
  • Negotiating between organisational boundaries and personal limits

-Individual reflection and small group discussion: How can organisations deliver this type of program in a sustainable way?
  • How can we use our current resources differently?
  • What might need to change in the system to enable us to deliver effective peer support?

-Reflections back to the whole group

-Whole group discussion and brainstorming: Do we need to advocate for peer programs within an NDIS environment?
  • Key advocacy strategies for providers, peer workers and participants
  • Influencing big-picture change - getting involved in systemic advocacy

Q&A (10 min)

Learning Objectives

Learning Objective (1): Workshop participants will learn about the importance of appropriately delivering and supporting peer support as an option for people who identify as LGBTIQ+ and who are accessing the NDIS. Participants will draw on the example of Wellways’ development and practical application of an Intentional Peer Support program within the NDIS; and explore practical strategies to effectively support this type of work within their own organisations, professional roles and advocacy activities.

Learning Objective (2): People within the LGBTQI+ community experience a higher incidence of mental health issues than the general population, and also experience significant barriers to accessing health services. Peer support is increasingly recognised as an effective tool to support engagement and recovery; and the barriers to applying best practice peer support models within the current NDIS environment and the need for innovation and advocacy are urgent issues within the community-managed mental health sector.

References


Anna Love¹, Julie Anderson², Frances Sanders², Kate Thwaites¹, Nicole Edwards¹
¹Office of the Chief Mental Health Nurse, Australia, ²Office of the Chief Psychiatrist, Australia

Biography:
Anna Love is the Chief Mental Health Nurse, Victoria. I have worked as a Director of Nursing both in Mental Health and Drug and Alcohol services. I was involved in the decommissioning of the North Eastern Metropolitan Psychiatric Services which gave me my first experience of managing service change and reform and it has been an area of interest since that time. My vision is to ensure we have a skilled Mental Health Nursing workforce for the future which is flexible, responsive and works collaboratively with consumers and carers encouraging self-determination and self-management of mental health and wellbeing.

Julie Anderson is the Senior Consumer Advisor in the Office of the Chief Psychiatrist in Victoria. She is experienced in consulting with people who have a mental illness about services and would say it is the best part of her job. Julie has advised Federal and State Governments on mental health policy.

Frances Sanders is the Senior Carer Adviser with the Office of the Chief Psychiatrist in Victoria. Prior to this she has worked leading NDIS business development, consumer and carer services and strategy and has held executive roles in the mental health and employment sectors since 1995.

Kate Thwaites is a mental health nurse working in the Victorian Office of the Chief Psychiatrist which includes nursing leadership projects with the Victorian Chief Mental Health Nurse. My professional vision is a compassionate health care system which provides evidence based care, nurtures, values and develops clinical staff.

Nicole Edwards is a mental health nurse advisor at the Office of the Chief Mental Health Nurse. Nicole has 24 years’ experience working in a range of mental health settings and is committed to educating the mental health nursing workforce, reducing restrictive practices and improving safety for consumers and staff.


Presenters: Anna Love, Victorian Chief Mental Health Nurse, Kate Thwaites, Mental Health Nurse, Julie Anderson, Senior Consumer Advisor, Nicole Edwards, Mental Health Nurse Advisor, Frances Sanders, Senior Carer Advisor, Office of the Chief Mental Health Nurse

Key Words: Recovery, Trauma informed, Clinical Issues, Innovation, Quality, Lived Experience, Collaboration, Workforce

Unifying themes: Quality and Safety innovation

Anna Love, Victoria’s Chief Mental Health Nurse initiated the development of a training and development package to support a new clinical practice framework for mental health intensive care in Victoria. The aim of the program of work is to guide nursing care for intensive care for consumers in inpatient settings in Victoria, with a view to state wide implementation following a pilot across all inpatient settings. The project covers a number of key areas, including modules of training focusing on research based evidence on attitudes and values, recovery and trauma informed care principles, and therapeutic engagement foundations and training.

The development of a framework for Mental Health Intensive Care has included:
• a state-wide review of current high dependency units;
• the review of the current policy High Dependency Unit guideline from the Chief Psychiatrist
• engagement and consultation with key stakeholders, including peak consumer and carer bodies to inform a framework of Mental Health Intensive Care.
• the concurrent project of training for nursing staff has been developed by the Office of the Chief Mental Health Nurse’s senior consumer and carer advisors.
• the training and development modules for nursing staff aims to ensure competency and skill development in providing mental health intensive care to our most vulnerable consumers.
• this training package was piloted at a service where an immediate need for training and development of nursing staff was identified.
• the training was delivered by senior consumer and carer advisors. and senior nursing staff from the Office of the Chief Mental Health Nurse.
• the program is delivered in a multimedia platform with videography and face to face training modules
• evaluation and feedback on the framework has informed the state wide program delivery

The Mental Health Intensive Care framework intends to distinguish Mental Health Intensive Care as a specialist care type that can be delivered across settings. When applied, the concept of Mental Health Intensive Care uses the patient need as the determinate; henceforth a patient may be in receipt of MHIC whether treated in a MHIC area (formerly HDU), or in any other treatment environment as is available, and deemed the most appropriate by the service provider. The Mental Health Intensive Care framework and guideline is intended to support decision making about the use of mental health intensive care, as well as the development of local policies and procedures to ensure consistent standards and to maintain safety.

Mental Health Intensive Care is a specialist care type that exists to support and maintain safety and therapeutic engagement for individuals experiencing increased risk associated with an acute mental illness. Mental Health Intensive Care can be delivered in any treatment environment, and should be organised to ensure that specialist resources and interventions are in place, and that mechanisms for continuous appraisal, early identification of deterioration, and processes for timely escalation are in place.

All decisions regarding Mental Health Intensive Care must reflect consideration of consumers’ rights and recovery goals and the risks and anticipated benefits of the care type.

**Learning Objectives**

Learning Objective (1): The audience will learn the process of development of a clinical practice framework in Victoria for a mental health intensive care framework focusing on recovery oriented care principles.

Learning Objective (2): The topic is relevant to the audience as the work was a collaboration of carer consumer and clinical staff to deliver an innovative program of skills development about intensive care nursing care developed around the experiences of consumers, carers and clinical staff.

**References**

National Minimum Standards for Psychiatric Intensive Care in General Adult Service, national association of psychiatric intensive care & low secure units, 2014
Delivering Quality and Value: Focus on: Psychiatric Intensive Care Units (PICUs), NHS Institute for Innovation and Improvement, 2008
A National Quality Improvement Program for Organisations Designing and Delivering Suicide Prevention Programs and Services.

Michelle Kwan

1Suicide Prevention Australia, Sydney, Australia

Biography:
Michelle Kwan is Knowledge Exchange Manager at Suicide Prevention Australia, leading The Suicide Prevention Hub: Best Practice Programs and Services project. Michelle has a Bachelor of Public Communications and Masters in International Public Health. Michelle has worked extensively in the not-for-profit sector over the last 8 years specialising in marketing and campaigns in organisations including the National Breast Cancer Foundation, The George Institute for Global Health and The East Bali Poverty Project.

The improvement of quality standards in suicide prevention requires a national whole-of-sector approach. It also requires broad support among service providers, Federal and State Government funding agencies, and other stakeholders delivering regional, evidence-based, and locally-tailored suicide prevention programs and services.

The Suicide Prevention Hub: Best Practice Programs and Services (The Hub) is a user-friendly and publicly available evidence-based online resource. The Hub was created to strengthen the evidence-base and drive quality improvement among suicide prevention programs and services. It will support and inform Government and other providers involved in service planning and commissioning of suicide prevention activities at a local and regional level by providing the best available evidence on suicide prevention programs and services.

The scientific criteria for the submission of programs and services into The Hub for independent review were informed by an Expert Advisory Group consisting of representatives from Lived Experience, public health research, clinical research, evaluation, behavioural research, and service delivery backgrounds. The methodology was developed to facilitate the evaluation of a range of program and service types. This ranges from large national programs and services to small community-delivered grassroots and innovative programs.

The selected evaluation framework enables scientific rigour across a range of program and service types incorporating standards set by the National Health and Medical Research Council (NHMRC), strategies and frameworks developed by national and international bodies (WHO, 2014) and evaluation experts (Evergreen, 2018).

The Hub is the first resource of its kind in Australia aimed at sharing knowledge about what works in suicide prevention and why, and will also identify areas where programs and services may need strengthening or enhancement. Through The Hub, organisations may be eligible for mentoring support to build capacity in program design and/or evaluation.

This presentation will provide a broad understanding of the development process for a national quality improvement program and some of the key learnings for organisations designing and delivering suicide prevention programs and services.

Learning Objectives

Learning Objective (1): Audiences will gain insight into the design, development and implementation of a nationally coordinated, evidence-based, and stakeholder informed online resource to support service planning, delivery and continuous quality improvement.

Learning Objective (1): This presentation will identify the types of programs and services that are shown to work in communities and why. It will also provide guidance to those designing and delivering programs and services of their own.

References
Following Whispers: Resilience Coaching

Emma Mauro¹, Steve Bobs¹
¹Centacare FNQ, Cairns, Australia

Biography:
Emma Mauro is a Resilience Coach. She enjoys watching people grow and develop as they embrace life after a mental health diagnosis. Passionate about her own growth and development, she is an active participant in the creative arts, which she attributes the progress she has made in her own recovery.

Steve is the team leader at Centacare Coaching Team. She came from a private wellness coaching practice which utilised coaching modalities with mindfulness, meditation, Qi Gong and Movement. Steve is passionate about people taking leadership in their own lives. Married with 2 beautiful girls and a naughty old dog.

Background: Looking for a best way forward in recovery, Centacare Mental Health Resource Service sat down with people living with a mental illness, their friends and family, staff and service supervisors to design an effective person-centred, recovery-oriented personalised support program. Centacare FNQ Mental Health Service consumers living with complex, severe and persistent mental illness, and their carers of the Cairns and Hinterland Hospital and Health Service.

Aims: We explore how Resilience Coaching improves outcomes for people living with mental illness, how it inspires leadership in those living with mental illness from their experience of being coached by workers with a lived experience or who can come from their own experience of overcoming adversity. Concurrently, this encourages lived experience workers to embrace their own leadership journeys. To share some of the tools and techniques we use as Resilience Coaches with coachees. To discuss a coaching session and creating an individual coaching plan.

Method: Resilience Coaching evolved from narrative coaching by combining a number of coaching modalities and Intentional Peer Support with a person-centred recovery-oriented practice. Practitioners can use Resilience Coaching to follow the whispers of the coachee’s story and listen to what is between the lines to uncover the needs the coachee requires to meet in order to move forward in their recovery. Resilience Coaching also hears the whispers of a person’s wellbeing and can contribute to building their resilience and allow them to stretch further into the recovery space using somatic practices. We use tools such as mindfulness, NLP, EFT, drumming, and directive writing to embody resilience in coachees. Resilience Coaching looks holistically at individuals: Body, Soul, Spirit and Contribution. Coachees also learn to retell the stories of who they are and what their lives can be, creating a Declared Vision for themselves and moving towards it. The coaching model adopted by Centacare FNQ Mental Health Resource Service has also been implemented internationally, notably in the United Kingdom, The Netherlands and Canada. Coaching practices in this service have built leadership capacity in the local community, grown the number of people with a lived experience working in services and supported other local volunteer Consumer and Carer groups.

Conclusion: The Resilience Coaching approach is improving and empowering the lives of people living with a mental illness through action based learning to build resilience and support them in their recovery stories. It is also creating leaders from amongst the lived experience workforce. Resilience coaching is always evolving.

Workshop Outline
The aim of the workshop is to:
- Explain "Why Coaching?" and "How we use it"
- Share sample questions to establish coachability
- As a group, learn a selection of self-assessment tools
- Create an individual coaching plan
- Discuss a coaching session
- Q & Q

Learning Objectives
Learning Objective (1): In this workshop, participants will learn how to a simple self-assessment tool, create an individual coaching plan and review a basic coaching session. They will also learn how coaching can be used as effective tool in a person’s recovery journey.
Learning Objective (2): Resilience coaching is relevant to mental health services and mental health issues as it is a new and developing part of the mental health service landscape and a service that can be offered to people living with a psycho-social disability under their NDIS plans that are action based and future focused.

References


Using the Internal Nurturing Parent and Creative Writing as a Therapeutic Intervention for Healing from the Impacts of Childhood Trauma

Di Frost¹
¹Creative Heart Healing, Kempsey, Australia

**Biography:**
Di is a psychologist survivor who works with child, adolescent and adult survivors of childhood trauma, helping them connect with their creativity and inner resources for healing. She works individually and holds specialised retreats that enables deeper connection with the childhood wounds through exploring writing and creative arts for healing.

We cannot heal in isolation. When a child's trust is betrayed by abusive carers, healing requires a loving, nurturing, trustworthy parent figure to support, encourage and love the survivor back into wholeness. Connecting survivors with their own internal nurturing parent gives them access to unconditional love and support for their own healing.

Trauma memory and emotions are stored in the right hemisphere of the brain which is also where creativity resides. We can use the creative arts to help clients access the traumatic emotions of childhood in a gentle and safe way, so they can be processed and integrated into their lives.

Creative writing helps to integrate right and left hemispheres of the brain as it connects imagination/creativity from the right brain with the left brain’s process of putting thoughts and ideas into words and onto the page.

This paper will explore how we can use brain science and ideas from a range of therapies to teach clients a process that allows them to find the internal resources to support themselves, write about their traumatic/triggering events, take care of their painful emotions, be soothed by their internal nurturing parent, and be re-empowered to let go of past hurts.

**Learning Objectives**
Learning Objective (1): The audience will gain an understanding of how creativity, in particular writing can be used to heal the wounds of childhood trauma. The audience will be able to implement strategies that can be used with clients and consumers to process past traumas and current triggers.

Learning Objective (2): Research, in particular the Adverse Childhood Events study, has demonstrated that childhood trauma is linked to adverse mental and physical health issues in adulthood. Being able to resolve trauma is the key to healing and recovery. The creative writing strategies suggested in this paper are a powerful tool in trauma recovery.

**References**


Mental Health Recovery in the Context of Tenancy Conditionality

Judith Lewis

Welfare Rights Centre, Adelaide, Australia

Biography:
Judy is a social worker with an established background in clinical mental health and housing. BSW (Hons 1), BSPlan, PhD Candidate. Judy is currently the social worker for the Welfare Rights Centre, Housing Legal Clinic's SACAT program which specialises in assisting people avoid eviction and homelessness.

There can be no question that safe, affordable and appropriate accommodation underpins continued wellbeing (Muir et. al, 2008). For clients with ongoing mental health problems safe, affordable, appropriate and sustainable accommodation as a contribution to wellbeing is often critically undermined in the context of a higher vulnerability to tenancy failure (Habibis, 2007). Public housing in South Australia has undergone significant change in recent years and there is evidence of increases in conditionality with relation to problems associated with tenants with chronic mental health problems. With levels of affordability and conditionality in the private rental market placing private tenancies out of the reach of many mental health sufferers, governments at all levels need to embrace the notion of joined services in the development of new models of early intervention around tenancy challenges including anti-social behaviour and hoarding and squalor. A review of alternative housing/accommodation arrangements more sensitive to the needs of this vulnerable population are warranted. Current models of public housing available to people with ongoing mental health problems are leading to tenancy failures, homelessness and the likelihood of rapid declines in mental health that require acute medical intervention and extended stays in high cost mental health facilities.

Learning Objectives

Learning Objective (1): To gain a greater understanding of the housing problems faced by many Australians with mental health problems.
Learning Objective (2): This presentation challenges mental health services to consider how joined up services, early intervention and more sensitive models of public housing support mental health recovery.

References

‘I know why the caged bird sings’: Untangling Human Rights in Mental Health.

Indigo Daya

1VMIAC, Brunswick East, Australia

**Biography:**
Indigo Daya is the Human Rights Advisor at VMIAC and an independent mental health consultant. She has lived experience of trauma, madness and mental health services, and has held consumer leadership roles across the mental health sector, academia and government for over a decade.

‘I am calling on states to move away from traditional practices and thinking, and enable a long overdue shift to a rights-based approach.... Mental health policies and services are in crisis - not a crisis of chemical imbalances, but of power imbalances.’ (OHCHR, 2017).

Last year, the United Nations Special Rapporteur on the right to health issued a critical report on human rights breaches in mental health services internationally. His report echoed the narrative of consumers over many decades – yet the mental health sector continues to struggle with human rights.

Mental health legislation and policy increasingly speak about promoting and protecting the consumers’ human rights, but what does this really mean in practice for consumers, for services, for government? Right now, it is not uncommon for consumers to have around half of their human rights breached while using a mental health service. Are we doing enough, or have we not even begun?

This session will use consumer perspective to explore human rights issues in mental health services. This will include understanding human rights breaches, problematic misunderstandings about human rights, rethinking the intersection between human rights and quality and safety, and strategies for a more authentic approach to human rights.

**Learning Objectives**

Learning Objective (1): Attendees will take away a more critical understanding of the complexity of promoting human rights in a mental health service, and strategies for implementing positive change.

Learning Objective (2): This talk is relevant to any mental health worker, manager, policy maker, carer, or consumer. The obligation to uphold human rights exists for all mental health workers. And all mental health workers and systems face the impact of rights breaches on consumers –the better we understand the scale and complexity of these issues, the more effective we can be in upholding our duty.

**References**


Utilising a Communities of Practice to increase sector capacity through the NDIS reform: NDIS and Mental Health Community of Practice in Southern Adelaide.

Karrin Marshall¹, Nina Sabetzedah¹

¹LWB, Adelaide, Australia

Biography:
Nina Sabetzedah
Life Without Barrier’s Program Manager for SA Mental Health, and Homelessness services. Nina has a Bachelor and Masters Degree in Social Work and has filled a variety of roles in Mental Health, Homelessness and Child Protection sectors in South Australia.

Nina has a strong background in therapeutic approaches, group-work, team-building, service development and capacity building.
Nina has worked with people across the human life span including infants, young children and adolescents and has experience working with individuals, groups and families in a variety of settings and contexts.

Life Without Barriers (LWB) is a social purpose organisation working in more than 440 communities across Australia. Nationally, our services currently support just over 14,000 people living in their own homes or in residential houses that we manage. In South Australia we support children, young people and families, people with disability, older people, people with mental illness and people living with drug and alcohol concerns. We work with people who are homeless and refugees and asylum seekers.

Partners in Recovery (PIR) is a commonwealth program aimed at providing improved coordination of supports to people with severe and persistent mental illness, their carers and families in a more collaborative, coordinated and integrated way. Southern Adelaide, Fleurieu and Kangaroo Island (SAFKI) PIR is a consortium of agencies who are committed to bringing together community stakeholders to improve service delivery for people living with a mental illness in the Southern Adelaide region, with Life Without as the lead agency.

In 2017 with the roll out of the National Disability Insurance Scheme (NDIS) beginning across South Australia for those people with a psycho-social disability, SAFKI PIR identified the need for opportunities to share knowledge, expertise, increase capacity building and mutual support in changes to service delivery in the mental health sector through the reform that is the NDIS. After some research, it was decided that the establishment of a local NDIS and Mental Health Community of Practice (COP) would be the most appropriate forum for this development and growth.

The SAFKI PIR COP provides a forum for sharing knowledge, expertise and information between stakeholders who have an interest in psychosocial disability – this includes service providers/organisations who engage with customers who anticipate transitioning to the NDIS, as well as customers, their carers and families.

SAFKI PIR considers the NDIS to be an important, reform and welcomes the inclusion of people with psycho social disability in the scheme. We also recognise that there are unique principles of service, history, context and language in mental health that will need to be recognised and responded to for the scheme to operate effectively for people with psychosocial disability. Some of the key objectives of the CoP are as follows:

- Joint learning and innovation from CoP participants which include mental health customers, families and carers; community mental health and disability service providers (both Commonwealth and State); clinicians; key government agencies, and
- Other key stakeholders (such as local council ‘round tables’, GPs, practice nurses and NDIS).
Effective relationships are developed between the above stakeholders, which result in an increased ability to understand and facilitate the effective inclusion of customers with a psychosocial disability who anticipate engaging with the NDIS.

The SAFKI PIR COP, highlights that building and investment in individual and sector capacity cannot be undertaken in isolation. The SAFKI CoP maximises collective knowledge, generates insights and ways of working, aids in solving problems and creating innovations within the community.

Information and analysis produced from the COP informs organisational research, practice development and policy action to ensure the reforms we are undertaking are reflective of the need in the community. There is particular emphasis on the inclusion of consumers, family members and carers, in relation to the successes, concerns, challenges and changes associated with NDIS in the sector. The COP provides mechanisms for active reflection on the current environment and the opportunity for the sharing of common experiences in this reform.

The reflection and review process has supported SAFKI PIR to conduct needs analyses within the local community. We have had various findings which have informed practice as well as assisting local stakeholders to have a greater understanding of local community needs.

Through the implementation of the COP we have been able to strengthen local capacity, increase the learning for staff and stakeholders in relation to the NDIS, respond to the needs of the community and create an opportunity for new and innovative ideas.

Learning Objectives

Learning Objective (1): How a communities of practice can increase local communities capacity in the transition to the NDIS
Learning Objective (2): NDIS will impact on people accessing mental health services and this workshop will provide information on how to support this sector moving forward

References


Promoting Consumer Rights

Julie Anderson¹, Indigo Daya²
¹Office Of The Chief Psychiatrist Victoria, Melbourne, Australia, ²Victorian Mental Illness Awareness Council (VMIAC), Brunswick, Australia

Biography:
Julie Anderson is Senior Consumer Advisor in the Office of the Chief Psychiatrist in Victoria. She is experienced in consulting with people who have a mental illness about services and would say it is the best part of her job. Julie has advised Federal and State Governments on mental health policy.

Indigo Daya is the Human Rights Advisor at VMIAC and an independent mental health consultant. She has lived experience of trauma, madness and mental health services, and has held consumer leadership roles across the mental health sector, academia and government for over a decade.

One of the four statutory roles of Victoria’s Office of the Chief Psychiatrist is:
‘to promote the rights of persons receiving mental health services’ (s120, MH Act, Vic, 2014)
The Victorian Office of the Chief Psychiatrist has focused its consumer rights work on reducing restrictive interventions, and on promoting gender and sexual safety. These issues remain high priorities, however it is clear that the need to promote consumer rights, and the issues and contexts related to rights are becoming increasingly complex. The aim of this paper is to outline a project that begins to explore mechanisms to support the Chief Psychiatrist in the statutory obligation and build a stronger, more strategic and consumer-driven foundation for the ongoing and effective promotion of consumer rights. The project will ensure that an outstanding requirement of the Act is properly implemented with outcomes being the development of a guidance document: an action plan for the Office of the Chief Psychiatrist that proposes short, medium and long term actions, priorities and resources to fulfil the above statutory role; formation of a Victorian Consumer Rights Advisory Group that provides ongoing, expert advice to the Chief Psychiatrist about the above statutory role.

Learning Objectives

Learning Objective (1): The audience will learn the process of placing Human Rights in the centre of the Statutory role of the Office of the Chief Psychiatrist in Victoria.

Learning Objective (2): This topic is relevant in that it is an enabler for Human Rights to be overt in Mental Health.

References

Improving Social Outcomes For People Living With Complex Mental Illness: Presenting The Vision For The Anne Deveson Research Centre

Michelle Blanchard

\(^1\)SANE Australia, South Melbourne, Australia

**Biography:**

Dr Michelle Blanchard is the General Manager Research, Policy and Programs at SANE Australia, a national charity working to promote the wellbeing of people affected by complex mental illness. Michelle is developing SANE’s research agenda which will partner with people with mental illness to drive both policy and social change.

In 2018, SANE Australia will establish the Anne Deveson Research Centre to promote social outcomes for Australians living with complex mental health problems, their family, friends and colleagues. The Centre honours Anne Deveson’s extraordinary contribution to the lives of Australians experiencing mental illness.

As Janet Meagher AM noted in accepting the 2017 Australian Mental Health Prize, more often than not, mental health research focuses on understanding brain science – that is, the biology or cognition of mental illness, rather than understanding how the illness may affect an individual’s social outcomes.

The Anne Deveson Research Centre is unique in that it aims to bring together researchers from a range of backgrounds and disciplines with a non-government organisation (SANE Australia) and other sector and industry partners, to explore these complex challenges in a cohesive way.

The Centre will work with existing Research Centres where relevant, and will advance the understanding of how best to promote social outcomes for people living with complex mental illness and their family, friends and colleagues.

Importantly, the Centre will actively engage people with lived experience of complex mental illness as researchers, co-designers of new approaches, and as experts in their own experiences.

**Learning Objectives**

Learning Objective (1): This session will make the case for the important role of psychosocial research in improving health and social outcomes for people living with mental illness.

Learning Objective (2): The research undertaken by the centre will be critical in promoting social outcomes for people living with complex mental illness.
The Complexity of Lived Experience: Exploring Consumer/Carer Differences, Alliances and Tensions

Indigo Daya1, Vrinda Edan1,3, Lorna Downes2, Rachel Lovelock4
1VMIAC, Brunswick East, Australia, 2St Vincent’s Hospital, Melbourne, Australia, 3University of Melbourne, Parkville, Australia, 4Wellways Australia, Fairfield, Australia

Biography:
Indigo Daya is the Human Rights Advisor at VMIAC and an independent mental health consultant. She has lived experience of trauma, madness and mental health services, and has held consumer leadership roles across the mental health sector, academia and government for over a decade.

Vrinda Edan is a PhD student at University of Melbourne and Chair of the VMIAC Committee of Management. Vrinda has worked from a consumer perspective and human rights position for 20 years, including senior health management and as chief investigator on PULSAR, a Mental Illness Research Fund project.

Lorna has worked in mental health for 15 years, in a range of family/carer lived experience roles, and lived experience workforce development. She is passionate about peer work, and purposeful sharing of personal narratives to increase understanding and improve relationships between family members, friends, consumers and service providers.

Rachael is a manager, advocate and family/carer leader who draws on her lived experience and community development background to lead, design and implement advocacy strategies, community and peer educations programs at Wellways Australia. She advocates to ensure lived experience is heard, rights are upheld, and principles of co-production are upheld.

“‘It is not our differences that divide us. It is our inability to recognize, accept, and celebrate those differences.’” (Lorde, 1994)

From the 1960s on, Audre Lorde brought the attention of feminists to the reality of intersectionality. She reminded the world that the experience of a black woman is not the same as that of a white woman, nor of a black man. Difference and struggle often sits in the intersection of difference. In mental health, one such intersection is that of consumer and carers, meeting in the space of ‘lived experience’.

Consumers and carers are increasingly put together on committees. Sometimes, unfortunately, we are even considered interchangeable. Sometimes we are expected to speak for each other, or we are expected to reach a consensus. While each of us has a lived experience, naturally our lived experiences can differ significantly - which means what we want can be very different too. And to complicate matters more, many of us have both types of lived experience.

What does this mean for the integrity and effectiveness of our advocacy efforts?

This workshop is for consumers and carers, and it will explore the ways that consumers and carers tend be in a natural alliance, and the common kinds of tensions that can arise when consumers and carers come together. What are these different opportunities and challenges, and how can we work with them in ways that lead to less confusion, more ethical practice, and better outcomes for all of us?

During this workshop we will work collaboratively to find mutually respectful understandings of difference, and generate ideas for improved ways of working.

This workshop will not always be a comfortable space, however we are committed to creating a respectful place. We will encourage conversations which are often avoided or only hinted at. The workshop is designed and facilitated by two consumers and two carers with a long history of working collaboratively.
Workshop outline:

Setting the scene
• Introduction
• Historical differences, alliances and tensions
• Strategies for mutual respect

Interactive workshop
• Introduction by facilitators
• Key areas of alliance, including respect, inclusion and helpful services
• Key areas of tension, including power, who speaks for whom, safety vs freedom, trauma vs family blaming
• Ethical dilemmas, including wearing both hats

Working with difference
• Strategies for changing how we work: recognising difference, accepting difference...celebrating difference?

Debrief and close

Learning Objectives

Learning Objective (1): Attendees will gain an enhanced appreciation of the difference and similarities between consumer and carer perspectives, and strategies for how to translate this understanding into more ethical and effective work.

Learning Objective (2): This talk is relevant to anyone working from consumer or carer perspective in order to influence change in mental health services and systems. It is particularly relevant to those consumers and carers who want to better understand how to navigate areas of historical tension between consumers and carers.

References

Walking the Line: The ever-present tensions of being a peer-run organisation in a complex operating environment.

Eschleigh Balzamo
*Brook RED, Brisbane, Australia*

Biography:
Eschleigh’s career has focused on working into the nexus of evidence and experience. Eschleigh is currently CEO of Brook RED where she has the incredible privilege of working in a team of Lived Experience practitioners who deliver a range of mental health and suicide prevention services from a peer framework.

Lived-experience practice is a values-based way of working. This rapidly evolving approach was born of the desire to implement ways of working that are built on the knowledge gained from a personal experience of working toward recovery. Brook RED is a medium-sized community mental health and suicide prevention service which is governed, managed, and operated entirely by people with a personal lived-experience. This paper explores the challenges that the organisation faces as it grows and works to stay viable in an increasingly complex funding and operating environment.

Challenges to be explored include: human resources considerations, addressing competition, managing the tension between customer versus consumer priorities, clinical governance, the commodification of recovery and suicide prevention, and engaging the people accessing services in organisational planning.

Learning Objectives

Learning Objective (1): Attendees will have an increased understanding of the operational and strategic tensions experienced by a lived-experience service as it grapples with the realities of being viable as a business while holding its values.

Learning Objective (2): It is critical that we are aware of the environmental factors influencing Lived-Experience Practice and that we are reflective in managing these in order to ensure fidelity to values and high-quality Lived-Experience Practice.

References


Understanding the Experience of People Living With Personality Disorder in Australia

Michelle Blanchard\(^1\), Elise Carrotte\(^1\)

\(^1\)SANE Australia, South Melbourne, Australia

**Biography:**
Dr Michelle Blanchard is the General Manager Research, Policy and Programs at SANE Australia, a national charity working to promote the wellbeing of people affected by complex mental illness. Michelle is developing SANE’s research agenda which will partner with people with mental illness to drive both policy and social change.

Elise Carrotte is a Research Assistant at SANE Australia. She is also completing her Masters in Clinical Psychology.

SANE Australia was engaged by the National Mental Health Commission from December 2017 to May 2018 to conduct a research project, which aims to understand how best to meet the needs of Australians living with personality disorder. This project is designed to consolidate and extend existing work in this field.

The project included:

1. The preparation of a discussion paper examining the prevalence of personality disorders in Australia and identifying evidence-based approaches to prevention; early intervention; treatment; and support for recovery and relapse prevention.
2. Engagement with Australians living with personality disorders and their families, friends and other support persons, to explore their experiences with prevention; early intervention; treatment; and support for recovery and relapse prevention through a small qualitative study.
3. An environmental scan of key activities relating to improving wellbeing for people living with personality disorders and support persons in Australia.
4. Provision of key recommendations for improving services and clinical practice in this context.

This presentation will focus on the findings from this research and explore recommendations for improving services and clinical practice for people living with personality disorder.

**Learning Objectives**

Learning Objective (1): The audience will gain an understanding of the experiences of Australians living with personality disorder, including some of the challenges they face accessing help and support

Learning Objective (2): This session will provide recommendations for improving the provision of mental health and other services for people living with personality disorder.

**References**


Better Off With You: Putting Lived Experience at the Centre of Suicide Prevention

Jack Heath¹, Michelle Blanchard¹, Philippa Costigan¹
¹SANE Australia, South Melbourne, Australia

Biography:
Jack Heath has been the CEO of SANE Australia since 2012 and has been working to improve the lives of Australians affected by mental illness for more than two decades. After the suicide of his 20-year-old cousin in 1992, Jack was motivated to establish the Inspire Foundation and ReachOut.com, using the internet to address Australia’s then escalating rates of youth suicide.

Dr Michelle Blanchard is the General Manager Research, Policy and Programs at SANE Australia working to promote the wellbeing of people affected by complex mental illness. Michelle is developing SANE’s research agenda which will partner with people with mental illness to drive both policy and social change.

Philippa Costigan is General Manager Digital and Communications at SANE Australia. She is a multichannel digital communications specialist and writer with extensive experience in the arts, government and not-for-profit sectors.

The tragic impact of suicide on the lives of so many Australians is recognised in the Government’s Fifth National Mental Health and Suicide Prevention Plan which calls for a national, coordinated systems-based approach to suicide prevention that includes, among other elements, the need for public information campaigns to support the understanding that suicide is preventable.

The Better Off With You campaign concept draws on evidence-based frameworks which identify potential risk and protective factors that can be modified for suicide prevention, as well as communication approaches and techniques that have been shown to resonate strongly with target audiences.

As a starting point the campaign concept uses Thomas Joiner’s Interpersonal Theory of Suicide prevention which identifies ‘perceived burdensomeness’ as a key belief for individuals who are having suicidal thoughts, and leverages the power of peer-to-peer communication to create compelling messaging and stories that are expected to resonate strongly with target audiences and, over time, will contribute to changing attitudes and behaviour.

This presentation will explore how the insights of people with lived experience of suicide have informed the development of the Better Off With You concept through participatory design and formative evaluation.

Learning Objectives

Learning Objective (1): The audience will gain an understanding of how a campaign targeting burdensomeness in people at risk of suicide has been developed in partnership with people with lived experience

Learning Objective (2): Lived experience insights are critical to understanding how best to design a campaign to prevent suicide in those most at risk

References


Trauma Transformation

Louise Lamont\textsuperscript{1}
\textsuperscript{1}Phoenix Support & Advocacy Service Inc., Perth, Australia

\textit{Biography:}
Louise Lamont has held senior positions in the community sector and in State and Federal Government. When working as a clinician and trainer Louise specialised in the areas of domestic violence, sexual abuse and family therapy. Louise is a certified Self-Regulation practitioner through Canadian neuroscientist Dr Stuart Shanker.

This paper will provide an overview of a trial program developed and run by Phoenix Support & Advocacy Service, and known as 'Trauma Transformation'. This psycho-educational program was provided for adult survivors of child sexual abuse with the intention of providing relevant information to assist participants to understand the impact of traumatic experiences in childhood. The program also gave participants the opportunity to experience alternative therapies such as trauma informed yoga and mindfulness techniques. In addition, art and music activities were included along with the opportunity to learn about self-regulation strategies and experiment with these in the program and at home. The intention of the program was to enhance the individual counselling support provided by Phoenix and to provide an opportunity to develop a peer support network with those that had had similar experiences in childhood. This presentation will also provide an overview of the outcomes of the trial and some qualitative examples of feedback received from participants. Information about how safety and support was built around this program will also be discussed.

\textbf{Learning Objectives}

Learning Objective (1): The audience will gain insight into the benefits of a psycho-education program in addition to one to one counselling support.
Learning Objective (2): The audience will gain insight into the benefits of offering a range of strategies for those seeking ways to address their mental health challenges and support their wellbeing.
Alternatives to Suicide - an alternative to suicide prevention approaches.

Joe Calleja\(^1\), Lyn Millett\(^2\)
\(^1\)Calleja Consulting, Victoria Park, Australia, \(^2\)MercyCare, West Perth, Australia

**Biography:**
Joe Calleja is a social worker who has held senior positions in government and the non government sector. His most recent role was as CEO of Richmond Wellbeing in Western Australia. He now runs a part time consultancy in mental health organisational repositioning.

Lyn Millett is a Clinical Psychologist who is currently Executive Director Family and Community Services with MercyCare in Western Australia. She has previously held positions as WA State Manager of Headspace and in Forensic Psychology.

There is very little focus in Australia of engaging the Lived Experience in the design or co-design of activities in response to suicide. The Alternatives to Suicide approach offers a peer-based approach which supports people through some of their darkest moments and thoughts of wanting to die. It draws on people’s wisdom gained from having survived this far to create a safe space for participants to talk through their distress and thoughts. It is non clinical and does not use risk assessment to manage or screen participants. The approach is based on similar principles to that of groups in the Hearing Voices Network. MercyCare first introduced this approach into Australia in February 2017 and brought the trainers back in March 2018. The Alternatives to Suicide Peer Support approach was developed by the Western Massachusetts Recovery Learning Community from listening to people who said they stopped disclosing their thoughts of suicide because of the interventions they experienced when they reached out. The interventions experienced by many were described as being more distressing than the feelings that were causing them to consider suicide. The approach can be an option that some might choose to engage in if available in Australia.

**Learning Objectives**

Learning Objective (1): Attendees will understand the basis of the Alternatives to Suicide peer support approach from the Western Massachusetts Recovery Learning Community from the US and why it is relevant to Australia.

Learning Objective (2): Attendees will learn how the Alternatives to Suicide peer support approach is being introduced to Western Australia through a Steering Committee led by MercyCare Western Australia.

**References**

Davidow, Sera: Suicidal Tendencies, Part I: I'm Suicidal Because I'm Mentally Ill Because I'm Suicidal January 24, 2016
https://www.madinamerica.com/author/sdavidow/

Davidow, Sera: Suicidal Tendencies, Part II: The Real 'Stigma' of Suicide March 2, 2018
https://www.madinamerica.com/author/sdavidow/
Supported Independent Living and Psychosocial Disability - 18 months on, where are we now?

Mark Heeney1
1Mind Australia Ltd, Melbourne, Australia

Biography:
Mark has over 15 years’ experience in the mental health, disability and homelessness sector in Victoria, NSW and overseas. He has a keen interest in advocacy and research, especially in the space of peer support and co-designing residential services. Mark has a background in Applied Sciences, and is currently the Business Development Manager for Supported Independent Living and Dual Disability at Mind.

Once the NDIS has completely rolled out Supported Independent Living will account for one third of the operational costs.* Latest figures show only 6.4% of NDIS participants have a primary psychosocial disability, less than half than expected. ** At TheMHS, Sydney 2017 a presentation was made about the history of Mind's residential services and what the future holds in relation to NDIS – SIL. Including how a sector approach was needed to advocate for individuals with a psychosocial disability to be funded for SIL.

Since then, Mind has successfully transitioned all the existing state block funded customers in the North East Melbourne Area to NDIS - SIL. As a result, this has given customers greater choice, control and opportunity to imagine better by having access to greater levels of support. Mind has also commenced SIL services in other parts of Victoria as well as QLD.

This presentation will draw on the positive and sometimes negative experience customers have had of the transition, as well as how Mind is delivering a number of types of SIL models including an enhanced dual disability model and enhanced family focussed model.

Learning Objectives

Learning Objective (1): The audience will leave this session with a greater understanding of how Supported Independent Living (SIL) can be offered to NDIS participants with a psychosocial disability. How SIL quoting works and how peer learning workshops can be offered as a shared support.

Learning Objective (2): With state-based services in Australia transitioning in to the NDIS, this presentation explores how community managed mental health services are having to respond and advocate for individuals with a psychosocial disability to receive SIL within their NDIS plans.

References

*National Disability Service, Practical Guide SIL Quoting, Version 1, January, 2018
SANE Australia's Peer Ambassador Program

Michelle Blanchard\(^1\), Natalie Rutstein\(^1\), Sarah Coker\(^1\)
\(^1\)SANE Australia, South Melbourne, Australia

Biography:
Natalie Rutstein is the Lived Experience Coordinator at SANE Australia a national charity working to promote the wellbeing of people affected by complex mental illness. Natalie has been instrumental in the relaunch of the SANE Peer Ambassador Program

Dr Michelle Blanchard is the General Manager Research, Policy and Programs at SANE Australia. Michelle is developing SANE's research agenda which will partner with people with mental illness to drive both policy and social change.

Sarah Coker is the Head of Programs at SANE Australia where she leads SANE's suicide prevention programs and a number of other strategic projects.

SANE Australia recognises the valuable role played by those with lived experience and their loved ones. Their unique insights, perspectives and personal experiences are vital to the ongoing success of SANE Australia’s research, programs and resources as they are shared in a variety of ways with corporate, government and non-government organisations, the media and broader community. SANE Australia has a long history of partnering with people with lived experience. Historically, the SANE Speakers Program has created opportunities for people with Lived Experience to share their stories to reduce the stigma associated with living with complex mental illness.

In 2018 SANE reviewed and relaunched its Lived Experience engagement program as the SANE Peer Ambassador Program.

The SANE Peer Ambassadors Program brings together all those affected by complex mental illness – those with lived experience as well as their family, friends and colleagues. The new program partners with people with lived experience, their family and friends to:
1. Gain insight from a diverse range of people with lived experience of complex mental illness and their carers
2. Inform the direction or decisions being made within the organisation
3. Improves the quality of SANE’s services, programs and outcomes
4. Increases the relevance, profile and impact of advocacy and research
5. Gains new perspectives and solutions on issues
Helps to reduce stigma and reach others with complex mental illness in the wider community

This presentation will examine how this renewed program will strengthen outcomes for people with lived experience of complex mental illness and enable SANE to realise its mission.

Learning Objectives

Learning Objective (1): The audience will gain an understanding of the renewed SANE Peer Ambassador Program
Learning Objective (2): The engagement of people with lived experience is critical to improving mental health services and outcomes and reducing stigma and discrimination.
'From Within': The Spirituality of Peer Support

Jennifer Maries¹,²
¹Inner West Area Mental Health Service, Melbourne, Australia, ²Melbourne Health, Melbourne, Australia

Biography:
Jen Maries has been a peer support worker in Melbourne for eighteen months. She has a keen interest in spirituality and how it intersects with peer support practice. Prior to her current role, Jen worked in education. She is learning to love the upsides of being a bit crazy.

This presentation explores the extent to which peer support can be said to involve working with the spirituality of consumers of mental health services. It proceeds from an understanding of spirituality as that which at its most basic level concerns meaning-making. The paper proposes that meaning-making can constitute simultaneously both a great strength and a great weakness of consumers, individually and collectively; the implications of this for working constructively and creatively with spirituality are considered. Examples from the presenter’s own practice as a peer support worker are given to demonstrate both the spiritual talents of consumers, and the ways in which peer work can be used to support the shift of spirituality towards healing and away from harm. The facility of the IPS model, along with other structures and characteristics of peer support, for enabling this aspect of the work, are discussed. Lastly, the interface between spirituality and the politics of the consumer movement is considered. Delegates who attend may expect to gain an understanding of the intersection between peer support practice, spirituality, and politics; and how a spiritual element to recovery may be facilitated ‘from within’.

Learning Objectives

1. Delegates will take away from this presentation an understanding of:
   - how spirituality (understood as that which concerns meaning-making) forms an integral part of peer support;
   - how working with spirituality can be done from ‘within’ (within spiritual practice and within the lived experience);
   - what the characteristics of peer support that enable this work are.

2. This topic is relevant to mental health services as the potential interplay between recovery, resilience and spirituality is increasingly recognized, and clinicians seek to understand how spirituality can form part of recovery-oriented practice. It is relevant to the mental health issue of lived experience work and how the consumer workforce and clinical staff can work together for the benefit of consumers.

References


Understanding What It Means to be Socially Included for People with a Lived Experience of Mental Illness

Kate Filia\textsuperscript{1,2}, Henry Jackson\textsuperscript{3}, Sue Cotton\textsuperscript{1,2}, Eoin Killackey\textsuperscript{1,2}
\textsuperscript{1}Orygen, The National Centre Of Excellence In Youth Mental Health, Parkville, Australia, \textsuperscript{2}Centre for Youth Mental Health, University of Melbourne, Parkville, Australia, \textsuperscript{3}Melbourne School of Psychological Sciences, University of Melbourne, Parkville, Australia

Biography:
Dr Kate Filia is a postdoctoral researcher at Orygen, The National Centre of Excellence in Youth Mental Health. Her research interests include social inclusion and mental illness, with a particular focus on early intervention and improving long-term outcomes for young people with severe mental illness.

Social inclusion is an important contributor to good mental health outcomes. A lack of consensus exists regarding key contributors to social inclusion. The input of those most vulnerable to social exclusion, people with severe mental illness (SMI), is lacking in discussions regarding this issue.

The aim of this study was to obtain such an understanding from people with a lived experience of SMI. A consensus was sought regarding the importance of a list of 147 potential contributors to social inclusion from three groups (N=104): people with a diagnosis of SMI (n=32), carers or family members of individuals with SMI (n=32), and general community members (n=40).

Consensus was quickly reached regarding a large number of items. 122 were noted as important contributors, 21 by 100\% of participants. Twenty-five items were not considered important. Contributors that received high endorsement regarding their relevance to social inclusion were related to availability/affordability of housing, health, financial ability to participate in activities, stigma and discrimination, and negative life events.

These findings demonstrate what the true experts in social inclusion and SMI consider most important to social inclusion. Insight from individuals living with SMI is essential in the planning, delivery and implementation stages of service and policy.

Learning Objectives

Learning Objective (1): ‘What will people in the audience gain or learn from attending this presentation?’
A greater understanding of social inclusion from the perspective of individuals with SMI. An understanding of how these perspectives differ from those of professionals working in the field and the implications of what these differences might be.

Learning Objective (2): ‘How is this topic/issue relevant to mental health services and mental health issues?’
Improvements in social inclusion have been associated with greater mental health outcomes. People with SMI are amongst the most socially excluded of all groups. A greater understanding of what social inclusion means and what importance contributors to social inclusion hold to people with a lived experience of SMI is essential in developing appropriate and effective interventions and strategies to improve aspects of social inclusion and subsequent mental health outcomes for those affected by SMI.
Community Residential Facilities in Australia: Recovery-Focussed Practices and Symptomatic and Recovery-Oriented Outcomes for Service Users

Lisa Brophy1,2, Shifra Waks1, John Farhall3,4, Vrinda Edan1,5
1University of Melbourne, Melbourne, Australia, 2Mind Australia Limited, Heidelberg, Australia, 3La Trobe University, Bundoora, Australia, 4North Western Mental Health, Australia, 5Victorian Mental Illness Awareness Council (VMIAC), Brunswick, Australia

Biography:
Lisa Brophy is Associate Professor in the Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne and Principal Research Fellow at Mind Australia. Lisa’s research interests include the implications of the shift to individualised funding for people with psychosocial disability and efforts to reduce coercion and restrictive practice. She is also actively leading program evaluation and outcome measurement projects.

John Farhall is Associate Professor, Psychology and Counselling, La Trobe University and Consultant Clinical Psychologist North Western Mental Health. His research and clinical work focuses on understanding psychosis and psychosocial treatments and services for people living with psychosis.

Shifra Waks is a consumer researcher at the University of Melbourne. She has recently finished her studies in psychology and has a Masters in International Public Health. Shifra is a current PhD candidate at Swinburne University and hopes to continue to strengthen consumer voices in the mental health system, education and research spaces.

Vrinda Edan is a consumer researcher, educator, PhD student at the University of Melbourne, and Chair of the Victorian Mental Illness Awareness Council (VMIAC) Board.

Community residential facilities are an important component of comprehensive mental health services in many countries world-wide, including within Australia, especially for people living with complex mental health problems. PARCS (Prevention and Recovery Care Services) are sub-acute residential services provided across Victoria and more recently in other states, operating in a partnership model that integrates clinical mental health care with intensive recovery-focused psychosocial support, however the role and outcomes of the service model are not well established. The Prevention and Recovery Care (PARC) project is an NHMRC-funded evaluation of the appropriateness, effectiveness and efficiency of adult PARC services in Victoria. The project is a partnership between four universities (Melbourne, Monash, Deakin, LaTrobe University), Mental Health Community Support Services (MHCSS), clinical mental health service providers and the Victorian Government. This symposium will report on preliminary results to date through two papers and stimulate discussion via a panel session.

Paper One: Are Prevention and Recovery Care Services (PARCS) delivering the intended services, and who is using them?
Emerging results from service mapping and case register studies
Presenters: Lisa Brophy John Farhall.

Background: The almost complete system of PARCS in the state of Victoria provides an opportunity to consider their role and outcomes at a state level. We describes PARCS, including their consumer profile, and treatments and recovery-informed practices offered.

Method: Nineteen adult Victorian PARCS were profiled in a service mapping exercise using an international tool (QuIRC) to assess the quality of care, and a purpose-designed questionnaire, to collect data about operations. Consumer profile, and symptom and admissions outcomes, from case register data for 43,640 individuals admitted to an acute inpatient unit, and/or a PARC service, across a six-year period, were examined.

Results: PARCS vary substantially across service and contextual domains, including the living environment and the treatment and interventions offered. Most PARCS users also accessed acute inpatient units. PARC-only users
accounted for 32% of admissions and were more likely to be female, voluntary and have a mood or anxiety disorder. PARCS consumers had significantly fewer subsequent acute inpatient admissions and bed days compared with Acute unit–only consumers, however, their total bed days across both service types was greater.

Conclusions: Services and quality indicators vary across PARCS. Consumer profiles overlap with inpatient units but have distinct differences. Further studies now underway will enable a more complete picture.

Paper Two: Consumer satisfaction and lived experiences of PARCS across Victoria
Presenter: Shifra Waks
Quantitative and qualitative findings from one Prevention and Recovery Care PARCS project sub-study will be presented and discussed in this presentation. This state-wide longitudinal study is monitoring the recovery and wellbeing outcomes of people who access PARC services across Victoria. The findings include presenting data collected from over 200 consumers examining the results from the Mind Australia Satisfaction Survey (MASS), the INSPIRE and qualitative analysis from consumer participants’ responses. The MASS is used to measure consumers' satisfaction with mental health services and the INSPIRE is used to assess consumers’ experiences of support they receive within services to support their personal recovery. It is crucial that consumer experiences of services are engaged to understand and help guide service delivery reform, recovery-oriented practice and research in the Australian mental health system and world-wide and we aim to share findings that will help identify the strengths and limitations of the PARCS model.

Paper Three (Panel discussion): Perspectives on Prevention and Recovery Care Services (PARCS)
Presenters: Lisa Brophy (Chair), Vrinda Edan, others TBC
The Panel session aims to share the perspectives of study partners on the purpose and effectiveness of PARCS across Australia, and to discuss the emerging results from the state-wide Victorian study presented in the preceding papers. The panel will include representatives from PARCS providers, both clinical and community mental health support services, as well as consumer and carer perspectives. The panel members will discuss how findings that are emerging from the PARCS project are influencing their current thinking about PARCS and directions for ongoing service innovation. This will be an interactive session with the audience.

Learning Objectives

Learning Objective (1): The audience will better understand the consumers satisfaction and experiences of engaging with PARCS services and what impact these services may have on the recovery of consumers.
Learning Objective (2): There will be increased understanding regarding how research focused on PARCS is influencing service development and innovation

References

Allies: Opening Doors in Postgraduate Education

Julia Bocking¹, Brett Scholz², Anna Curtis³
¹HETI, NSW and Synergy Nursing & Midwifery Research Centre, , , ²Synergy Nursing & Midwifery Research Centre, Canberra, , , ³HETI, NSW Government, ,

Biography:
Julia Bocking has been an advocate in the consumer movement for 16 years. She draws on her own experiences of hospitalisation, coercion, forced medication and resulting stigma in her work. Julia is a current PhD (Public Health) candidate at the University of Canberra, exploring consumer roles. She is passionate about social justice and improving the system.

The involvement of consumers in educating health professionals is proven to enhance educational offerings. Research shows that students gain more empathy and insight about recovery. Despite the positive impact reported in the literature, involving consumers in postgraduate education is not well established. Allies are needed to create such roles and other opportunities for consumer-led teaching. Allies are defined here as non-consumers who support the knowledge which people with lived experience hold. We created a unique partnership between a consumer, university, and government to offer teaching from a consumer perspective. Each partner was able to use their expertise to add value. It is important that allies use their influence to facilitate opportunities and resources (do what they can), and avoid directing the content or speaking for the consumer movement (knowing their place). We all benefited from our partnership, including our students!

Learning Objectives

Learning Objective (1): An example of a successful partnership to incorporate consumer-led teaching in postgraduate health education
Learning Objective (2): Two key principles for academic allies to the consumer movement

References


The Whisper Behind Metaphors Used In Reflective Practice Supervision

Terri Burton
Tabor College of Higher Education, Morley, Australia

Biography:
Terri Burton is an academic and researcher with vast Reflective Practice Supervision and counselling experience. She is passionate about supporting parents in their parenting roles particularly during the early years. Her research interests include alcohol misuse, peri-natal depression experiences for both parents, and eating disorders in pregnancy.

Reflective supervision is well established as a crucial instrument for supporting effective practice with families of young children, particularly those families where parents have mental health concerns. This interaction with families can be emotionally evocative and complex, therefore, it is imperative that practitioners take time to reflect upon and process the intricacies of what has transpired within these relationships. Regular reflective practice supervision occurred for nursing staff at an early parenting support facility in Perth, Western Australia over the past four years, with Reflective Practice Supervisors additionally meeting monthly during this time for ongoing supervision.

During these reflective practice sessions, it was noticed that an abundance of metaphors proliferated discussions. Metaphors enable people to ascribe affect to language by evoking past emotions and have been demonstrated as an effective means to enable the expression of feelings which might be too painful to address directly. An exploration of the metaphors used by the reflective practice supervisors of early parenting practitioners highlighted the complexities of practice and broadened the cognitive landscape of the supervisors as they listened to the whispers underneath the roars of communication. Learning from practitioner’s metaphors used can provide greater insight into practice with clients with mental health concerns.

Learning Objectives

Learning Objective (1): Participants will have greater awareness of the power of metaphors used by practitioners who have been involved in early parenting support of families with mental health concerns.

Learning Objective (2): Participants will gain knowledge on the magnitude of Reflective Practice Supervision for practitioners involved with families with mental health concerns.

References


The Value of Authentic Cultural Change

Manu Sione
Emerging Aotearoa, Auckland, New Zealand

Biography:
Manu is of Māori (Ngāti Whātua), Samoan and Cook Island (Pukapuka) descent born and raised in Auckland. He is National Manager - Culture for Emerging Aotearoa. His role is to support the development of Māori and Pasifika cultural awareness, responsiveness and competency within the 900+ staff working at Emerging Aotearoa.

This presentation will show what Emerging Aotearoa has done to achieve one of their Strategic Pou (priorities) to date i.e. "Meeting the needs of Māori tangata whaiora". It will include video and korero (feedback/discussion) from tangata whaiora (those seeking wellness) and whānau (families). It will highlight the Emerging Aotearoa Kaupapa (vision, purpose, values and principles) within the organisation.

Takarangi Competency Framework was introduced to Emerging Aotearoa in February 2016. Takarangi was developed by Māori clinicians, tangata whaiora, managers, and whānau within the addictions and mental health sector and endorsed by Matua Raki (an entity of Te Pou Whakaaro).

Takarangi Competency Framework provides support and better understanding of engagement, communication, tikanga (Māori protocols) and Te Reo (Māori language) from a Te Ao Māori (Māori world view) that is integrated with clinical practice to provide a best practice service model.

To date 577 staff have attended the Takarangi 2 day training hui (gathering) which includes an overnight stay on a Marae. Staff develop their Takarangi portfolio as evidence of practice within their service. 22 Takarangi assessors work with staff to assess their practice. Video's will highlight the positive changes for tangata whaiora and whānau as a result of staff making cultural changes.

Learning Objectives
Learning Objective (1): The audience will know how cultural responsiveness and competency has improved engagement, communication and assessments and outcomes with whaiora (those seeking wellness) and whānau (families) at Emerging Aotearoa.
Learning Objective (2): Audience will see how whaiora have shown progress in their mental health and wellbeing. It will show the engagement of whaiora, whānau and communities in the journey of recovery and wellness.
Emerging Minds: The National Workforce Centre for Child Mental Health

**Bradley Morgan¹**

¹Emerging Minds, Hilton, Australia

**Biography:**

Brad Morgan is Director of the National Workforce Centre for Child Mental Health, a new initiative established by the Australian Government to strengthen the capacity of workforce groups supporting parents, children and families to identify, assess and support children at risk of mental health difficulties.

Supporting children’s mental health should be a responsibility of all health and welfare practitioners and organisations, whether they work directly with children or not. The Emerging Minds: National Workforce Centre for Child Mental Health has been established to assist professionals and organisations who work with children and/or parents to have the skills to identify, assess and support children at risk of mental health difficulties.

The National Workforce Centre incorporates three key components: an online workforce gateway for members of diverse workforce groups to access resources such as practice guides, training, webinars, tools and apps; a national network of regionally-based Child Mental Health Workforce Consultants to support workforce development, systems change, information exchange and collaboration; and, a communication and knowledge translation strategy to support the diffusion of evidence into practice.

**Learning Objectives**

Learning Objective (1): Reflect on opportunities to integrate a parallel focus on parent and child mental health in adult or child focussed mental health services.

Learning Objective (2): Identify resources that can assist mental health organisations to strengthen workforce capacity to respond to the mental health needs of parents, infants and children.

**References**


"Our Voice" shares the journey that Red Cross is on in partnership with people with lived experience at the centre to rethink how we can best respond to the needs of people with mental health concerns - designing new solutions with people that address and resolve social exclusion amongst those experiencing mental ill-health so that they can live connected, meaningful lives as part of their communities.

Amber Mackinnon

Australian Red Cross, Adelaide, Australia

Biography:
Amber currently works at the Australian Red Cross leading complex service development projects to improve the wellbeing of people experiencing extreme vulnerability. Most recently this has been assisting the organisation to understand the impacts and prepare for the disability, mental health and aged care reforms and preparing for transformational change in establishing a culture of consumer centred care and leading a national initiative using co-design to rethink how we can best respond to the needs of people with mental health concerns.

Amber has worked in the non-profit sector for the last fourteen years across diverse portfolio areas including; Families and Communities, Justice, Homelessness, Food Security, Youth Engagement, Membership and Corporate Engagement. Prior to this Amber’s back ground was in Human Resources, practising both domestically and internationally. Amber has her own lived experience of mental health and is a very proud Mum of two beautiful, active boys and loves watching them grow up and being apart of their lives. In her spare time, Amber enjoys spending quality time with her family and friends, which is usually focussed around food and getting her hands dirty in the garden.

Australian Red Cross is using co-design to rethink how we can best respond to the needs of people with mental health concerns and to design new solutions with people that address and resolve social exclusion amongst those experiencing mental ill-health so that they can live connected, meaningful lives as part of their communities. Our co-design journey commenced in March 2017 and still continues.

People with lived experience are the experts, the ‘voice of experience’ and are at the heart of this process.

This project has actively engaged with more than 250 people across the Mid-North in South Australia, Kalgoorlie in Western Australia and Hervey Bay in Queensland, including carers, family members, volunteers, local community stakeholders and government, but most importantly, community members with lived experience. The number of people who wanted to share their story and improve their life was incredible.

This presentation titled “Our Voice” shares the design journey, the concepts that have been developed, where we are in the process of implementation and presents reflections from community members with lived experience of mental health concerns who partnered with us and so bravely shared their stories.

We look forward to sharing our story with you.

Learning Objectives

Learning Objective (1): People in the audience will:
* gain an understanding of what co-design is;
* the learning's of using co-design as a methodology for service design; and
* the benefits of embedding consumer voice in service design.
Learning Objective (2): This presentation is very relevant to mental health issues. The entire focus of the presentation is about putting people with lived experience at the heart of a co-design process and together designing new solutions with people that address and resolve social exclusion amongst those experiencing mental ill-health so that they can live connected, meaningful lives as part of their communities.

References

Mad Studies: Exploring an emerging (anti-disciplinary) discipline.

Flick Grey¹
¹Independent, Melbourne, Australia

Biography:
Flick Grey is a wandering Mad academic, consultant, trainer, peer support manager and supervisor. She has child parts and takes delight in connecting with rivers, unicorns and enlarged spaces embracing human vulnerability and richer, more complex and nuanced ways of thinking about experiences, beyond the medicalisation of distress.

Mad Studies is an emerging discipline* internationally, offering more expansive ways of thinking about experiences of distress and extreme states (that have been - in recent history and in some cultural contexts - more commonly described as "mental illness"). Mad Studies brings together a diversity of scholars (including activist scholars) who think beyond the narrow medicalisation of human experiences (or any of the dominant psy- stories about what experiences mean), engaging deeply with questions of history, politics, gender, sexuality, culture, power, social justice, philosophy, spirituality, etc.

Mad Studies is inclusive of multiple perspectives, but privileges the experiences and meaning-making of folks who are Mad-identified (or whatever self-identification makes sense**), much as queer studies, black studies and Indigenous studies take seriously the engaged knowledge production of these specific communities (rather than the knowledge production of "disinterested" observer "experts", like an old-school anthropologist studying "the natives" or medical/legal experts studying "the homosexual").

There are a few small pockets of Mad Studies emerging in Australia and this workshop is an opportunity to come together to better understand what's happening in Australia, what Mad Studies is (or could be) and what kind of supports we might need from our Allies (ie. folks who are not Mad-identified, but who appreciate the crucial work of Mad scholarship).

You don't have to be Mad to attend this workshop, but it will definitely be fun, challenging and lively.

(*arguably Mad Studies is better understood as an anti-discipline, in that it challenges traditions of "disciplining" of knowledge into separate(d) disciplines

**Not everyone loves this word "Mad", but Mad Studies acknowledges there is never going to be a single word that unites such disparate experiences and meaning-making. It's a reclaimed word, like Queer, that is intended to be confronting, and to open up new space for thinking differently).

Learning Objectives

Learning Objective (1): Participants will come away with an understanding of what Mad Studies is, could be and might need to grow in Australia.

Learning Objective (2): Mad Studies is an incredibly generative space for thinking about experiences that get described as "mental health issues". If mental health services are to meet people in their full diversity, and respect their meaning-making, Mad Studies can support the intellectual infrastructure required to offer space beyond the medical model.

References


Lessons from Oakden - Where Lived Experience and Coproduction is Enabling Culture Change

Rebecca Wheatley¹, Lorraine Baff, Brett Partington

¹SA Health, Adelaide, Australia

Biography:

Lorraine Baff
Retired CEO of a Registered Training Organisation.
Wife of Jim Baff, carer of Jim
Have advocated in the area of mental illness for over 30 years, worked with HEROCS, Disability Action, WorkCover Focus Groups, Patients Rights Assoc, DIRC numerous submissions to the DDA Commissioner Sir Ronald Wilson to disallow SA Govt an exemption under the Disability Discrimination Act of mental illness being excluded under the WCRA of 1996.


Rebecca Wheatley - Senior Medical Practitioner, Older Persons Mental Health, SA health – Northern Adelaide Local Health Network, passionate regarding human rights of individuals having worked in various primary health care settings from youth to older persons. With a significant interest in mental health of persons in homelessness. Worked in Indonesia following the 2004 Tsunami and received the Humanitarian Overseas Service Medal – Indian Ocean – for work under dangerous circumstances: Australian Federal Civilian Government Award. Trainer of trauma informed care with a focus of elimination of restrictive practice.

Mental illness is often shrouded in prejudice ignorance and myth. Oakden was a classic example, The Oakden Report described a culture of institutionalisation, over medication, and general lack of compassion merely because there was thought to be no other option for older people with enduring mental illness and dementia. Oakden is not isolated. Mental illness has been plagued with controversy for decades.
We cannot continue to look backwards, it is time to look forward. Our coproduction working group consisting of health professionals, and those with lived experience is producing innovative practices, empathic staff and a culture of caring that enhances the quality of life of those we care for.
The mental health service has learnt to listen – not just hear the words of those who have experienced the solitude that those with mental illness and their families suffer. We are producing an inclusive cultural change through our work at Northern Adelaide Older Persons Mental Health Service – we are endeavouring to implement change to give a voice to those who cannot express their feelings.
Change can only be implemented by education not merely just training. The collaboration and engagement of coproduction has been instrumental in the culture change to reduce restrictive practices and to provide compassionate care that is surrounded in hope.

Learning Objectives

Learning Objective (1): The sharing of the experience of the coproduction process both the highlights the challenges and barriers encountered in the coproduction of reduction of restrictive practices. The inspiration to model this elsewhere to embed culture change.
Learning Objective (2): Changing restrictive practices through culture change with collaborative coproduction being the foundation of change to enable paradigm shifts in mental health care.

References

South Australia: SA Health, Department for Health and Ageing.
Hear the raw whisper of creative discovery - Transform your journey through poetry!

Alise Blayney, Lynda Hennessy

1South Eastern Sydney Recovery College, Sydney, Australia, 2WayAhead Mental Health Association NSW, Woolloomooloo, Australia

Biography:
Alise has been a Peer Worker for five and a Poet for life. She is intrigued by the relationship between mental and emotional distress, creativity and the power of language. She learns by holding the hope for people who are on a transforming journey moving from breakdown towards breakthrough.

Lynda has been involved with the Consumer Movement since 1997. She has worked as a Consumer Participation Coordinator for 8 years, and a Consumer Representative on a wide range of committees and organisations. She is currently involved with the SUPER CRO (Service Users Participating Educating, Researching, Consumer Run Organisation).

This writing workshop aims to draw upon the Recovery themes of Hope, Responsibility and Empowerment, Shaping Identity and Healing and Finding Meaning and Establishing Connection.

We plan to utilise creative writing and poetry exercises to help people gain an understanding of how these recovery themes are important to their mental health discovery journey.

Words are weapons, they can either empower us or destroy us - therefore we have the responsibility to be mindful of how we use language and how we can use it to shape, transform and rebuild identity.

A further aim of this workshop is to be a pre-cursor for linking, promoting, providing exposure and celebrating the creative work that will be performed at the MAD Pride concert during the TheMHS conference (date for the concert TBA).

Brief background of MAD PRIDE: MAD PRIDE is a world-wide movement fighting and advocating for issues that are important to consumers. It is the celebration of mad culture which seeks to reclaim the language that is central to and surrounds it. It can be liberating for consumers to call ourselves "mad".

Outline of workshop:

1. Introduction:
   - Welcome & Acknowledgements
   - Benefits of creative writing and poetry for mental health
   - History of MAD Pride concerts
   (10 mins)

2. Warm up activity: Free Writing Exercise
   - Stream of consciousness / automatic writing exercise to engage people with the tool of writing – Participants are encouraged to write for 5 minutes without judgement or self-censorship to get creative juices flowing. (5 mins)
   - Brief post discussion to examine this modality, feedback from how people found the activity. (2 mins)

3. Poetry Writing Exercise:
   Make your scars your stars - The I AM poem
- Poetry writing exercise based on a template provided for completion. Participants create a work that is an own ode to their journey and experience. (15 mins)

4. Sharing our creations
- Willing participants share their work with the group.
This is a great opportunity for self-expression, supporting social connectedness and promoting inclusion. (15 mins)

5. Mindfulness / self-care reflective exercise
- Checking in with the group, reflective practice, guided meditation. (7 mins)

6. Close
- Questions
- Resource List handout
- Feedback & Evaluations. (6 mins)

**Learning Objectives**

Learning Objective (1): The audience will learn and develop skills in poetry, creative and expressive writing by participating in exercises to gain an understanding of how recovery themes of responsibility, hope, self-expression and empowerment are important to mental health.

Learning Objective (2): This topic is relevant to mental health services and issues as it is a new pathway to care and is being utilised in the Recovery College's Creativity for Recovery course and MAD Pride workshops. It is also a therapeutic and healing way to work through trauma issues such as PTSD as it promotes wellbeing and can re-shape, re-claim and re-build identity. Drawing on the creative arts culture, we can foster social connectedness by sharing our stories through the powerful medium of language and imagination. Creative / expressive writing and poetry also has the capacity to bring about meaning-making by helping people understand their personal experiences and what has happened to them. It can also challenge the dominant bio-medical model and lead people towards finding new ways of making sense of their journey, through exploring different explanatory frameworks of mental/emotional distress.

**References**


Borderline Personality Disorder and other (nonsense) stories I've been told.

Flick Grey

Independent, Melbourne, Australia

Biography: Flick Grey is a wandering Mad academic, consultant, trainer, peer support manager and supervisor. She has child parts and takes delight in connecting with rivers, unicorns and enlarged spaces embracing human vulnerability and richer, more complex and nuanced ways of thinking about experiences, beyond the medicalisation of distress.

Many of us have been offered stories about our experiences ("diagnoses") that make some sense, but when we spend years and years really reflecting and thinking (and researching, and going to conferences, and working in the sector, and connecting with other fellow travellers and international experts and generally doing everything we can trying to get our head around it all), we realise sometimes diagnoses are a kind of nonsense, or in the words of Adelaide-based child psychiatrist Dr Jon Juredeni, they can be "unexplanatory" - they fail to explain our experiences, in fact they get in the way of explanation. For me, the label Borderline Personality Disorder (BPD) has been the worst offender of this nonsense (or unexplanation). This talk will offer some other explanatory frames I have found to be more useful for understanding experiences that get labelled as BPD, drawing on both the wealth of diverse international thinking and on original research.

Learning Objectives

Learning Objective (1): The audience will gain a range of other possible ways of thinking about experiences that get labelled as BPD.
Learning Objective (2): This diagnosis is one of the most maligned within mental health services, and this talk hopes to offer more compassionate frameworks for meaning-making.

References


Anti-anti-"stigma" - a search for more useful words.

Flick Grey

Independent, Melbourne, Australia

Biography:
Flick Grey is a wandering Mad academic, consultant, trainer, peer support manager and supervisor. She has child parts and takes delight in connecting with rivers, unicorns and enlarged spaces embracing human vulnerability and richer, more complex and nuanced ways of thinking about experiences, beyond the medicalisation of distress.

This paper critically examines the word "stigma" and argues that this term causes more problems than it addresses. The paper draws on doctoral research into patterns across different ways of understanding prejudice, othering and marginalisation, the "anti-stigma" literature, and a wealth of analyses of how "anti-stigma" rhetoric has been deployed, to argue that the word "stigma" reduces understanding, and has become a short-hand for "barriers to help-seeking from mental health professionals" (ie. it can be understood as a sophisticated advertisement for mainstream mental health services). This paper explores a broader conceptual landscape, offering some richer, more precise and (hopefully) helpful language.

Learning Objectives

Learning Objective (1): People will gain a deeper understanding of how the term "stigma" gets in the way of tackling the problems it purports to address
Learning Objective (2): Stigma is often identified as an important issue for mental health workers to address

References


Extending our Reach: An Integrative Treatment Approach

Maree Brogden

Biography:
Maree Brogden is a registered practitioner, NZRN (1986) AThR (2008), who uses an interdisciplinary approach to resource her clinical practice, “where working with complex mental health needs is to acknowledge the diversity necessary for an expert clinical approach. As an RN and AThR, my practice interest extends to integrate a contemporary psychological practice content. This was achieved by self-funding further postgraduate education”. Recent work includes Team Lead and Lecturer roles for a New Zealand tertiary education provider.

Deterioration and deprivation occurs as an ongoing problem of small and large concern. It is significant that we can ask about what we know, as unknowingly, to know more and differently in the context of social change. Contemporary mental health treatment in New Zealand considers the people in relationship. To identify local treatment needs provides the opportunity for an intimate local insight. A transfer of this treatment philosophy into the domains of practice accountability, will transform your practice. A positive symptom of the whisper is opportunity. Without the opportunity to be heard, the whisperer is silenced, “Ko hea waiata of the grieving Kōkako? Hē korero e werewere ... tū tahanga”.

To extend the rudimentary whisper, we need to know about the people, e koia te pū!

Nga kōmuhu
haumūmū ki te muhu hau,
kō te hau
o tētahi te tukutuku,
reflection, review and reform.

Extending our reach across the professions of a contemporary healthcare practice, is where the practitioner who can listen across disciplines, will also hear the whispering story. Various reiterations of these whisperings misheard, is perhaps what we most often investigate in mental health practice. Investigation is to consider, ‘how the lived-experiences of our client groups may occur as phenomenological evidence about the conscious and unconscious collective voice’ of the one and many peoples with whom we live, together and alone.

Learning Objectives
Learning Objective (1): An Introduction to an integrative practice, ‘attaining and sustaining wellbeing in healthcare’
Learning Objective (2): An overview of a contemporary cross-discipline practice approach for mental healthcare that recognises the complex whole treatment.

References
Safe Spaces - Creating a New Way for Communities

Rachel Watson
1Wesley Mission Queensland, Kedron, Australia

Biography:
Rachel is a social worker with over 25 years experience in the NGO and Govt sectors. She has a broad experience across Indigenous communities, health promotion, mental health, housing and homelessness. Social inclusion creating places and communities around people is a major focus of Rachel's work. Rachel is a Director of the Residential Tenancies Anchority (RTA) and the Chair of Queensland Shelter (peak body for housing and homelessness. She believes that housing is a right that enables people to connect in to their community and that it is a significant factor to increasing people feeling mentally healthy and resilient. She is a proud supporter of the North Queensland Cowboys.

Safe Spaces in North Brisbane has been a process of utilising community collateral to create a integrated system of locations both public and private that facilitates people with a mental illness to choose not have a hospital presentation. The process of developing a community of shared understanding and then implementation of a process to offer a scaled safe space intervention for people experiencing psychological distress has created a more collaborative system. Development of safe space logos and brand for each site to indicate what level of support they can offer a person is creating a place based response to people with a mental health issue living in the community. Building on what existing services are already able to do eg: libraries, community centre, local business is they key to the development of a safe space movement.

Learning Objectives

Learning Objective (1): The audience will gain practical skills to build a safe space movement in their local areas. Exploration of the wins and challenges of implementation of a community development model to address mental health in the community.
Learning Objective (2): The session will offer in learnings of the project and an opportunity to join post conference a community of practice in relation to safe space.

References

Angela Taylor, Brisbane North PHN, Mental Health Coordinator
Hear the whispers, not the roar, of the Peer Network process - learnings and outcomes from their partnership in the Brisbane North five year regional plan.

Paula Arro\textsuperscript{1}, Rebecca Wyeth, Hellie Fox-Taylor
\textsuperscript{1}Brisbane North PHN, Brisbane, Australia

Biography:
Paula Arro
Paula Arro is the Consumer and Carer Participation Coordinator for Mental Health and Alcohol and Other Drugs at the Brisbane North PHN. The role includes all Consumer and Carer engagement within the PHN and working externally to build the capacity for a coordinated and collaborative approach that is person centred.

Rebecca Wyeth
As a consumer with a living experience of mental illness I have become passionate in being a part of the Consumer/Carer Participation world in mental health. I am currently studying a Cert IV in Mental Health and Cert IV in Mental Health Peer Work as well as participating in a variety of Governance Consumer Representative roles. My role gives me the opportunity to represent, learn, facilitate and/or present up to date information to various stakeholders.

Hellie Fox-Taylor
Hellie has both a historical and current experience with the mental health sector and is active in improving services for people both as a consumer and/or carer. Hellie is currently a peer worker at Neami at Strathpine, a peer mentor/tutor for Certificate IV in Mental Health & Peer Work with a local RTO, a carer for a number of family and others as well as a representative on committees.

Hear the whispers, not the roar, of the Peer Network process, learnings and outcomes from their partnership in the Brisbane North five year regional plan.
From ‘Blue Sky Dreaming’ through to implementation planning.
The Brisbane North Peer Participation in Mental Health Services (PPIMS) Network is a group of People with Lived Experience (PLE) in Brisbane North that meet monthly (since 2016). The purpose of the Network is to ‘work collaboratively to actively participate in mental health systems and reforms’. PPIMS aims are to having a collective voice, support other PLE to get involved, have regular sector updates, recommend strategies to improve PLE engagement, provide advice on emerging issues and participate in co-design opportunities.
Membership includes a range of PLE who live and work in the region in a variety of roles including peer workers, trainers and academics. PPIMS collects quarterly membership profile data that identifies our makeup, gaps in representation and special interest/expertise areas of members to support particular program areas.
Activities linked with PPIMS meetings have included scholarship programs for PLE, showcasing at regional, state, national and international forums/conferences, most recently the National Stepped Care PHN Workshop and contributing feedback to PHN’s seeking PLE engagement on mental health service reform.

Learning Objectives
Learning Objective (1): How to establish, develop and operate as a collective voice of people with lived experience in a local and regional level.
Learning Objective (2): How to build a culture within the mental health sector to actively engage with people with a lived experience at all levels not just one’s own service delivery.

References
Randall, R. (2016). Consumer co-creation in health: Innovating in Primary Health Networks (Evidence brief – Consumers Health Forum of Australia and the Australian Healthcare and Hospitals Association – August)
“Sometimes you need to ROAR to get things going!” – Lived Experience Workforce Development

Paula Arro\(^1\), Eschleigh Balzamo\(^2\)

\(^1\)Brisbane North PHN, Brisbane, Australia, \(^2\)Brook RED, Australia

**Biography:**

Eschleigh Balzamo

Eschleigh’s career has focused on working into the nexus of evidence and experience. Eschleigh is currently CEO of Brook RED where she has the incredible privilege of working in a team of Lived Experience practitioners delivering a range of mental health and suicide prevention services from a peer framework.

Paula Arro

*Paula Arro is the Consumer and Carer Participation Coordinator for Mental Health and Alcohol and Other Drugs at the Brisbane North PHN. The role includes all Consumer and Carer engagement within the PHN and working externally to build the capacity for a coordinated and collaborative approach that is person centred.*

Following on from the last TheMHS conference, a diverse group of Lived-Experience Practitioners began meeting to discuss their experiences, concerns, and the potential for collaboration to address issues facing the Peer Workforce in QLD. The roundtable is hosted by Brook RED and Brisbane North PHN and identified several shared issues impacting all regions across a range of services in QLD:

1. **Peer Work Leadership involvement is insufficient**
2. **No clear benchmark or standards exist for the Peer Workforce**
3. **The quality of training for Peer Workers varies considerably and is often inadequate**
4. **Limited supervision and supports exist for the Peer Workforce**
5. **There is a lack of an active Consumer Advocacy Peak Body**

The roundtable resolved to continue working together on a number of priority actions.

- Identification of resources to support sustainable regional representation in the Roundtable
- Mapping Peer Workers and networks and workers in the state to support inclusive communication and consultation
- Supporting the establishment of peak body and/or advisory structure to support the Peer Workforce and hosting a Lived Experience Leadership Forum to shape Statewide structures.

This paper will share the experience of an organic process of gathering many whispers together into a ROAR and will report on more recent meetings of the Roundtable, the outcomes of an open forum to explore the establishment of a Peer Work peak body and/or advisory structure, and the collective’s next steps.

**Learning Objectives**

*Learning Objective (1): Strategies for developing a statewide collective voice of Peers to advocate for Lived Experience Leadership and Workforce Development*

*Learning Objective (2): Identification and discussion of common themes and recommendations for turning research into practice.*

**References**


Let’s get real

Robyn Shearer

1Te Pou o te Whakaaro Nui, Auckland, New Zealand

Biography:
Robyn Shearer is the Chief Executive for Te Pou o te Whakaaro Nui – national centre for mental health, addictions and disability workforce development. Te Pou supports the Ministry of Health, agencies, services and frontline staff in New Zealand with workforce, research and data.

Robyn has worked in the sector for 30 years – beginning her career in nursing, then moving on to clinical leadership and management roles. She has worked at the Health Research Council of New Zealand and Ministry of Health leading programmes on mental health. She has been at Te Pou for 9 years and is on a number of national boards and advisory groups, as well as international leadership networks.

Let’s get real - a foundation framework to ensure we get the basics right and engage everyone working in health as a member of our workforce

In 2008 the Ministry of Health in New Zealand launched the first knowledge, skills, values and attitudes framework – Let’s get real. This was in acknowledgement that any worker in the mental health and addiction system needed to demonstrate appropriate knowledge and skills, underpinned by values and attitudes to support people with mental health and addiction problems. Let’s get real has served many purposes – describing the essential knowledge and skills required of all workers, regardless of role or profession. It aims to complement professional competencies and create a common understanding about the fundamentals of good practice. It has helped shape recruitment, HR practices, training, skill development and very importantly how values and attitudes shape someone’s experience in receiving services.

We are now in 2018 and the Let’s get real framework is being refreshed. The focus is on a framework that is for anyone in health working with people who experience mental health problems and addiction problems. The shift from the specialised workforce to anyone enables us to move towards a much wider remit for supporting people who need support in our communities.

Te Pou has lead the development and implementation of Let’s get real in New Zealand. I would like to share the experience of how this workforce framework has helped shape our conversations and practices in mental health and addiction. I am willing to consider a workshop, paper or symposium (preferred) discussing this important strategy for New Zealand (which has also been widely used in Australia).

Learning Objectives

Learning Objective (1): To learn about how a national knowledge, skills, values and attitudes framework can be utilised to equip the broader health workforce to support people with mental health problems and addiction

Learning Objective (2): Creating earlier access to mental health services includes equipping the health workforce to respond and support people regardless of what part of the health system they access.

References


Investigating the stigma cycle at the interface of mental healthcare for people with Borderline Personality Disorder.

Daniel Ring¹, Sharon Lawn¹,²
¹College of Medicine and Public Health, Flinders University, Adelaide, Australia, ²Department of Psychiatry, Flinders University, Adelaide, Australia

Biography:
Daniel is a 3rd year medical student from Flinders University.

The stigma of borderline personality disorder (BPD) is an open truth in mental healthcare. Discrimination against people with a diagnosis of BPD is often the norm in many healthcare settings with workers openly expressing their discontent with such patients. In mental health, stigma especially has a profound effect on access to care, engagement in care, relationships and the quality of care provided to this population (Corrigan, 2004). For people with a diagnosis of BPD, not being taken seriously by healthcare providers and the systems in which they deliver care is a major concern (Lawn & McMahon, 2015). Despite the advent of national BPD guidelines and evidence of some improvements in treatment options for people with a BPD diagnosis, inequity of access to care and experiences of discrimination continue for many people with this diagnosis.

An extensive review of the international empirical research investigating the perspectives of workers and people with a BPD diagnosis yielded 10 articles for each side. Results were synthesised to construct a model of how stigma is systemically reinforced and how both parties feed into a vicious self-perpetuating cycle that stalls effective treatment and engagement, leading to disempowerment and poorer outcomes for all concerned.

Learning Objectives
Learning Objective (1): The audience will gain an understanding the major themes of the literature worldwide in regards to BPD, mental healthcare and stigma.
Learning Objective (2): They will also gain an understanding of the complexity of impacts and consequences of stigma for people who experience BPD and for mental healthcare providers; in particular, how these undermine current efforts to improve service delivery to people with a BPD diagnosis, and how to address this situation.

References
Hear the Whisper, Not the Roar: Adverse Childhood Experiences and Substance Use Disorder

Marilyn McMurchie

1 East Sydney Doctors, Sydney, Australia

Biography:
Marilyn McMurchie is a general practitioner in inner Sydney, who is authorised to prescribe methadone and buprenorphine in the setting of opioid substitution treatment and medications to treat HIV, hepatitis B and hepatitis C infections.

The Adverse Childhood Experience (ACE) Study found that adverse childhood experiences are common and are associated with many chronic health problems in adult life, including mental ill heath and substance misuse.

The Royal Commission into Institutional Responses to Child Sexual Abuse showed that long term mental health problems were the most common impact of child sexual assault (CSA) in Australia.

Quality Improvement activities are required by the Royal Australian College of General Practitioners to maintain general practitioner accreditation.

Following the impact of the Royal Commission on several of my patients in opioid substitution programs, I decided to ask this group to consent to complete the short ACE questionnaire. Other data collected germane to the study: duration of prescriber patient relationship, whether the person has a GP separate from the opioid prescriber, other chronic medical conditions, and access to or having accessed mental health support.

Learning Objectives
Learning Objective (1): Prevalence of ACE in adults with Substance Use Disorder.
Learning Objective (2): Acceptability of ACE screening.

References
www.childabuseroyalcommission.gov.au
ACE study TED talk (by paediatrician Nadine Burke Harris)
Responding to diversity: Supporting local champions to drive change in a changing mental health landscape.

Kimberley Wriedt�, Shehani De Silva

*Victorian Transcultural Mental Health (VTMH), Melbourne, Australia*

**Biography:**
Shehani De Silva
Shehani has worked in the Transcultural mental health field for over 10 years in Australia. Before arriving in Australia, she worked for a number of years in the refugee and migrant mental health sector and with Schizophrenia Fellowship Wellington Branch in New Zealand. Shehani has had extensive experience in Sri Lanka working with a number of mental health services and was also with UNICEF Sri Lanka as a Psychosocial Specialist. Before joining VTMH, Shehani coordinated the Transcultural Mental Health Access Program at Action on Disability within Ethnic Communities.

Kimberley Wriedt
Kimberley completed a Bachelor of Occupational Therapy (Hons) and has worked in the mental health field within the community managed mental health services sector. Currently in the role of Education and Service Development Consultant at VTMH, Kimberley commenced with VTMH in 2011, and has been involved in a variety of projects and programs since this time. Prior to joining VTMH, Kimberley worked in the community managed mental health services sector, in both group-based and individual programs, and as a team leader for an outreach service.

Victorian mental health services must think innovatively about how they provide services that support the wellbeing of Victoria’s diverse communities. Victorian Transcultural Mental Health (VTMH), a state-wide education and service development unit, engages with key staff across Victoria’s mental health workforce to champion and drive change within their services and implement culturally responsive practices.

VTMH continues to respond, adapt and innovate across its programs to support these local ‘champions’ (also referred to as Cultural Portfolio Holder’s (CPH), a term coined as a requirement for mental health services in the Cultural diversity plan for Victorian’s specialist mental health services 2006-2010, Victorian Government Department of Human Services, 2006), in the face of the current shifting landscape of mental health service delivery in Victoria. This includes the NDIS, and the necessity to promote a workforce culture that practices a rights and inclusion based approach to address the mental health and well-being needs of migrant and refugee communities in Victoria.

VTMH has supported CPH’s in a variety of ways since the term was first introduced, including through the Victorian Cultural Portfolio Holder Program (VCPHP). Over 2017, a number of changes and innovations were made to both the VCPHP structures, and the way VTMH collaborated with these champions.

This paper will describe the process of the changes made to the VCPHP over the last year, including learnings from collaborative conversations with portfolio holders, and how VTMH is advocating for greater accountability and support from the Department for this work.

**Learning Objectives**

Learning Objective (1): Highlight organisational arrangements and service development practices that challenge CPH’s in advocating for the delivery of culturally diverse mental health service systems

Learning Objective (2): Highlight supports required to progress and implement cultural diversity practices within mental health services, to address the mental health needs of, and within, culturally diverse communities.
The Power of Language in Mental Health.

Jennifer Benham
1Skylight, Adelaide, Australia

Biography:
Fractured reality at 5. I was the mouse that barely whispered. At 20 I reached my dream as a Registered Nurse. 22 I roared, I lost ME. At 49 I let go of the pain and dreamed again. I write, paint and live and I’m an active member of the live experience work force. I am no longer a victim of my label. I am me.

Label / Diagnosis, Psychosis / Altered Perception, Problem / Challenge, Suppress, Deny, Disempowerment / Acknowledge, Understand, Hope, RECOVERY.
Psychiatry is a language driven art. Words used can build or destroy. They can foster hope or demolish all sense of self.
I lived with voices from around 5 It was my reality. Like a frightened mouse I whispered my fears – Nobody heard until at 22 – a crisis, I roared. I was labelled schizophrenic. I was a Nurse. I was told I would never work again. I believed the words of the doctors. I became the label.
We will discuss language, does it build bridges or crush the very foundation of the soul.
There have been changes but are these changes from the essence of respect and empowerment or is it just lip service, just wasted space.
Do you see the person or the symptoms. Think, it is your choice. We are each individuals and it is often language that brings us together or tears us a part. The language in mental health is changing with Strength, Hope and Recovery entering the partnership.

Learning Objectives

Learning Objective (1): To open people’s minds to the power of their language and invite the audience to look within and feel their language. What is the message. Are they sowing seeds of hope or despair. Psychiatry is language intense and the power of the language can change a person’s entire outcome. If the audience stops long enough to see the individual not just the symptoms then the objective will be covered. During the paper the audience will be invited to think of this metaphor and ask themselves if they would rather tackle the challenges of mental illness as a gardener spreading seeds of compassion and nurturing them until they take root or trade the spade for a hammer and smash all that does not fit their learnt perception of reality under the guise of clearing out the old so the new can grow.
Learning Objective (2): All things in life are relevant they are interconnected and language like the spiders web keeps the fragments together. We make judgements with our language and our language can mark who we are. Words in mental health can build or destroy the very essence of who we are so the relevance is in the interpretation of the words. In 1982 the message I got was that you can recover from cancer but mental illness keeps you flawed for life. Now recovery, empowerment, independence are part of the mental health language and I hope that the audience will be able to see the relevance of these minor changes.
Sick Leave and Workplace Wellbeing for Peer Support Workers

Patricia Tran
Curtin University Lived Experience Educator, Perth, Australia

Biography:
Trish has worked since 2015 as a peer worker and peer manager within clinical services (inpatient and community), where she has supervised up to ten peer support workers. This includes working at an Executive level. Trish is passionate about creating change dialogue.

Through open dialogue, the presenter of this paper will examine what occurs in the workplace when a peer support worker (PSW) take sick leave due to injury, illness or psychological distress (including Worker’s Compensation claims). The motivation for this presentation comes from the author’s personal experience and observations of supporting peer staff through illness, injury and distress as well as her own experiences of similar. Despite acknowledgement that the peer support workforce is continuing to expand (Anthony et al., 2017), very little research has been conducted in terms of the effectiveness of service responses to peer support workers returning to the workplace post sick leave. Using Slade’s CHIME framework (Leamy et al., 2011), the author seeks to identify what supports and scaffolding are required to ensure effective transition through sick leave and longevity of PSW employment.

Areas which will be explored:
• Trust as a modifying factor and a discriminatory agent
• Medical model employers and managerial responses: covert bias or unconditional support?
• The role of the Lived Experience Manager in supporting peer workers through sick leave
• Mechanisms which promote PSW wellbeing in the workplace

Learning Objectives
Learning Objective (1):
- Audience members will gain an understanding of challenges experienced by peer support workers when taking sick leave / returning to work.
- Audience will gain skills and insight as to how to foster workplace wellbeing for peer support workers (this is transferrable across to the greater workforce).

Learning Objective (2): Audience will begin to consider the responsibilities which mental health services have (as employers of PSWs, whose lived experience place them at greater risk), to ensure effective support and protective systems are in place.

References
What Works? What Matters?

Anisa Ross

Biography:
Anisa Marie Ross is a mother, writer and Registered Mental Health Nurse. Diagnosed with Bipolar Affective Disorder in 2001 after a manic episode and hospitalisation Anisa strives to maintain her mental health. She uses writing as a therapeutic tool to aid personal development; to educate and to dispel stigma.

These questions plagued me for a long time. During the therapy that sustained me for over a decade I examined every aspect of my experience. I devoured books; I asked questions and I searched. I wrestled with fear and tussled with doubt.

One answer that rings true for me was emblazoned on the front of a book titled “An Uncommon Dialogue” written by Debra Drake.

Dr Jon Jureidini, an Adelaide Child psychiatrist at the Women's and Children's Hospital, described this book as “A compelling first-person account that teaches us that the relationship is the therapy.”

I believe that to be true. In my experience, the relationship is the therapy. These qualities facilitate effective communication, develop a foundation of trust, lead to a person feeling valued and foster a sense of belonging.

These are aspects of healthy relationships we strive for, in therapy, and in everyday life. Fairness, equality and individuality synthesise with playfulness and fondness to elicit warm acceptance. We are all similar and different. Can we co-exist and live harmoniously? Can we accept difference as an interesting variation on the elusive normal?

Learning Objectives

Learning Objective (1): Audience have a greater appreciation of the importance of the therapeutic relationship.

Learning Objective (2): Audience are reminded how important healthy relationships are in our work and personal lives. Relationship building is the foundation of effective mental health care.

References


Getting On Track In Time: Got It! : Contributing to reform using reflection and review.

Sharon Haarsma

NSW Health: MH-Children & Young People, Sydney, Australia

Biography:
Sharon Haarsma has been at NSW Health in the Mental Health- Children and Young Persons team, since 2015. Sharon is an Occupational Therapist with over 30 years of experience as a clinician, manager, private practitioner, educator and project officer. She has worked in child, adolescent and adult mental health as well as in other health areas, both here in Australia and in the UK, Canada and Hong Kong. She is now in the role of the state-wide program manager for Got It! Program Manager. Sharon is also supporting NSW Health in a health policy role, supporting the reporting of mental health reform activities in NSW.

Getting on Track in Time - Got It! is an early intervention specialist school-based program led by CAMHS teams in partnership with Department of Education staff. Got It! aims to reduce the frequency and severity of conduct problems in young children (five to eight years) at a time when intervention is likely to be most effective and prevent the development of severe behaviour problems in young children. This program is in an exciting stage of rollout across NSW under mental health reform funding.

The program was funded under Keep Them Safe funding, with three trial teams commencing in 2011, and with an independent evaluation process established to review the effects of the Got It! program over two years. Following positive outcomes from this review and evaluation process, involving a process, economic and outcome evaluation, mental health reform funding was provided to support the development of 17 teams, across 15 local health districts and two specialty networks.

Teams offer evidence-based approaches to children aged 5-8 and their families, and work in schools to support skill development of teachers and the embedding of principals of Got It! into school and home communities.

Conduct disorder is the most common mental health concern amongst children, with disruptive behaviours accounting for up to half of children seen by mental health services (1). Conduct disorder also touches our more vulnerable families, with higher rates of conduct disorder reported in some disadvantaged communities (2). Got It!, by addressing conduct disorder at an early point in the lifecycle, aims for more optimistic outcomes for young people later in life. It is estimated that up to 40-50% of children who develop conduct disorder at an early age go on to experience problem antisocial behaviours and criminality, if left unsupported (3).

The Got It! model of care builds on the positive outcomes that are associated with early intervention, universal access and the promotion of positive relationships between child, family and school systems. Primary intervention strategies involve providing training for teachers to better manage conduct problems in the classroom and to deliver universal social emotional programs in the class. Information is also provided to parents through presentations and newsletters. Secondary intervention strategies include assessment of children identified through screening as having elevated disruptive behaviours and the provision of a parent and child-focused group program integrated with parent education over an 8-10 week period. The group program is supplemented with individual behaviour management support and further referral as needed. The Got It! model of care provides a framework and set of principles that incorporate a range of strategies and evidence-informed interventions.

An ongoing process of review and reflection is taking the Got It! program into its next stage of roll out into all NSW communities, supported with over $10M funding by NSW Health.

The 8 minute Got It! video, to be shared in part in the presentation, outlines the many benefits and stories of success, as experienced by parents, children, schools and the wider community.

Learning Objectives
Learning Objective (1): Conference participants will gain from learning about the benefits of a trial project using systematic implementation and evidence-based approaches, and how the process of review and reflection has lead to a state-wide consistent and effective approach across larger populations. The benefits of partnering between organisations will also highlight the advantage of and potential for inter-agency work.

Learning Objective (2): Prevention of conduct disorder is relevant to parents, schools and the community across Australia as we work together to prevent the development of more significant mental health concerns, with Got It! providing an example of positive effect for children aged 5-8 with emerging behavioural concerns and conduct disorder.

References

Language in the Service of Psychiatry

David Butt, Jon Jureidini, Anthony Korner, John Walsh

Biography:
David Butt, as Director of the Centre for Language in Social Life at Macquarie, used text linguistic tools to examine relationships between language and contexts of critical care – eg. in psychiatry; in surgery; at law; in education/training of various professions; and in public debate.

Jon Jureidini is a child psychiatrist heads Adelaide University’s Critical and Ethical Mental Health research group (CEMH), which promotes safer, more effective and more ethical research and practice in mental health; and the Paediatric Mental Health Training Unit (PMHTU), which provides training in non-pathologising approaches to primary care mental health.

Anthony Korner works in Sydney as a psychiatrist and psychotherapist, primarily in public practice. He is Director of the Master of Medicine (Psychotherapy) Program at the University of Sydney. His research interests are in psychodynamic psychotherapy, linguistics and philosophy. He completed a PhD in Linguistics, on psychotherapy in 2015.

John Walsh works in the tradition of Systemic Functional Linguistics, in which the aim is to understand how language works in the service of everyday living, both personal and professional domains. His current research interests are language in education, language in sport, as well as language in mental health.

This symposium addresses the relationship between the fields of psychiatry and linguistics and how collaboration across these disciplines can provide new knowledge and understanding for mental health clinicians. Two presentations will be made reporting on collaborative projects in Sydney and Adelaide. These will be followed by a discussion around the benefits and potential for bringing a focus on language into the domain of psychiatry and the work of psychiatrists.

The Sydney project is centred at Macquarie University and Westmead Hospital where Russell Meares, Anthony Korner and colleagues have worked with David Butt and colleagues using Meares’ Conversational Model of therapy. The work is encapsulated in the following description.

Embodied language as personal process
Humans live in two worlds. One is the world of physical contingencies fixed in the present. The other is the symbolic world of language. We can’t ignore the demands of physical existence but we can spend quite a lot of our time in thought and the pursuit of interests that aren’t simply the products of immediate needs for food and shelter. We develop a capacity for story-telling. This endows us with the capacity for understanding human lives as stories. Each person can be considered an embodied and incomplete text, an unfinished story.

In each life there is a tension that develops around how to express feeling – in behavioural action or through speech. If speech isn’t encouraged within the early social environment there will be a greater tendency towards indirect communication through behaviour and forms expression that may be confusing to others (these patterns include those referred to clinically as dissociation). The full realization of individuality is dependent upon there being sufficient encouragement of speech to allow the development of an inner world and a capacity to be at home either alone or with others. Therapeutic engagement in Mental Health Care necessarily involves encouragement of the individual’s capacity to communicate about his or her condition.

The Adelaide project involves Jon Jureidini from the Women’s and Children’s Hospital and John Walsh at Adelaide University. They have conducted small scale research on the process of case formulation with a view to understanding how formulations are constructed on the basis of a patient assessment. They have investigated formulation through an
Case Formulation in psychiatry
Effective responses to mental illness require more than an illness label. Presentations need to be formulated, a process whereby psychiatrists develop and articulate their understanding of why this patient presents with this problem at this time. Case formulation is a fundamental skill within mental health, but the literature indicates that formulation is rarely explicitly addressed in the psychiatric curriculum; rather, it is inferentially developed through modelling and/or clinical practice, with inconsistent understanding and practice. The lack of explicit training has become more salient as increasing numbers of internationally trained doctors from culturally and linguistically diverse backgrounds undertake psychiatric training in Australia; what is implicitly understood as good practice may vary across culture and language. The aim has been to understand formulation from a linguistic perspective to describe the choices of language that constitute successful formulations. Specifically, the analyses highlight patterns from different subsystems of language, for example conjunctive resources, lexical relations and generic organisation, identified as the most salient and the most appropriate to be brought to the attention of trainees as part of a more explicit approach to the teaching of formulation within the psychiatry curriculum. A training package has been developed out of this research, and further language analysis of the psychiatric interview/assessment is planned as a step towards making explicit the principles and processes involved.

Public discourse on Mental Illness
In associated work Jureidini and Walsh have looked at journalists’ writing about mental illness. The paucity of language with which to describe and inform the public exemplifies the cultural difficulties in addressing mental illness. It is argued that the stigma linked with mental illness precludes a helpful public language. What remains is silence, platitudes, or reductive psychiatric labels. Furthermore, much public discourse depicts subjects as passive recipients of mental health ‘issues’. This has the effect of establishing the illness as an entity to be treated by a doctor with the patient potentially reduced to an interested bystander. We argue for a different approach that preserves agency for the sufferer without increasing stigma. A focus on language can play an important part in the destigmatising process. The two presentations will be followed by an open discussion around the potential benefits of bringing language to the surface in clinical practice.

Learning Objectives
Learning Objective (1): Participants will gain a greater understanding of the role of language in mental health assessment and therapy.
Learning Objective (2): Enhance communication about patients experience and predicaments in both professional and public discourse.
Neighbourhood Disadvantage and Type 2 Diabetes Comorbidity in Serious Mental Illness: A Systematic Review of Literature

Rayma Walson¹, Andrew Bonney¹,³, Darren J Mayne¹,²,³, Nagesh Pai¹,³,⁴, Xiaoqi Feng⁵, Renin Melkias Baby Selvi Toms¹

¹School of Medicine, Faculty of Science, Medicine and Health, University of Wollongong, Wollongong, Australia; ²Public Health Unit, Illawarra Shoalhaven Local Health District, Warrawong, Australia; ³Illawarra Health and Medical Research Institute, University of Wollongong, Wollongong, Australia; ⁴Mental Health Services, Illawarra Shoalhaven Local Health District, Wollongong Hospital, Wollongong, Australia; ⁵Population Wellbeing and Environment Research Lab (PowerLab), School of Health and Society, Faculty of Social Sciences, University of Wollongong, Wollongong, Australia

Biography:
Ramya is a PhD candidate in Graduate school of medicine, University of Wollongong. Her research proposes to quantify the co-occurrence of Serious Mental illness and Type 2 diabetes in Illawarra Shoalhaven and to determine its association with neighbourhood factors such as socio economic disadvantage.

Aim of the study: This study aimed to systematically synthesise the body of literature examining associations between neighbourhood socioeconomic disadvantage and serious mental illness (SMI) – type 2 diabetes (T2D) comorbidity. Understanding these associations would be useful in developing evidence based holistic interventions and health care policies.

Methods: We conducted an electronic search of four databases: PubMed; Scopus; Medline; and Web of Science. Studies were considered eligible if they were published in English, peer reviewed, quantitative, and focussed on the association between neighbourhood disadvantage and SMI-T2D comorbidity. Study conduct and reporting complied with PRISMA guidelines, and the protocol is available at PROSPERO (CRD42017083483).

Results: The one eligible study identified reported a higher burden of T2D in persons with SMI, but provided only a tentative support for the association between neighbourhood disadvantage and SMI –T2D comorbidity.

Conclusion: Research into neighbourhood effects on SMI-T2D comorbidity is still in its infancy and the available evidence inconclusive. This points to an urgent need for attention to the knowledge gap in this important area of population health. Further research is needed to understand the health resource implications of the association between neighbourhood deprivation and SMI-T2D comorbidity, and the causal pathways linking them.

Learning Objectives

Learning Objective (1): Summarise the association between neighbourhood disadvantage and serious mental illness – type 2 diabetes comorbidity
Learning Objective (2): Understanding these associations would also help us in developing evidence based holistic interventions, health care policies and even help us in designing healthier life spaces.
How people with psychosocial disability living in supported residential services (SRS) experience choice and control in the first 12 months of the National Disability Insurance Scheme (NDIS).

Liz Dearn
1Future Social Services Institute (FSSI), Australia, 2RMIT University, Australia

Biography:
Liz has worked in the area of policy and social equity for over 20 years in local and state government and not for profit organisations. Liz started working life in residential rehabilitation services in the early days of deinstitutionalisation and has maintained a strong interest in psychosocial disability since that time. As coordinator of the Policy and Research Unit at the Office of the Public Advocate, Liz had portfolio responsibility in all areas of mental health including policy and legislative reform in Victoria. Liz was instrumental in the Long Stay Patient Project, a Community Visitor initiative that raised concerns about the indefinite detention of many consumers in secure extended care units. Liz has published research in the area of deaths of young people in nursing homes and in 2015 led OPA’s responses to the Ombudsman’s Inquiry into violence in disability settings and the Royal Commission into Family Violence. Liz’s PhD study explores the experience of choice and control of people living with psychosocial disability in supported residential services (SRSs) over the first 12 months of the NDIS.

The NDIS is based on the object of enabling people with disability to exercise choice and control over their goals and the services and supports they need to meet those goals, and the premise that greater choice and control will result in better life outcomes for people with disabilities. Concerns have been raised in Australia that people with complex needs and inadequate advocacy support and resources, like residents in supported residential services (SRS), may become further marginalised in the NDIS context.

Rational choice theory, on which the NDIS is premised, conceptualises the individual as an active agent in decision-making, free of structural constraints. Yet, sociologists see choice as occurring within a ‘complex sphere of interrelationships, vulnerabilities and interdependencies’ (Collyer et al 2015, p.2). Using Bourdieu’s theory of practice (1977), which offers a theoretical framework from which to understand the way everyday practices like choice are made in institutional environments, this paper aims to show how social, economic and cultural capital influence the experience of choice and control of 12 SRS residents over the first 12 months of the NDIS. This paper will provide early findings from this study.

Learning Objectives

Learning Objective (1): People will take away from the session a better understanding of the barriers and enablers to choice and control for people living in private congregate care facilities (or Supported Residential Services).

Learning Objective (2): This topic is relevant to mental health services as around 60% of people in private congregate care facilities (or Supported Residential Services) experience psychosocial disability.

References


‘Mud’

Terry Lynch
1South Alive, South Invercargill, New Zealand

Biography:
Terry is a writer, producer and presenter of various publications. He has published five books, produced and presented two regional radio programs, founded numerous mental health consumer groups, was the first elected Chair of ‘Moving Forward’ (the District Health Board’s consumer group), and an advocate and member of numerous Trusts and mental health networks.

Mud is a theatrical collection of poetry, stories, commentary and a song which has become a coping mechanism for Terry to deal with his OCD and anxieties. This performance will show how using poetry and creative self-expression can assist in overall mental well-being. Inspired by Shaun McNiff’s ‘Art Heals’, Terry has been exploring how art therapy is a tool for healing and how the rhythm of poetry can promote mental well-being. Mud will weave a tale of Terry’s life-experiences ranging from growing up in the central South Island and fishing the Rakaia river, through his adolescence and on to working at the freezing works.

Learning Objectives

Learning Objective (1): The audience will learn that poetry is not only an exciting form of self-expression, but also a tool for self-healing.

Learning Objective (2): Mental health consumers often struggle to express themselves, and Mud encourages self-expression through the form of poetry.

References

BAS: The innovative Bed Allocation System and Journey Board; a useful communication and planning tool in the clinical setting.

Ruth Lange¹, James Moller², Robyn Coulter³

¹Rural & Remote Mental Health Service, Country Health SA, Local Health Network, Adelaide, Australia, ²OPD Management, Beaumont, Australia, ³Southern Mental Health, Southern Adelaide Local Health Network, Adelaide, Australia

Biography:
James Moller started OPD Management in 1997 to assist businesses with IT support and database development. James took over as the developer of the Bed Allocation and Journey Board System in 2008. He has seen the system grow from 3 health service units to well over 800 using the program.

Ruth Lange is Team Leader for Distance Consultation Liaison Service which includes the Rural & Remote Mental Health Triage Service. Ruth has worked in this role for 5 years. The service, based at Glenside Health Service, covers all of country South Australia.

The Electronic Journey Board enables:
- Communication between all members of a healthcare team to progress the client’s journey as it is happening through the unit and supports the clients return to the community.
- the identification of all country mental health clients who are booked for a bed or are in inpatient units in Adelaide or across country South Australia
- Planning ahead to manage patient flow

We will present a live demonstration of the bed allocation and journey board functions from the time of bed request through to the transfer of care in supporting the client returning to their community.

Country South Australia has diverse communities that are spread out over a large area contributing to the challenge for clients in accessing services. We will present on the role of Emergency Triage and Liaison Service (ETLS) which provides direct support to clients and families in crisis situations as well as assisting in pathways to care for mental health issues. ETLS also assists country GPs and country hospitals in assessment and management of clients.

Learning Objectives

Learning Objective (1): The audience will gain an understanding and experience a tour of the innovative electronic journey board; the Bed Allocation System (BAS), how it works, and its importance in quality service provision.
Learning Objective (2): The audience will understand the unique work of the Emergency Triage and Liaison Service in mental health service provision in the diverse communities of country South Australia.
Sustaining people through the NDIS process using a coproduced education approach

Dianne Hardy, Sue Belmore

1Mind Australia, Australia

Biography:
Dianne Hardy has extensive experience in capability building and leadership development. She led the establishment of the Mind Recovery College from inception and is the Director of the College. Dianne draws on her lived experiences and has a passion for mental health services that focus on people and their strengths.

Sue Belmore has had a diverse career, working in different countries enjoying the challenge of different cultures. Over the past 18 years she has held a number of leadership roles in the mental health sector. Drawing on her own ‘lived experience’ she currently works at the Mind Recovery College™, and provides consultancy services within the mental health sector.

The Mind Recovery College™ specialises in coproducing and codelivering courses that students use to aid their MH recovery and to help others. The National Disability Insurance Scheme promises increased resources and control for people with psychosocial disabilities to live a better life. Understanding and navigating the requirements of the Scheme comes with a lot of difficult challenges such as maintaining wellbeing whilst having to share the ways mental health negatively impacts on people’s lives. Focussing on the things individuals can’t do or find very difficult often comes with strong, even overwhelming, feelings of failure, worthlessness, grief, loss, shame and hopelessness.

Drawing on first hand experiences when preparing for NDIS planning meetings, the Mind Recovery College™ set out to design a course that would not only help people understand what the NDIS is about but also take them through exercises to explore their strengths in each domain whilst identifying the gaps where support is needed. More than 270 consumers, carers and professionals have done this 9 hour course now and feedback has been overwhelmingly positive. Come and hear about the design and lessons learned about the power of taking a strengths-based, lived experience approach to supporting ourselves through complex changes.

Learning Objectives

Learning Objective (1): Understand how coproduced education can help people manage change better.
Learning Objective (2): Understand how reframing preparation for the NDIS to include strengths and needs can help sustain ourselves through the often difficult planning process.

Deborah Milford¹, Danielle Hanisch¹
¹Life Without Barriers, Adelaide, Australia

Biography:
Deborah Milford is has worked in the community services sector for 11 years with 10 of those focusing in mental health. She is current a Program Coordinator in our Partners in Recovery Program. She has also worked in Returning Home, Intensive Homebased Support Service, and Individual Psychosocial Rehabilitation Support Services.

Danielle Hanisch is a social worker with over 12 years’ experience across many fields in the human services sector. She is an Operations Manager with Life Without Barriers across mental health, homelessness and alcohol and drugs services. She is currently completing a PhD in Mental Health and Trauma.

This paper presents on an innovative resource developed by Life Without Barriers (LWB) called My Pathway, My Future. This resource aims to help people with a psychosocial disability access more inclusive pathways to education, training and employment. This presentation will preview the My Pathways, My Future resource so that it can be widely accessible for both service providers and people living with a psychosocial disability. My Pathway, My future was developed by listening to and engaging with people with lived experience, through focus groups and surveys to support people with a psychosocial disability to explore what they can do when considering or planning employment, education and training opportunities. This presentation will demonstrate how service providers and consumers can use it as a collaborative tool, thereby encouraging service providers and formal and informal supports to assist someone with a psychosocial disability to realise their potential. The presentation will demonstrate how the resource will assist individuals to advocate for themselves and recognise their inherent value, while also encouraging a positive change and culture where there is hope and opportunities for people living with a psychosocial disability.

Learning Objectives

Learning Objective (1): The co-design of this resource was implemented by inviting people with a lived experience and service providers to our four focus groups and also to complete our survey. The outcomes of the survey and focus groups realised the knowledge and hopes of people with a lived experience. This resource is innovative in that it embraces those hopes and expands on them. In sharing this paper and resource with people in the audience, we hope to make the resource widely accessible. This will mean that service providers can access and use the resource to work with their consumers to uncover or rediscover a person’s inherent value and highlight the opportunity for positive change. Secondly, we are hoping that sharing this resource will support breaking down the negative stigma that people with mental health conditions often face and instead promote a positive culture and narrative of hope and change.

Learning Objective (2): Psychosocial disability is an internationally recognised term under the United Nations Convention on the Rights of Persons with Disabilities, used to describe the experience of people with impairments and participation restrictions related to mental health conditions. Pathways to gaining employment, entering into education or training creates positive changes and opportunities in people’s lives not only financially but also increased self-worth, independence, connection to community, sense of purpose, confidence, reduces isolation and supports overall improved well-being. This topic is especially relevant to mental health services as it offers them a free tool to use to work with their clients. This tool is grounded in both lived experience and service provider experience so should easily be able to be used in conjunction with other tools. It will enables us to challenge ourselves about how are we as a society recognise the strengths, values and abilities of people with a lived experience. This resource will create a pathway that breaks down the stigma and supports change of negative attitudes while making way for a culture of hope.

References

Shooting for Stars

Marinette Dames1, Len DeAraugo1
1Wellways Australia, Frankston, Australia

Biography:
Marinette Dames: Registered Mental Health Social Worker with 30+ years’ experience in the human services field. Born in Namibia, grew up in South Africa, 16 years’ Australian citizen. Passionate advocate for participation in team sport for good physical and mental health, and for living the best life you can.

Len DeAraugo: Business Coach with 20+ years’ experience in influencing, developing and mentoring people. People and Sport are two passions in Len’s life. Development of the Basketball league provides him with a focus on welcoming and valuing participation by all and giving some individuals the confidence to fully participate in the community.

The debilitating impact of loneliness is often compounded for individuals and families effected by mental illness and other disabilities. The issues of being, and feeling different to the norm, stigma, social injustice, social exclusion and bullying leaves permanent scars and thousands of rooms full of lonely people.

Community inclusion comprises of two essential commitments,
1. All individuals have an opportunity to fully participate in the community,
2. Communities actively seek out welcome participation of everyone, valuing each individual’s uniqueness and abilities.

Creating welcoming communities is one of the fundamentals of community inclusion. Initiatives like the Shooting Stars Basketball league that has no diagnoses, client type, or program criteria other than being welcoming of all abilities, evidence the power of belonging. The rapid increase of not just the player numbers but also the involvement of friends and families in this program demonstrates the urgent need for safe and welcoming places. The individual stories of personal happiness, growth and development through being accepted in this program echoes the message that community inclusion is a human rights issue that cannot be ignored or delayed. “People don’t need more referrals to mental health services, they need referrals to life and community” (Rapp,1996)

Learning Objectives

Learning Objective (1): The audience will get a powerful insight from a lived experience perspective of how belonging can change your life.

Learning Objective (2): This topic demonstrates the truths and realities of implementing evidence base practice through innovative community inclusive programs.

References

Creating a mental health friendly social enterprise – “Café Options in the Port”

Kim Smith

1Diamond Clubhouse, , Australia

Biography:
Kim Smith is the author of this paper. She has been the Director of Diamond House, since 1997. Kim is the Chair of Clubhouse Australia which is the peak body for the 7 Australian Clubhouses. She has worked in the community mental health sector for over 20 years and is passionate about reducing stigma associated with mental illness, promoting positive mental health and increasing community awareness about mental illness.

This paper aims to provide an overview of the process that Diamond House went through in 2017 to develop an innovative employment model that would focus on social change, expanding the existing employment program, incorporate Clubhouse principles, create a mental health friendly workplace and increase employment & training opportunities for people considered socially and economically disadvantaged.

The people involved in this project are Members of Diamond House who have lived experience of mental illness, CALD backgrounds, were unemployed and struggled to find work and often faced stigma and discrimination associated with employing people with mental illness including age, language and cultural barriers.

The challenges will be outlined including having enough resources of time, money, equipment and people but committed staff, members and volunteers gave their time and energy to get this project off the ground.

After 12 months of conducting research, risk assessments, developing a business plan, applying for grants, facilitating regular planning meetings the decision was made to establish a social enterprise.

In January 2018 funds refurbishment from the Stronger Communities Grant, Kickstart employment payments and wage subsidies we opened the social enterprise “Café Options in the Port” and 8 people are now employed on award wages.

Learning Objectives

Learning Objective (1): People in the audience will learn the step by step process of setting up this social enterprise, how we incorporated the International Clubhouse model of psychosocial principles into the project and the importance of collaborative working partnerships.

Learning Objective (2): This topic is relevant to mental health issues as it is an example of an innovative approach to increasing employment and training pathways for people with lived experience of mental illness, one that supports social change, reduces barriers to employment & training, promotes a supportive mental health friendly work

References

“A Social Enterprise is when an organisation uses a business model of buying and selling goods or services but unlike a traditional business, its prime motivation is to fund or support social causes, so considering a social enterprise model might be the first step in creating a lasting change in your community and developing the sustainability of your organisation.”

DCSI—Sustainable Community Services 2015

“Social enterprise is a means by which people come together and use market–based ventures to achieve agreed social ends. It is characterised by creativity, entrepreneurship, and a focus on community rather than individual profit. It is a creative endeavour that results in social, financial, service, educational, employment, or other community benefits.”


Addressing the needs for people with mental health issues

Queensland Mental Health Commission
“Social enterprise ... is a bold attempt at redressing many of the issues that people who are marginalised in our society have, by building their confidence and in their capacity to help themselves.”
Social Enterprises in Australia (2002)
“A place for anyone and anything”: Evaluation of the ReachOut.com Online Youth Mental Health Peer Support Forum

**Kathryn Cairns**, Louisa Welland, Rawan Tayeb, Liberty Shuttleworth, Mariesa Nicholas, **Sophie Potter**

ReachOut Australia, Australia

**Biography:**
Kathryn Cairns is the Senior Evaluation Manager at ReachOut Australia. She has an interest in promotion, prevention and early intervention approaches to reducing the burden associated with mental illness within the community. Kathryn has over ten years’ experience as a researcher and evaluator in public health, adolescent health and education.

Sophie Potter has been working in youth work and community development across the UK, South East Asia and Australia for over fifteen years. Since 2011 she’s been with ReachOut Australia, delivering online prevention and early intervention programs, and is currently the Senior Program Manager for ReachOut Parents at ReachOut Australia.

Online forums are a valuable adjunct, or alternative, to treatment for many young people experiencing mental health difficulties. Online platforms and peer support have been identified as national policy priorities and can play an integral role within a stepped-care model. However, there is a lack of research into the implementation and effectiveness of these forums. The ReachOut.com moderated peer support forum, launched in 2006, is one of the best established online youth mental health forums, however until recently it had not been subject to rigorous evaluation. The aim of this presentation is to present the findings from a process evaluation of the forum, which involved: an analysis of web analytics data; a qualitative analysis of forum posts; and an online diary study of forum users (including users who post on the forum, and those who don’t). The paper will present findings relating to:

- The volume, and nature, of user activity within the forum;
- User perspectives on the benefits and limitations of peer support; and
- The user experience and subjective impact of the forum on users’ mental health.

The implications of the findings for policy and practice, and next steps for research and evaluation of the forum will be discussed.

**Learning Objectives**

Learning Objective (1): Attendees will have a greater understanding of the benefits and limitations of peer support that is delivered in an online environment, and how and why young people may choose to engage with this support over, or in conjunction with, other support services.

Learning Objective (2): The peer workforce is increasingly acknowledged as critical to achieve better mental health outcomes. After attending the presentation, audience members will have a greater understanding of the role for peer support within the context of the broader youth mental health service system and a stepped-care model.

**References**

Men Care Too

Gregory Smith

*Men Care Too, Australia*

**Biography:**
An unpaid, informal carer for almost 20 years, Greg Smith shares his personal story and promotes conversations about the challenges faced by male carers with Men’s Sheds around the Central Coast, Hunter Region and Greater Sydney along with a variety of men’s groups, workshops and state, national and International conferences.

Introducing the topic of unpaid care through a personal story of lived experience, Men Care Too will explore relationships between the male caring role and topics such as masculinity, male suicide, health and social services workforce and social connectedness. Diversity of men in caring roles will be explored to encourage consideration of the social and emotional needs for male carers from ATSI, CALD and GBTI backgrounds along with reference to young men and seniors caring for someone. Discussion will then focus on how the Men Care Too online resource is aiming to support and encourage men in caring roles whilst also helping shape a more inclusive and effective approach to the management, planning and delivery of carer policy and programs. Men Care Too promotes discussion to improve social connectedness, physical and emotional wellbeing and utilisation of services by the 1.2 million men in Australia who are caring for someone with an illness or disability.

**Learning Objectives**

Learning Objective (1): “What will people in the audience gain or learn from attending this presentation?”

The audience will leave with an increased awareness of the social and emotional challenges along with real and perceived barriers to help seeking specific to men in caring roles. Attendees of the Men Care Too presentation will also gain a better understanding of the need to develop support services and programs that more effectively engage with different demographics of men in caring roles.

Learning Objective (2): “How is this topic/issue relevant to mental health services and mental health issues?”

In disability support or healthcare settings there is typically, and rightfully so, a focus on the individual requiring care or treatment. Often this results in the emotional impact, distress or needs of the support person or carer not being considered or addressed effectively. This is particularly true where men are the support person or carer and services are not designed to appeal or engage with men.

**References**

Disability, Ageing and Carers, Australia: Summary of Findings, 2015

There are several myths around alcohol use, but what does the recent data say?  
Myth 1: Young people are drinking more than ever before  
Myth 2: Alcohol is a problem for men but not for women  
Myth 3: Anxiety protects young people from drinking too much  
Myth 4: Letting teenagers drink at home protects them from alcohol related harms

Australia has some of the highest rates of alcohol use disorders in the world. However, the last decade has seen some compelling shifts in patterns of alcohol use and related harms in Australia. Data from the 2016 National Drug Strategy Household Survey indicates that fewer young people are choosing to drink, and those who do are starting to drink later. However, we are not necessarily seeing the same downward shifts across the whole population, or in all alcohol-related harms. There is some evidence that women are catching up to men in terms of alcohol use and related harms, and rates of risky drinking remain high among men and women in their 40’s, 50’s and. Alongside these trends, the latest data on the mental health of young Australians indicates that rates of anxiety and depression are high and associated with increased risk of alcohol use.

This symposium will present recent Australian and International data to challenge commonly held myths around alcohol use and will discuss innovative solutions to address these problems. The first presentation will give a brief overview of the latest Australian data on alcohol, young people and mental health. It will pose a number of key questions: Why is it that young people are drinking less and drinking later, and yet rates of anxiety, depression and self-harm remain high? Are women catching up to men in terms of alcohol use and alcohol related harms? If young people with anxiety are at risk of developing problems with alcohol, what can we do to help? And finally, what role to parents play? Should we be teaching our teenagers to “drink responsibly”?  

Presentations 2-4 will explore these issues further and present three empirical studies that are attempting to find innovative solutions to these questions. Presentation 2 will look at women and alcohol use and present data from the Australian Why Women Drink Study which aims to better understand patterns of, and reasons for, drinking among women to inform prevention and early intervention programs for females. Presentation 3 will present data from an innovative online program to address alcohol use and anxiety among young adults and Presentation 4 will give an overview of a new online school-based program which aims to prevent adolescent alcohol use and related hams by intervening among both teenagers and their parents.

Presentation 1: Population trends in alcohol use and mental health: an update and overview  
Presentation 2: Alcohol: the gender gap you don’t want to close. Data from the Why Women Drink Study  
Presentation 3: The Inroads program: An innovative online intervention for young people who drink to cope with anxiety.  
Presentation 4: Climate Schools Plus (CSP): An interactive online intervention for students and their parents to prevent alcohol and cannabis related harms among adolescents

PREMISE (PRevention and Early intervention in Mental Illness and Substance use) is a newly funded NHMRC Centre of Research Excellence which aims to provide a world-first synergy of the leading prevention and early intervention research and translation programs in substance use and mental disorders across five Australian universities. It brings researchers currently working independently across disorder silos (addiction, depression, suicide, anxiety, psychosis) together to share skills, synergise data, and harness new technologies to develop and trial innovative prevention and early intervention programs for substance use and mental disorders. The work presented in this symposium is being conducted as part of this newly funded Centre.

References
Featured Symposium: Teaching Tauma to the Next Generation of Clinicians.

Tully Rosen

Approaches to trauma are experiencing a renaissance as trauma informed care becomes policy around the world. In the aftermath of Inquiries and Royal Commissions into historical abuse there has been renewed focus on the practical ability for clinicians and care workers to meaningfully acknowledge and address behaviour related to complex trauma. While each profession continues to review concepts of trauma within their own disciplines, it is unclear how or what the shared principles are for teams to be able to “speak the same language” when it comes to providing a safe and nurturing environment for traumatised individuals.

This symposium will provide a platform for each of the professions to outline the conceptual frameworks that each discipline works within when training clinicians to recognise and respond (or not) to trauma. Each pannelist is at the forefront of syllabus development for their professions, and will provide insight on the scientific, social, political and cultural contexts that they work within. Are there common assumptions or principles that could help bridge the cultural divide?

OBJECTIVES:
- Audience members will gain insight into the theory and practice underpinning approaches to trauma, complex trauma, and trauma informed care.
- Panellists and audience members will have an opportunity to discuss what has been, what is, and what could be taught to our next generation of clinicians and workers.

Tim Heffernan

This symposium seeks to explore the groundswell of support for the establishment of the National Mental Health Consumer Organisation (NMHCO) in Australia. Despite lying dormant, perhaps reduced to ashes for three years, the National Organisation has been sending out roots deep into this ancient landscape. Since June 2015, when the Consumer Reference Group (CRG) put out its last, plaintive communiqué the NMHCO has existed in the hearts and souls of many who listened to the words of the Chair Ian Watts:

‘The reality is that if we want our vision to come to life, we can’t let it die.’ (Final Communiqué CRG, May 2015)

The symposium will interrogate what happened in 2015 and what we need to do to ensure success this time. While it is easy to blame a change of government for the withdrawal of funding from the NMHCO, it is now a good time to revisit the model (and all the structural elements that were produced from 2012 - 2015) and to see if things need to be changed for a renewed push to create a national organisation.

The symposium will explore the future structures that might best form and sustain such an organisation. It is proposed that the symposium brings together people who have been critically involved in the NMHCO since its inception, those who have emerged as strong voices in this current groundswell, and those who might be indispensable to the new organisation.

Different pathways exist to create the organisation. We could go back to the work abandoned by government in 2015 or we could seek a new model – one where the national body comprises representative of all state and territory peaks. Such a representative peak could build on existing network and ensure that the national body reaches consumers everywhere. It might also encourage those estates and territories who do not have a consumer peak to establish one.

In many ways the idea of the National Organisation sitting at the apex of a network of consumer organisations is consistent with the National Mental Health Strategy and plans that led to the establishment of state and territory Consumer Advisory Groups (CAGs) and the Australian Mental Health Consumer Network in 1992.

Not letting it die

Since May 2015 Consumer have maintained the vision to from a National Organisation through sustained action and engagement, such as:

- The formation of The Australian Association of Mental Health Consumers in November 2015, following long discussions by a group of consumers from the Facebook group CAPS: Mental Health Consumer Advocates and Peer Support network.
- The Consumer Day at the 2017 TheMHS Conference in Sydney generated passionate calls for a consumer-run organisation. There was a strong sentiment that people were tired of passively waiting for government to implement their own mental health policies around a consumer organisation. This enthusiasm carried over to the main conference and resulted in the Federal Minister agreeing to consider the idea. As a result, a meeting took place with the Minister’s office following an extensive and inclusive consultation via social media.
- Sustained debate throughout consumer and peer worker networks since the launch of the organisation ‘Australians for Mental Health’.

Recently the cause has been taken up by peak national community organisations.

- Mental Health Australia’s pre-budget submission (March 2018) called for the restoration on funding for ‘self-governed consumer representation’ and for significant new investment to strengthen existing structures and to build new processes.
- Community Mental Health Australia issued a media release on 4 April 2018: ‘CMHA calls for a national mental health consumer peak’. CMHA President Liz Crowther noted that, ‘A significant missing part of the mental health sector is an established and funded mental health consumer peak that provides a united national voice for mental health consumers’.
• The Australian Mental Health Party supports the call from Community Mental Health Australia to establish a national peak body representing people who access mental health care. Ben Mullings, Chair, noted that ‘Perspectives from consumers are often missing from decisions about the direction of mental health policy’.

Learning Objectives

Learning Objective (1): The audience will gain an understanding of the history behind the formation of a National Mental Health Consumer Organisation, the current situation, the steps needed to realise its formation and the possible structure that is needed for success.

Learning Objective (2): The symposium is critically relevant to mental health as it explores issues and structures that are fundamental to all mental health consumers in Australia. A great deal of work has been done previously to establish a National Mental Health Consumer Organisation and there is a widespread understanding amongst consumers that this is unfinished business as we move to mature, representative and recovery-oriented structures and systems in Australia.

References


Mental Health Support Needs of Australian Chinese

Alan Woodward

There are more than 1 million Chinese residents in Australia. The Chinese Australian community is the largest of the immigrant communities in Australia and, according to the 2016 Census conducted by Australian Bureau of Statistics, one of the fastest growing in numbers. There have been Chinese migrants to Australia for several hundred years, with some migrants to Australia arriving shortly after European settlement of the country.

The mental health and support needs of the Chinese Australia population have been studied in some respects, but few studies have tested service preferences to meet these needs.

The Bridging Hope Charity Foundation has partnered with the Lifeline Research Foundation and research company DiverseWerks to explore the support needs of the Chinese Australian community - from a consumer or potential consumer perspective. This study has examined the demand for culturally appropriate delivery of mental health and wellbeing support services.

Survey Findings:
A key component of the study has been a community survey, promoted widely through community associations, groups and social networks in Sydney, New South Wales, where high concentrations of Chinese Australians reside. The survey received n=2775 responses. Both online and hard copy response were received. The survey questions were as in English and Simplified Chinese to make it as easy as possible to engage with respondents.

The chart below shows the survey results on a question about ‘what things do you experience stress about’:

Two key results emerge from these findings:
1. The high proportion of family, relationships and financial worries as ‘stressors’ reflect similar presenting issues to the national crisis helpline in Australia, Lifeline 13 11 14.
2. There is evidence showing that cultural context and the experience of being a migrant to Australia are additional ‘stressors’ for Chinese Australians.

Discussion:
There is a clear need for culturally appropriate mental health support for Australian Chinese people. It is important to provide support services and outreach programs in language and ways that are culturally adapted to a Chinese understanding.

Services need to offer privacy and confidentiality as the cultural belief of ‘saving face’ or ‘losing face’ is strongly influential for why individuals and families may or may not access mental health services.

Communication about mental health needs to be sensitive to these barriers to seeking help within the Chinese Australian community.

Services that provide a first point of contact for help seeking, without the need to disclose family and medical information would be beneficial and would assist in building individual and family confidence to use the Australian health and social services systems.

There is an underlying demand for mental health services within the Chinese Australian population that is not currently being fully met. There is potential for Australian service providers to reach out to Chinese Australians to a greater extent.
The Mental Health Phase of Care Clinical Refinement Project Abstract

Stephen Mirfin, Alix Higgins

Independent Hospital Pricing Authority, Sydney, Australia

Biography:
Stephen Mirfin – Occupational Therapist
Stephen has expertise in the following areas of clinical implementation of activity based mental health funding systems in the UK, implementation of new clinical outcomes measures including HoNOS, group and individual therapeutic interventions and has working with adolescent, adult, aged care, forensic consumer groups in both admitted and community settings.

Alix Higgins – Manager, Classification Standards, Independent Hospital Pricing Authority
Alix moved into Health Information Management at the Independent Hospital pricing Authority from nursing 5 year ago, and has worked on the Australian Mental Health Care Classification and the development of the Mental Health Phase of Care since 2014.

The Mental Health Phase of Care (MHPoC) is a clinical instrument designed to categorise the prospective goal of treatment for consumer’s into groups which have similar clinical and resource requirements. The instrument brings together two key concepts, that consumers needs change over time as they move between different stages of their illness and that the focus of treatment and associated resources needed change accordingly. The MHPoC is being introduced into routine practice in public sector mental health services across Australia as part of the Australian Mental Health Care Classification (AMHCC).

A recent study on the interrater reliability of the MHPoC found that although clinicians largely agreed with the concept of using the MHPoC in clinical practice, the definitions required some additional work to increase the interrater reliability of the instrument as a reporting tool across all settings and specialities, particularly when used in Child and Adolescent and Older Persons mental health services.

In 2017 The Independent Hospital Pricing Authority (IHPA) commenced a clinically led project to review and refine the MHPoC. The project aims to: increase the clarity and reduce the ambiguity of applying the MHPoC instrument in practice and for reporting, ensure that the instrument is clinically meaningful and reflects contemporary care models, and is consistently applied as part of routine practice. The project is led by six mental health clinicians, from different professions and clinical mental health professions, who will present a final report by the end of 2018. The presentation will provide an overview of the MHPoC clinical refinement project including the quantitative and qualitative methods being used to gather data, the process of data analysis and the expected outcomes of the project.

Learning Objectives

Learning Objective (1): Attendees to this lecture will gain a greater understanding of the work currently being undertaken in reviewing and refining the mental health phase of care, including some of the challenges and barriers for national implementation.

Learning Objective (2): The Mental Health Phase of Care is clinical instrument which has been implemented into all mental health services provided by the public hospital system. All clinicians that work within the public hospital system, be it admitted, ambulatory or residential, are required to use the Mental Health Phase of Care. This project aimed to review and refine the clinical instrument for the purposes of increasing the reliability and decreasing the ambiguity between the different phases.

References