VICSERV (Psychiatric Disability Services of Victoria) SUBMISSION to Senate Select Committee on Mental Health

May 18 2005

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VICSERV

Psychiatric Disability Services of Victoria (VICSERV) Inc., known as VICSERV, is the peak body for Psychiatric Disability Rehabilitation and Support (PDRS) Services in Victoria.

Our member agencies are the PDRS agencies who provide housing support, home-based outreach, psychosocial and pre-vocational day programs, residential rehabilitation, mutual support and self help, employment, training and support, carer education, respite and advocacy.

VICSERV provides a range of services to our member agencies which include:

- Sector Co-ordination, Support and Advocacy;
- Training and Professional Development;
- Policy Development; and
- Information Services (Publications, Library, Web site).

VICSERV is an incorporated association which is governed by a committee of management comprising representatives of ordinary member agencies.

Introduction
VICSERV (Psychiatric Disability Services of Victoria) is pleased to have this opportunity to contribute to this national inquiry on the provision of mental health services in Australia. While there have been many productive and liberating changes for consumers over the last few decades in mental health care, there is still need for significant structural and cultural change, and this enquiry brings with it the opportunity to embrace these changes.

This submission provides direct responses to each of the Terms of Reference. However this response is first contextualised with background material about the Psychiatric Disability and Rehabilitation Support (PDRS) sector in Victoria – a vital part of the mental health service framework in that state. This submission seeks to bring to the attention of the Senate Select Committee the following key points and issues:

- **The presence and practice framework of psychosocial rehabilitation services in Victoria**
- **The need for an expanded role for these services not only in Victoria but throughout Australia**
- **The need for mental health services to focus upon the consumer centred recovery process, underpinned by respect and hope for people experiencing serious mental health issues**
- **The need for improved communication and mutual respect between clinical and non-clinical services in Australia**
- **Highlight some programs which exemplify best practice in the psychosocial rehabilitation model of service delivery**

We request the opportunity to appear before the inquiry to discuss these matters in more detail, and invite Senators involved in the enquiry to visit some of the services described in this document. A list of suggested services is included at the end of this submission.

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1 Executive Summary

Victoria's Psychiatric Disability Rehabilitation and Support (PDRS) Sector offers a valuable model for developing a national framework of effective, well trained and cost effective psychosocial mental health services. In Victoria the PDRS sector is a vital part of a comprehensive mental health service system. Unfortunately, even in Victoria, the sector is dramatically under-funded and this not only limits its ability to deliver best practice services, but in some areas threatens the sustainability of particular services.

The Psychosocial Rehabilitation (PSR) approach employed by Victorian PDRS services focuses upon disability not illness and delivers services which are:

- Socially-focussed
- Environmentally contextualised
- Strengths-based
- Client-centred
- Relationship based
- Voluntary, and which
- Foster hope.

The worker-client relationship forms the basis of the rehabilitation strategy and the approach relies upon close linkages and collaboration with clinical mental health services and other relevant community services (such as housing). Services are delivered within specialist program streams to address housing, life skills and other needs. Whilst services are well established, there is a significant need for Australian research into psychosocial rehabilitation approaches.

The Australian mental health system needs dramatic reform. VICSERV of course agrees that the sector as a whole requires more resources, but also, and just as important, mental health reform needs to occur in how services are focussed upon assisting people with psychiatric disabilities. Attitudinal reform requires a focussing upon recovery and upon psychosocial rehabilitation approaches. The burden of mental illness and psychiatric disability is increasing and we need a smart and cost effective response to this crisis. In this regard Australia would benefit from examining the New Zealand approach to restructuring the mental health system.

The under-development and under-funding of the PDRS sector Australia-wide forms the basis for many of VICSERV's responses to the Terms of Reference of this inquiry.

VICSERV is requesting the opportunity to address the Senate Select Committee and to recommend an itinerary to visit innovative and best practice Victorian PDRS services. This, we believe, will be vital to the Committee developing an informed and comprehensive understanding of how to build a well balanced, effective and cost effective mental health system.

2 The Victorian Psychiatric Disability Rehabilitation and Support (PDRS) Sector

Psychiatric Disability Rehabilitation and Support (PDRS) Services are a vital part of Victoria's specialist, tertiary mental health services. They constitute a major part of the non-clinical mental health system in Victoria and are primarily managed by community based organisations. Approximately $45M in services are delivered across Victoria in more than 170 programs administered by 72 different organisations in metropolitan, regional and rural areas. They provide rehabilitation and support services to more than 11,000 people and employ over 1,000 staff.

2.1 *Historical context*

Although growth has been significant since the early 1990s, the sector remains relatively small in the context of total state government expenditure in Adult Mental Health, representing approximately 11% of total funding in Victoria.

Victorian PDRS services have their origins in a diverse range of history, rooted in a commitment to assisting those most marginalised in our society. These origins include:

- Welfare models which have sought to assist the poor generally through providing such services as counselling, food, housing, social opportunities and other resources
- The closure of large psychiatric institutions which has brought physical and staffing resources and patients out of institutions and into community environments.
- A set of values, characteristics and practice models which have evolved *from* people who have experienced serious mental illness and which have imbued the service frameworks within which PDRS services operate.

2.2 *Guiding principles and values of the PDRS sector*

First, it is important to recall the distinction between the **symptoms of mental illness** and the **psychiatric disability** which restricts the ability of a person to 'live a normal life'.

PDRS services focus upon the disability rather than illness through offering **psychosocial rehabilitation** programs. Three important conceptual elements underpin psychosocial rehabilitation:

- The concept of "recovery"
- The principles of psychosocial rehabilitation
- The characteristics of psychiatric disability rehabilitation and support services.

2.2.1 The concept of "recovery"

Fundamentally the psychosocial rehabilitation approach believes that people who experience serious mental health issues can recover. This is a passionate disavowal of one of the most persistent myths of mental illness - that people experiencing mental

illness are condemned to a situation which is incurable and irretrievable. Central to the refutation of this myth, and to recovery from mental illness is ***hope***.

Harding (2003), reporting on a number of long-term studies into the recovery of people with schizophrenia, concluded that people "*…received the greatest benefit when they were told that someone believed in them…this illustrated the importance of hope and showed that hope was connected to the natural self-healing capacities of people*."

'***Recovery'*** in relation to serious mental illness is highly conceptualised and articulated through a very active worldwide consumer movement. Recovery refers to a way of living a satisfying and hopeful life, despite the limitations caused by mental illness and associated stigma. Recovery doesn't necessarily mean cure - the symptoms of mental illness may remain. It reflects a process of the person regaining control of their life by learning to manage the illness and its impacts, rather than being managed by them (for example see Davidson 2004). PDRS services use the practice ***relationship*** to re-instill in a person the hope of a continuing life, of recovery beyond the mental illness.

2.2.2 Principles and Characteristics of the Victorian PDRS Sector

The sector is guided by two different yet related sets of Principles and Characteristics which describe an approach which is:

- Socially-focussed
- Environmentally contextualised
- Strengths-based
- Client-centred
- Relationship based
- Voluntary, and which
- Fosters hope.

In 1992 the practice and values of the Victorian sector were given formal recognition by the sector's affirmation of the following ***Principles of Psychosocial Rehabilitation*** developed by Cnaan *et. al* (1988). The adoption of these principles was fundamental to consolidating a common sense of purpose for Victoria's NGO PDRS services and for building the coherent sector which exists today.

The Major Principles of the PSR Approach

1. Under-utilisation of full human capacity.
2. Equipping people with skills (social, vocational, educational, interpersonal and others).
3. People have the right and responsibility for self-determination
4. Services should be provided in as normalised environment as possible.
5. Differential needs and care.
6. Commitment from staff members.
7. Care is provided in an intimate environment without professional, authoritative shields and barriers.
8. Early intervention.
9. Environmental approach.
10. Changing the environment.

11. No limits on participation.
12. Work-centred process.
13. There is an emphasis on a social rather than a medical model of care.
14. Emphasis is on the client's strengths rather than on pathologies.
15. Emphasis is on the here and now rather than on problems from the past.

Following this, the sector felt there was a need to properly delineate the character of the community-based Victorian services from those provided by clinical services and to articulate a set of ‘characteristics’ of Victorian services. Whilst incorporating PSR principles in their practice, Victorian PDRSSs also exhibited other characteristics which the US principles did not describe.

A distinct difference is the emphasis, in the American model, upon *work* as a primary rehabilitative strategy. It was regarded by the Victorian sector in 1993 that work, whilst an important element, was only one form of “activity” and ‘did not always reflect the hopes and aspirations of all participants’. Rather it was felt that an emphasis upon ‘hope’ and ‘social relationships’ was more important (McKenzie 1998). This gave rise to a set of 'characteristics' which defined PSR practice in Victoria.

Characteristics of Non- government Community-managed Community Mental Health Rehabilitation and Support Services

1. Flexibility of structure and service models.
2. Non-obligatory attendance.
3. Support for mobility and choice of service options.
4. Active participant involvement in services.
5. Support for participant decision-making.
6. Concentration on quality of relationships and interactions between participants and staff.
7. Encouragement of peer support.
8. Responsiveness to participants' needs.
9. Provision of most 'normal' environment.
10. Effective psychosocial rehabilitation.
11. Autonomous community accountability.
12. Utilisation of a broad range of skills.
13. Active community education function.
14. Active advocacy function.
15. Cost-effectiveness: both operational and preventative.

2.3 *Translating Principles into Practice – From PSR to PDRSS*

PDRS services make a specialist contribution to the mental health system and are the only mental health or community based health services that are specifically committed to a psychosocial rehabilitation mode of service delivery.

In PDRS services, the **Key Worker** assists a person to achieve their life goals in areas such as independent living, social relationships, recreation/leisure, education, personal development, vocational activity and housing. The principles of psychosocial

rehabilitation focus on the need to equip individuals with a range of skills to survive, thrive and build on their strengths in the community.

Services are flexible in design to meet individuals needs, and service delivery is provided in as normalised and intimate an environment as possible. Staff are committed to lowering unnecessary professional shields and barriers, concentrating on the quality of relationships and interactions between themselves and participants.

Services take into account the whole environment of the participant, examining ways to positively change the environment, and are consistent with a social model of health. People's right to self-determination is acknowledged and participant involvement in services is voluntary though encouraged.

In the eyes of Victoria's funding bodies, cost effectiveness is central to the sector's existence. Psychosocial rehabilitation approaches are less expensive than clinical models. However this should not be seen as an either/or situation as the cost benefits also accrue from the very real ability of PSR strategies to minimise relapse and re-hospitalisations and thus to reduce the need for expensive clinical interventions.

Crucial to effective staff practice with consumers is:

- The generation of hope
- The facilitation of social relationships
- The application of the principles of psychosocial rehabilitation in programs, and in staff/consumer relationships.

2.3.1 Elements of PDRS Service Delivery

A number of key elements require elaboration prior to a description of the specialist services which constitute the PDRS framework of service delivery.

2.3.1.1 *The PDRS Sector in Victoria – specialist, sophisticated and central to comprehensive mental health service delivery*

With the growth in size and sophistication of Victoria's PDRS system the following additional characteristics have become apparent:

- Need has dictated that service delivery is now focusing upon the *higher end of the disability spectrum*
- Service users have a strong and unique role in the design, development and evaluation of programs
- Services embrace a specialist advocacy role, ensuring consumer rights
- They are delivered in specialist models of service which.

The sector is now a functional segment of a comprehensive health services system which responds to the complex and diverse needs of people with a psychiatric disability. This includes other programs with specialist roles, for example, acute and community based clinical mental health treatment services, drug and alcohol services, HACC etc.

VICSERV provides the core of the capacity of the sector to provide professional workforce training and support for effective governance.

2.3.1.2 *The Key Worker and Planning*

The effective practice of psychosocial rehabilitation requires a key worker to be skilled and competent in their understanding of illness, planning processes and many of the skills of case management, and a high level of maturity and sensitivity in working with clients who experience complex social problems. They need to be able to work with people through periods of illness, as well as periods of the development of well-being and the process of recovery. It is imperative that they can work with people to help them identify opportunities for recovery and the development of hope. The key worker is the primary contact person for the consumer in the PDRSS, and is responsible for ensuring facilitation of the psychosocial rehabilitation process for each individual.

Individual Program Plans (IPP) outline and guide this process. The IPP is developed by each service user, with the support of their key worker. The plan guides a dynamic rehabilitation process, including identification of current environmental issues, goal setting, strategies for success, and regular reviews.

2.3.1.3 *Governance*

Services are managed by (amongst others) stand-alone PDRS organisations, multi-function community organisations, community health services and local government. Services can be successfully delivered in any of these environments, although to achieve this it is crucial that:

- The key principles of psychosocial rehabilitation and characteristics of PDRS services are applied;
- The role, functions and philosophy of the managing organisations are consistent with the principles of psychosocial rehabilitation and the generally agreed role and functions of PDRS Services;
- Programs are delivered as specialist services.

2.3.1.4 *Working in Partnerships*

The psychosocial rehabilitation approach usually involves working in **partnership** with a range of community services and programs so as to meet the complex health care and support needs of people with a psychiatric disability.

The relationship between clinical services (psychiatrists, GPs and case managers in community mental health centres) and PDRS services, is the cornerstone of the service system. Mutual understanding, support and referral is crucial to the provision of a comprehensive service for consumers, and to the most efficient use of resources.

Key workers and program managers within PDRS services also require effective community links including those with drug and alcohol services, community health and employment, education, housing and homeless services.

Victorian PDRSSs are a part of **Primary Care Partnerships**. They link with community health, local government, and a range of other specialist providers to ensure continuity of care for service users.

Community mental health is a major emerging issue in community health. In partnership with clinical mental health services based in the community, PDRSSs have a leadership role to play in community health planning.

2.3.1.5 *Health Promotion*

PDRS Services have a commitment to **mental health promotion**, challenging negative community attitudes and reducing stigma. Many PDRSSs have been instrumental in establishing community partnerships to effect mental health promotion initiatives such as Mental Health Week and associated activities.

2.3.1.6 *Early Intervention*

PDRSSs take an active role in **early intervention** strategies to facilitate optimum care and support for people in the early stages of mental illness or in the early stages of illness episodes. If effective supports are available at these early stages the long-term impacts of mental illness on the individual (and the rate of re-admissions into acute mental health facilities) can be significantly reduced.

Services work in collaboration with individuals, groups and other health care providers to promote awareness of the importance of early intervention strategies and to ensure that services are flexible and responsive to individual and community needs.

2.3.1.7 *Relapse Prevention*

Relapse prevention is an inbuilt component of the work of individual staff, who work with people to minimise the likelihood of relapse and re-hospitalisation. This may occur within the context of the key worker relationship where worker and client together plan strategies for better noticing and addressing mental health issues and possible relapse situations. Key workers are also critically involved with noticing or assisting the client to notice early warning signs which presage relapse. Finally, services may offer specific relapse prevention groups or classes for clients and families to help them formulate relapse prevention strategies. Over recent years Victorian PDRSSs have been more active in addressing relapse prevention with young people (aged 16-25) with serious mental illness so as to minimise the negative residual impacts of recurrent episodes of mental illness.

According to VICSERV's regular Training Needs Surveys, Key Workers come from a diverse range of backgrounds including social work, community development, public health, psychology, nursing, education, and the creative arts. A staffing priority is to employ who can build quality relations with clients so as to re-engage hope and foster recovery. VICSERV's training is conducted with this staffing diversity in mind and seeks to build on worker's knowledge and skills around strategies for recovery, accessing resources, as well as mental health knowledge.

These staffing priorities and the sector's ability to maintain a committed and well trained workforce means that ***PDRS services are not subject to labour market supply constraints.*** This contrasts sharply with existing shortages in similar professions such as psychiatric nursing.

2.3.2 The Specialist Program Streams of PDRSSs

2.3.2.1 *Home Based Outreach Services*

Home-Based Outreach (HBO) is conducted from more than 100 programs throughout Victoria. The role of the HBO worker is to support consumers, assisting them to generate independent living skills, community links, and friendship networks, and to engage in the recovery process.

One of the most significant initiatives which allowed the development of HBO as the single greatest component of PDRS was the ***Housing and Support Program*** (HASP)**.** In the early 90s the State Government showed great initiative in combining disability support with housing, at the service level. This was achieved by the distribution of funds from housing to regional DHS offices, where spot purchases of houses were made, based on criteria developed from the needs of PDRS clients on waiting lists for housing. This ensured highly appropriate housing from individual units to shared housing, and created a significant shift away from institutionalised group housing environments.

Intensive Home Based Outreach (IHBO) programs are time limited and provide intensive support to people with multiple, complex needs, and who are at risk of homelessness.

2.3.2.2 *Day Programs*

Day Programs provide a range of structured activities, as well as drop-in and unstructured activities. The psychosocial focus of programs involves providing a supportive environment which builds on the strengths of participants. This involves opportunities for skills and personal development in areas including living skills, pre-vocational activity, and socialisation.

Clubhouse programs warrants a separate mention as the model focuses upon activities and employment support. Members become involved at all levels of participation within the Clubhouse including administration, the kitchen and decision making. Transitional Employment Programs members into part time, temporary work placements. If the member is unwell and unable to do the job, a staff member will attend the place of work in their stead so the employer will not be disadvantaged. Support is also provided for those members who obtain independent employment.

2.3.2.3 *Planned Respite Care Services*

Planned respite care programs provide a range of respite events for both consumers and carers. Activities range from residential respite for consumers to outdoor / adventure activities for consumers and/or carers, and the provision of short-term

support which provide “breaks” for consumers and/or carers from their existing environment.

2.3.2.4 *Residential Rehabilitation Services*

There are 17 residential rehabilitation programs throughout Victoria – most with a focus on younger people 16 to 24 years. These programs provide intensive support to consumers within a residential setting in the community. Programs focus on long-term approaches to working with consumers to develop the capacity for independent living.

2.3.2.5 Mutual Support/Self-Help Programs

Mutual support/self-help groups throughout Victoria are based on a range of support models. The common element of all of these models is one of empowerment and support for individual consumers or carers, working through group processes, sharing life experiences with people who can relate their own similar experience, or developing support networks for crisis situations.

2.3.3 Developing an evidence base for Psychosocial Rehabilitation approaches

The evidence base for the effectiveness of psychosocial rehabilitation approaches is growing but needs to develop far more if we are to continue to dispel some of the persistent myths about mental illness and to develop strategies which can truly achieve rehabilitation. Of primary concern to PDRSSs is the ability to show the worth of PSR strategies.

Boston University's Centre for Psychiatric Rehabilitation leads the way in international research about psychosocial rehabilitation strategies (www.bu.edu/cpr/) and contains many resources for affirming the worth of the PSR strategies adopted by PDRSSs. As previously mentioned, Harding (2003) has completed a comprehensive review of ten three-decade longitudinal studies of people with schizophrenia and this identifies 'relationship' and 'hope', the central tenets of the psychosocial rehabilitation approach, as the key attributes which help people work on their own recovery. More detailed information about this study and associated recovery studies are available at www.bu.edu/resilience/examples/index.html.

2.4 *Conclusion*

We hope this summary of the PDRS sector has been useful to the committee. This submission now directly addresses the Terms of Reference which are relevant to PSR and the PDRSS Sector generally.

3 VICSERV's Comments and Recommendations Relevant to the Terms of Reference

3.1 *TOR A – National Mental Health Strategy*

The Senate Select Committee on Mental Health seeks to determine '*the extent to which the National Mental Health Strategy, the resources committed to and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress'*

VICSERV Response

The most recent National Mental Health Plan brings recovery and relapse prevention to the fore. This is a strong affirmation of values which the Victorian PDRS sector has been pursuing for nearly two decades. The National Mental Health Strategy aims to coordinate National Mental Health care reform through a range of strategies.

Amongst other things, those NMHS goals which are most relevant to the Victorian PDRS Sector and any national Community-Based Rehabilitation and Support (CBRS) Sector include those goals which seek to:

- *Ensure the public mental health sector 'dovetails' in with NGOs*
- *Ensure an appropriate service mix*
- *Enhance relationships between mental health services and other related sectors*

(paraphrased from Australian Health Ministers 2003:6)

VICSERV suggests that the creation of a national system of CBRS services is essential to achieving the above stated goals of the NMHP because:

- It is not possible to 'dovetail' with an NGO sector which does not yet adequately exist on a national scale;
- An 'appropriate service mix' cannot be achieved without a well funded, professionally organised, trained and delivered Community-Based Rehabilitation and Support sector;
- The presence of a strong CBRS sector is vital to fostering the development of inter-service relationships which meet both the clinical and psychosocial needs of people within a recovery focussed, client-centred framework.

Many national opportunities around these goals have not been met because of inadequate funding and incomplete cultural change. Insufficient funding, and a persistent culture which fosters and prioritises clinical 'illness-focussed' perspectives, has delayed the development of an important sector which focuses its work upon assisting the person in their recovery from the disability.

Whilst the Victorian PDRS sector is in a relatively good position, it is disappointing that the development of the CBRS sector in other states is so far behind Victoria because of the absence of appropriate funding priorities. The Victorian experience

shows the importance of developing CBRS services independently of clinical culture. **The presence of a national network of well funded, well trained, professional and respected CBRS Services is the key** to creating a 'critical mass' which will contribute to:

- Improving the lives of tens of thousands of people with serious mental illness;
- Improving the prospects of recovery for these people;
- Fundamental cultural change amongst clinical mental health services;
- Reaching a 'tipping point' for mental health promotion and a consequent reduction of stigma in the community.

Appropriate Funding Levels for a National Community-Based Rehabilitation and Support Sector

Although the Victorian PDRS sector is 'well funded' compared to other states, its development is severely hampered by funding shortfalls which threaten the viability of the sector. For example the Victorian level of funding (at 11% of the State Mental Health Budget) compares poorly with New Zealand where the NGO Sector receives 30% of the Mental Health budget.

Recommendations

- That adequate levels of funding be established for comprehensive CBRS services across Australia.
- That such services be funded directly from government, independent of health care and clinical service networks.
- That new funds be allocated to clinical and CBRS mental health services.
- That at least 30% of funding be apportioned to the CBRS sector.
- That the New Zealand example be examined closely to gauge the difference that 30% apportionment provides.

3.2 *TOR B – Adequacy of modes of care*

The Senate Select Committee on Mental Health seeks to determine '*the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care*'

VICSERV Response

The PDRS Sector in Victoria has a firm understanding of its place in the spectrum of mental health services, with a particular focus upon its roles in **early intervention** and **community care**, and the vital role of our partnerships with clinical and other services (see the VICSERV publication – 'Finding Our Place: Rehabilitation & Support in Mental Health Services – we have forwarded a copy of this document to the Committee).

In relation to community care the role of Victorian PDRSSs is firmly established, albeit under-funded.

CBRS services are providers of everyday relapse prevention services. These capacities are under-recognised and under-utilised not only in relation to relapse prevention but also in an early intervention context. There is further potential to build upon the role of CBRS services in early intervention through:

- Having a more specifically funded role in delivering services to young people experiencing first time psychosis
- Building our capacity to engage in targeting young people in schools

As they exist in Victoria, PDRS workers meet consumers in their everyday environment and spend time with them to increase their skills in illness management and social participation. Generally CBRS services are the most accessible when consumers are seeking strategies to help them strengthen their ability to intervene when early warning signs become apparent.

Recommendations

- Strengthen and increase the size of the CBRS sector so as to enhance the delivery of PSR services throughout the system, although particularly in relation to early intervention and community care.
- Investigate the New Zealand funding model and associated initiatives. Much of the expertise for expanding the CBRS sector throughout Australia can be found in Victoria.

3.3 *TOR C – Coordination of services*

The Senate Select Committee on Mental Health seeks to determine the *'opportunities for improving co-ordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care'*.

VICSERV Response

CBRS services are ideally positioned for delivering the various levels of coordination required during episodic mental illnesses. The models developed in the sector are able to deliver intensive support based on need, in a relatively inexpensive model. This reflects the sector's belief that whilst many mental illnesses may be episodic in nature, care should not be. Rather mental health care should be about a continuing relationship with access being flexible and based upon need. Many Victorian PDRS services deliver services which are able to 'step up' or 'step down' care as required. The efficiency of the sector positions it well for keeping a watching brief and assisting with relapse prevention during times of wellness.

Such an approach lends itself well to being a lynchpin in coordinating different modes of care in collaboration with clients, carers and, where required clinical services may be brokered.

Recommendations

- Increase the funding levels of the CBRS sector to achieve better coordination between mental health systems and to bring about effective and real efficiencies in a comprehensive system of mental health care

3.4 *TOR D – Roles of the Private and Non-Government Sectors*

The Senate Select Committee on Mental Health seeks to determine *'the appropriate role of the private and non-government sectors'*

VICSERV Response
The funding level for the Community-Based Rehabilitation and Support Sector should reflect 30% of the mental health services funding nationally.

Effective recovery requires a combination of clinical support and treatment, and more intensive community-based support and rehabilitation delivered by the Non-Government sector. The latter is missing in Australia where the focus to date has been upon clinical interventions.

NGO CBRS services are targeted at the most needy – the poor – who have a much higher chance of experiencing mental illness and relapse situations. It is widely proven that mental health is very much negatively correlated to wealth - poor mental health is exacerbated by poverty. Poverty is also strongly correlated with an absence of treatment options. As a result it is important to maintain a well trained and well-funded NGO mental health sector which can focus its service upon those most at risk: the poor.

Distinguishing 'Private' from 'Community-Based'
It is vital that a comprehensive mental health service delivery framework be maintained, including well funded and professional:

- Public clinical mental health service
- Non Government, Community-Based Rehabilitation and Support Services
- The 'private sector' which most often denotes 'private psychiatrists'.

Recommendations

- That appropriate emphasis (and funding) be given to the NGO sector (in conjunction with public mental health services) as being the first (and possibly only) rehabilitation option for those most vulnerable to mental health issues.

3.5 *TOR E – Unmet need*

The Senate Select Committee on Mental Health seeks to determine *'the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes'*

VICSERV Response

Adequate housing, supported accommodation, supported employment, greater employment options, and improved family and social support services for people with psychiatric disability all represent **major unaddressed needs** within the Australian mental health service system. Major restructuring and resourcing needs to occur to correct these gross deficiencies.

Housing

Stable housing is essential for recovery. The absence of secure available housing for people with mental health issues presents a number of difficult challenges. Four issues stand out for housing in relation to psychiatric disability.

1. **Insecure** housing for people with a serious mental illness is a major cause of stress
2. The **scarcity of secure, long term** and emergency housing for mental health services makes it very difficult to deliver effective recovery focussed services
3. More dedicated housing resources need to be allocated to CBRS services with **attached support**
4. The absence of affordable housing is of particular **stress to the general population**, creating uncertain conditions which act against good mental health

There have been some innovative and well funded programs in past years, especially the Housing and Support Program (HASP, see Sn 2.3.2.1). Whilst a great initiative, this program has not been consistent in its implementation. This is disappointing, given that secure well supported housing is critical to recovery and the maintenance of good mental health. The implementation of HASP has been sporadic, with some areas able to provide a continuing service as stock is 'rolled over' when the tenant is considered well enough to leave the HASP program. Usually when a transitional housing arrangement ends, the tenant needs to leave the house. In this case however the tenure of the property is switched from psychiatric-disability specific management to mainstream Office of Housing management and a new house is able to be allocated to the HASP program. This is an excellent initiative which is unfortunately available in only limited areas due to regional variations amongst staffing attitudes to this arrangement.

Supported employment

An array of employment options exists for people with mental health issues, from mainstream employment options (e.g. Job Network, standard employment situations) through disability-specific employment services to specific psychiatric disability

focussed employment services such as those provided by the 'Clubhouse' model (e.g. Transitional Employment Program Sn 2.3.2.2).

Unfortunately it is often the experience of those with mental health issues that disability employment agencies do not provide sufficiently focussed support for this client group, having a much stronger focus upon intellectual disability support. More stepped and supported employment options are necessary to assist people with mental health issues to build confidence, re-skill, and to access and retain employment.

Family services

Some innovative programs exist for women with a mental illness who have young children (e.g. Prahran Mission). Funding is quite limited for these programs and they are still in the early stages of implementation. CBRS support for parents with mental illness could be made more broadly available such as expanding the eligible age range so parents of older children may be included, and to include fathers.

Recent data from St Luke's Anglicare shows the prevalence of mental health issues amongst clients of youth and family services. This supports the need for better communication and cross-servicing between family services and CBRS services.

Recommendations

- That the Government establish and expand nationally initiatives which link housing and support for people with a psychiatric disability (such as HASP);
- That Government establish psychiatric disability-specific employment services;
- That Community Based Rehabilitation and Support services be expanded to include more family-specific mental health services to support parents with psychiatric disabilities, and to support their children.

3.6 *TOR F – Special needs of groups*

The Senate Select Committee on Mental Health seeks to determine *'the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence'*.

VICSERV Response

Increasingly CBRS services are becoming a default service for many with special needs who fall in the 'too hard basket' for some services (including clinical services), particularly those with dual disability, dual diagnosis and those with exceptionally complex needs (for instance ABI or borderline personality disorder).

At this time the CBRS sector does not generally work in the Child and Adolescent Mental Health (CAMHS) field. However there are some situations (such as children of parents with mental illness) which are funded in the sector (for instance the programs described in our response to ToR E). Increasingly the sector is delivering early intervention services which caters for young people aged 16 to 25.

The paucity of mental health services in geographically isolated areas of Victoria means that regional CBRS services (for instance Mallee Family Care and St Luke's in Central Victoria and the Mallee) are often the main point of contact for people living in these areas with a psychiatric disability. In these situations CBRS services are even more vital as continuing and efficient conduits to clinical services when required.

This regional perspective is even more pertinent when considering the regional concentrations of indigenous populations and the need for culturally sensitive and specific CBRS services. Approaches such as those developed by Indigenous Psychological Services and Tracy Westerman (Western Australia) provide important innovations from which CBRS services can expand and tailor their delivery of culturally specific services PSR.

Some Victorian PDRS services are funded to deliver psychosocial rehabilitation services to elderly people with a psychiatric disability although the funding of this is not consistent.

In addition some PDRS services and funding streams are dedicated to delivering services (and housing) to homeless people with a psychiatric disability.

Recommendation

- CBRS services have an important role to play in working with complex clients. National pilots which focus upon outreach (for isolated clients), dual diagnosis (in partnership with drug and alcohol services) and indigenous health (in partnership with indigenous health and community services) should be funded to better understand and develop best practice.

- PSR strategies are becoming more recognised as being relevant to many of these groups with special needs. Increased funding will assist the improvement and specialisation of the delivery of PSR services to these groups.

3.7 *TOR G – Training and Support for Carers*

The Senate Select Committee on Mental Health seeks to determine '*the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness*'.

VICSERV Response
The CBRS sector specialises in rebuilding hope for clients. As already shown, such an approach is vital to recovery and needs to spread beyond the sector and be more thoroughly inculcated in the general population, including primary carers.

Carers need to be well resourced and serviced to assist them to rekindle their own hope in the people they are caring for. Vital to this are the support groups which help provide links between carers and which are the best equipped to resource and train carers. **These mutual self help groups are not receiving sufficient funding to adequately deliver these support services and to organise training for carers.**

Recommendations

- That carer groups and Mutual Support and Self Help groups be identified as an important service option in meeting the needs of carers through training and support and that a strategy be developed to support their growth nationally.

3.8 *TOR H – Role of Primary Health Care*

The Senate Select Committee on Mental Health seeks to determine '*the role of primary health care in promotion, prevention, early detection and chronic care management*'.

VICSERV Response
Primary health care is often the first line of mental health care. There is still a great need for the raising of awareness amongst GPs about mental health issues, about recovery, as well as about the availability of psycho-social rehabilitation strategies to supplement the resources available to clinical services and to primary health care. In many cases CBRS Key Workers visit GPs with their clients, or are the first to identify relapse. **The Australian Primary Health Care system would benefit enormously from GPs having an improved knowledge about, a stronger relationship with, and access to referral to CBRS services.**

Such a strategy would primarily benefit primary health care efforts in the areas of chronic care management and relapse prevention.

3.9 *TOR I – Reducing Iatrogenesis, Promoting Consumer Involvement*

The Senate Select Committee on Mental Health seeks to determine *'opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated'*.

VICSERV Response

History is replete with examples of iatrogenic psychiatric care. Many of the residual disabilities dealt with by CBRS services are the result of one form of iatrogenic care - *institutionalisation*.

A key protection against repeats of this form of iatrogenesis is the involvement of consumers in the design and delivery of mental health services which is well established in Victorian PDRS services. In addition peer support is a critical part of our sector, particularly in the mutual support / self help services. Unfortunately here in Victoria these well established and effective frameworks are significantly threatened by insufficient funding.

In contrast, consumer-run services are rare and there is a need for these models to be trialled and evaluated.

Effective consumer-directed and consumer-centred outcome measures and a stronger evidence base for CBRS are vital to efforts to avoid iatrogenic care.

Recommendations

- Maintain and strengthen consumer involvement to limit the chances of iatrogenesis;
- Predicate funding upon the delivery of consumer-focussed services;
- Develop outcome measurement strategies which are consumer-designed and consumer-driven;
- Build and adequately fund consumer networks;
- Adequately fund peer support and mutual self help initiatives;
- Trial and evaluate consumer-run CBRS services.

3.10 *TOR J – Criminal Justice system*

The Senate Select Committee on Mental Health seeks to determine *'the over-representation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people'*

VICSERV Response

The pursuit of relapse prevention strategies is critical to reducing prison populations of people with mental illness, and to reduce criminal acts which are exacerbated by mental illness. Many CBRS services have experience with assisting people with serious mental illness in their transition from prison to community life. In most situations this is vital to preventing a relapse which could contribute to re-incarceration. Also required is close collaboration with prison authorities and access to appropriate resources such as transitional housing. In Victoria **Individual Support Packages** have provided comprehensive service packages which have proved very effective in assisting the transition to community.

An increased presence of CBRS services in the prison and post-prison environments will ultimately save on the enormous costs of judicial incarceration.

Issues

- Specific CBRS funding streams need to be allocated for ***working within prisons*** to deliver PSR services to prisoners, but also to establish good relationships with those prisoners who will be released in the near future.
- Specific transitional and long term ***housing*** resources need to be allocated for those leaving custody.
- The development of an appropriate level of funding for specific high needs ***support packages*** (such as IHBO (see Section 2.3.2.1) for those leaving custody. Having these support packages attached to housing options is vital to the well-being and reform of those leaving custody.
- Specific government co-ordinated ***partnerships*** need to be developed between clinical services, prison authorities, CBRS services and housing agencies to assist people leaving custody.
- ***Improved communication*** needs to occur between prison mental health services and CBRS services so that those returning to the community with mental health issues can make a smooth transition.
- The recent experiences of Cornelia Rau and Vivian Solon highlight some of the atrocious levels of stigma and lack of understanding about psychiatric disability within some of the nation's major political and bureaucratic institutions.

Recommendations

- That CBRS services be engaged to deliver PSR within prisons and for post-prison transitions

- That housing resources (with attached CBRS resources) be allocated to assist prisoners with mental illness to make successful transitions back into community life
- That partnerships and communication strategies be developed between prison authorities, clinical mental health services, CBRS services and housing agencies.
- That intensive transition packages such as Individual Support Packages or IHBO funding be established to decrease the possibility of re-incarceration due to relapse.

3.11 *TOR K – Seclusion in Mental Health Facilities*

The Senate Select Committee on Mental Health seeks to determine '*the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion*'

VICSERV Response

We note that the International Initiative for Mental Health Leadership believes that the use of seclusion is unnecessary and not beneficial to well-being, treatment or recovery.

3.12 *TOR L - Stigma*

The Senate Select Committee on Mental Health seeks to determine '*the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers'*.

VICSERV Response:

CBRS services are well placed to play a leading role in community education about the effects and consequences of mental illness. This is because they establish many partnerships and contacts across the community by dent of their solid foundation within their communities. They are often run by community-based boards of management and consumer input at a number of levels is critical to their successful operation. Depending upon their individual profiles within a community, they may be a first port of call for people seeking information about mental illness and rehabilitation options.

Stronger information networks need to be developed with GP networks about the fundamental role that CBRS services play in providing information to consumers, carers and families. The ability of CBRS services to engage in this sort of work is severely hampered by their chronic underfunding. They are thus not able to fulfil the potential that fits so comfortably with their community genesis.

Recommendations

- That CBRS services be provided resources for community development work to address stigma.

3.13 *TOR M – Proficiency and accountability of related agencies*

The Senate Select Committee on Mental Health seeks to determine '*the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness'*.

VICSERV Response

Our experience in Victoria is one of a growing (though sporadic) understanding within housing, law enforcement, employment and general health services, of the particular needs of people with a psychiatric disability, and an appreciation of the role that CBRS services can play in that person's life in those particular sectors.

However there is still a significant need for relevant training in these general agencies as well as with GPs and other primary health agencies about working with the person and their disability rather than focussing upon the illness.

Improved proficiency and accountability can come about through a reduction in stigma amongst staff working in these agencies. Whilst some clinical knowledge of symptoms may be useful, it is also useful to have an understanding of the nuances and communication skills required for working with people with a psychiatric disability, and to reflect upon one's own understandings and assumptions. Community Services Industry (CSI) Training is available to assist general staff to come to better understandings about psychiatric disability and has been delivered to such agencies as the State Library of Victoria and the Equal Opportunity Commission as well as other social and community services organisations.

Such training will provide a good generalised basis for reducing stigma and for improving the accountability and proficiency of the delivery of services to people with a psychiatric disability.

Similar initiatives could be undertaken with relevant housing and employment services to help improve their accountability and proficiency in relation to working with people with a psychiatric disability.

A key accountability measure is the funding of consumer organisations to act as watchdogs and advocates for people with psychiatric disabilities using general services.

Recommendations

- Relationship building and community development initiatives should occur regularly between CBRS services and general community services.
- Direct service staff in Community Services Industries should be trained about psychiatric disability and the scope of services available to people with a psychiatric disability.
- Adequate funding of consumer organisations and advocates should be provided.

3.14 *TOR N - Research*

The Senate Select Committee on Mental Health seeks to determine *'the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated'.*

VICSERV Response

As suggested previously there is a greater need for a stronger evidence base for PSR approaches. However as Professor William Anthony (Boston University Centre for Psychiatric Rehabilitation) argued in 2003, calls for a full implementation of evidenced based practice are premature in PSR because it potentially discourages innovation in a field still which is still evolving.

That being said, numerous studies (available in Jonikas and Cook 2000) have provided:

- Comprehensive overviews regarding the effectiveness of PSR
- Descriptive information about programs and desired outcomes
- Information on the effectiveness of PSR in reducing relapse rates for clients

However Dr. Joan Clarke (OAM), the recently retired CEO of Prahran Mission, has recently lamented the absence of appropriate research on the psychosocial rehabilitation approach. This highlights the acute absence of empirical research about PSR services in Australia.

Recommendations

There is a drastic need for funding at various levels to appropriately examine the processes and outcomes of Australian PSR approaches. Funding initiatives which might be federally fostered include:

- Industry specific post graduate scholarships
- Increased funding for cooperative research projects between universities and the CBRS sector
- Funding for individual services to research, reflect, write up and disseminate best practice examples.
- Research into outcome measures for CBRS services.

3.15 *TOR O – Data collection*

The Senate Select Committee on Mental Health seeks to determine '*the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards'*.

VICSERV Response

The Victorian PDRS sector, in conjunction with the Victorian Department of Human Services (DHS), is engaging in several projects to monitor and improve the quality of services. In the last three years DHS has requested the PDRS sector to provide information through the Quarterly Data Collection (QDC). This potentially provides very useful information for the sector to deliver and improve high quality services. However several issues exist around the QDC and data collection in general for the sector.

Issues

- Increased government reporting requires additional reporting for direct service staff. However ***sufficient additional resourcing*** has not been forthcoming to meet the additional workloads required. Higher levels of direct service staff resourcing are required to enable staff to reduce workloads so that appropriate time can be allocated to data collection, reporting, reflection and analysis. This will help ensure high quality services are monitored and maintained.
- The psychosocial rehabilitation principles seek to de-emphasise clinical diagnosis and the illness, and to focus the service engagement and relationship upon the individual, their recovery, and on finding ways to work with and overcome the disability the client is experiencing. Some DHS mandated ***reporting procedures work against*** these practices and force workers to ask questions which are inappropriate to focussing upon the strengths, abilities and capacities of the client. *Obligatory reporting procedures in CBRS services need to be able to* ***assist*** *the client to focus upon their recovery, rather than distracting the worker-client relationship onto focussing upon the illness.*
- Data collection provides important information for client recovery. However it needs to occur in such a way that it is not seen as 'another piece of paperwork'. Rather it needs to be, and be seen to be, as a fundamental part of the service that is assisting the client to focus upon their recovery. Some Victorian PDRS agencies have developed assessment and data collection tools which are framed in this way, assisting the client to focus upon their strengths and their recovery (for example St Luke's Anglicare).
- A comprehensive data collection tool which is an integral part of direct service delivery needs to be developed and employed nationally in CBRS services. This, ideally, will provide a rich (and confidential) source of information for outcome measurement and work practice. The Victorian Department of Human Services is currently in the process of instituting CRISSP (the Client Relationship Information System for Service Providers) for the community care and disability services NGO sector. This system will be a comprehensive service delivery and data collection system which will enable work efficiencies and allow interconnection with DHS.

Although CRISSP is being developed by DHS for many agencies (including those PDRSSs which are part of a wider youth, family services or disability agency) standalone PDRSSs are not permitted to use CRISSP.

- Appropriate data collection needs to occur which steps away from clinical models and which are relevant to the CBRS standards and can be used to better shape CBRS services.
- Feedback response times and available and flexible detail from centrally collected data needs to improve.

Recommendations

- That the Government fund the development of a national data tool which recognises and reflects the work of CBRS and is not simply a version of clinical service tools.

4 Final Comments and Suggestions

We are seeking to appear before the Committee to discuss issues raised in this paper.

We would encourage the Committee to consider visiting VICSERV to talk to our training and policy staff about specific issues which you may wish to have elaborated. We also wish to suggest some other sites which the Committee may find useful to be better informed about the nature, scope, practice and issues experienced by the Victorian PDRS sector.

Such visits might include:

- **St Luke's Anglicare in Bendigo.** This PDRS agency specifically operates their service from a strengths-based perspective and utilises strengths-based, client developed assessment tools to plan, conduct and measure their work.
- **Mental Illness Fellowship.** MIF operate various clubhouses around the state and a visit could provide a stronger sense of how psychiatric-specific employment PDRS models work.
- **Prahran Mission**. This is one of the oldest PDRSS in Australia and has forged many new programs including a mother-specific PDRS program.
- **NEAMI** – This Victorian PDRS service is expanding into NSW and South Australia and is gaining a wealth of experience in delivering CBRS services within a diverse range of state mental health systems.
- **Panda** – The Post and Ante Natal Depression Association Inc. is a statewide Mutual Support / Self Help group which works for women and their families affected by ante natal and postnatal mood disorders.

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