Working Together to Improve Mental Health in the Community
Community Mental Health Australia (CMHA) is a coalition of the eight state and territory peak community mental health organisations established to promote leadership and direction promoting the benefits of community mental health and recovery services across Australia. The peak groups are the:

- Mental Health Community Coalition (ACT)
- Mental Health Coordinating Council (NSW)
- Mental Health Council of Tasmania
- Mental Health Coalition of South Australia
- Northern Territory Mental Health Coalition
- Psychiatric Disability Support Services of Victoria/VICSERV
- Queensland Alliance for Mental Health
- Western Australia Association for Mental Health.

CMHA provides a unified voice for over 800 community managed, non-government organisations who work with the millions of people affected by mental illness across the nation and who are members of, or affiliated with, the various coalition members.

Social inclusion, good mental health and recovery from mental illness go hand-in-hand with physical health, stable accommodation and meaningful engagement (either through regular social and community contact and/or through meaningful employment, vocational training and/or education). Supporting people affected by mental illness to achieve this is the core focus of the community managed mental health sector.
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The Australian mental health care system has great potential but is currently deficient in particular with respect to mental health in the community.¹

(International Journal of Mental Health, 2011)

It is with great pleasure that I commend to you this publication, 'Taking Our Place — Community Mental Health Australia: Working Together to Improve Mental Health in the Community'. I hope that it provides a greater level of understanding of the critical role of not-for-profit, non-government community mental health services — which are delivered in partnership with people affected by mental illness and public, private and primary health care services — to ensure the economic, social and emotional health and well-being of all Australians.

When most Australians think about mental health services they think of hospital-based care for those few people who are extremely unwell and/or experiencing a psychiatric crisis at any given time. The contributions of private providers such as psychiatrists and psychologists, and increasingly GPs, might also come to mind. However, sound knowledge of community mental health services — both public (i.e. government) and community managed (i.e. non-government) — is often quite limited.

This thinking about Australian mental health services has in part been created by a mental health system that continues to be based on a medical model with its focus on illness, symptoms, hospital beds and medication. The social determinants of health, the principles of mental health recovery, the importance of social inclusion and trauma informed approaches are now well understood. Yet the restructure of mental health services to reflect this knowledge base has not been well targeted. National Health and Hospital Reform currently underway in Australia, including the important emerging role of Medicare Locals in strengthening primary healthcare responses for people with complex and diverse health and social needs, provides another opportunity to strengthen social determinants and human rights based approaches to mental health care that better supports prevention of, and recovery from, mental illness. However, this will not be achieved without a much greater awareness and knowledge of the community managed mental health sector and the services and programs it provides.

A key challenge relates to the risk of increasing fragmentation in service delivery as new providers enter the scene, including Medicare Locals and private health professionals delivering Medicare reimbursable mental health services. Health and community service providers are increasingly asked to work as part of interdisciplinary teams and to provide integrated services. Unfortunately, the evidence base related to service coordination and achieving integrated care is not well understood or established.² This includes an important gap regarding the views of people affected by mental illness and service providers in identifying the knowledge, skills and attitudes (i.e. competencies) required to achieve integrated care.

Australia has a rich, complex and diverse non-government community managed mental health sector that has been quietly delivering services that keep people well and out of hospital for more than 100 years. Unfortunately, the sector is not well understood or recognised beyond the many Australian’s fortunate enough to have received services from it. The community managed mental health sector has a critically important but marginalised role in ensuring the well-being of the millions of Australians affected by mental illness. Community managed mental health services need to be recognised, valued and further developed as a core provider of services to people affected by mental health problems.

Paul Senior, Chair
Community Mental Health Australia

² Mental Health Coordinating Council (MHCC, 2011). Care Coordination Literature Review and Discussion Paper. Sydney: MHCC.
The vision for mental health in Australia is a society that values and promotes mental health, maximises opportunities to prevent mental health problems and supports people with mental illness and their families and carers to live full and rewarding lives. A key principle of the ‘Ten Year Roadmap for National Mental Health Reform’ states that we must recognise the full range of services needed by people living with mental health problems and/or mental illness, and not be confined to the health system, as well as recognise in particular the important role of community-based services.³

(Ten Year Roadmap for National Mental Health Reform, 2012)

The community managed mental health sector is uniquely placed to facilitate recovery and social inclusion opportunities for people living with — or at risk to develop — mental health problems, as well as their families and carers.

A number of priority areas relating to mental health and well-being have been identified by the Australian Social Inclusion Board. These include:

- Supporting people with a mental illness to find appropriate employment/education
- Tackling the social exclusion resulting from homelessness and the lack of affordable housing
- Supporting early intervention and prevention for those at greatest risk of long-term disadvantage through health education and family relationship services. 4

National Health and Hospital Reform is yet to fully consider the contribution and situation of the community mental health sector. For this reason, an increased understanding of who the sector is, the services it provides, the staff and volunteers that provide them and the developing evidence base for the effectiveness of community managed mental health services is critical. This publication has been developed toward closing that knowledge gap. Its purpose is to familiarise the reader with Community Mental Health Australia (CMHA) and the range of services provided to people affected by mental illness by community sector organisations.

CMHA is a coalition of community mental health peak bodies in all eight states and territories. CMHA was established in 2007 in recognition of the shared activities, challenges and potential to effect change of the state and territory community sector mental health peak bodies and their respective memberships of more than 800 non-government community managed organisations (NGOs/CMOs) nationally. The primary goals of CMHA are to build a viable and sustainable community managed mental health sector and to promote the value and outcomes delivered by community managed mental health services based on a philosophy of recovery and social inclusion. This publication has been developed toward achieving these goals.

Contact details for CMHA and CMHA coalition members are provided as Appendix 1.

CMHA is a not-for-profit entity with a focus on improving the quality of and access to community managed recovery oriented psychosocial rehabilitation and support services. 5 The four year journey to establish CMHA as an incorporated association brought together the various concerns and priorities of eight separately constituted organisations, all of whom are funded by and work alongside numerous departments of state, territory and federal governments who have diverse perspectives on the appropriate role and function of the community mental health sector.

The 2011 edition of ‘Newparadigm’ has been devoted to an overview of the community managed mental health sector in six of the states and territories. 6 The journal notes that there is a strong sense of optimism about the future of the sector due to increases in funding, particularly from the Commonwealth. Establishment of the National Mental Health Commission has been welcomed by CMHA as an important vehicle for mental health reform particularly in relation to implementation and evaluation of Australia’s ten year ‘Mental Health Roadmap’ which clearly articulates the need for increased development of community-based mental health service options.

Additional information about the community managed mental health sector can also be found in a recent journal publication ‘Taking Our Place: Community Managed Mental Health Services in Australia’. 7 This special edition of the International Journal of Mental Health is devoted to exploring the current state of, and new directions for, mental health services in Australia and the important and growing contributions of the community managed mental health sector are recognised. The article provides more detail about the current context, implications, challenges and opportunities presenting for the sector.

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5 In stating this CMHA acknowledges that many community organisations also deliver ‘talking therapies’ (e.g. motivational interviewing) or may provide ‘medical’ services (e.g. diagnostic and functional assessments of people’s needs).
This publication provides important information about CMHA, the community managed mental health sector and the services it provides, and explains why they are important for achieving social inclusion and recovery outcomes. The positive impacts that community managed mental health services have in the lives of people affected by mental illness are described and specific examples of programs and how they help people are given. Future directions for the CMHA alliance are also considered.

Key points relevant to community managed mental health services ‘Taking Our Place’:

- National Health and Hospital Reform provides unique opportunities for community managed mental health services to increase their support to people living with and/or recovering from mental illness, and their families and carers.
- All Australians benefit from a reduction to the social and economic impact of mental illness.
- Community managed mental health services have led the way in establishing recovery oriented service delivery practice and culture change to counter stigma, discrimination and social exclusion.
- Community Mental Health Australia (CMHA) has been established to promote the positive impacts that community managed mental health services have in the lives of people affected by mental illness.
- CMHA undertakes leadership in increasing the availability of community managed psychosocial rehabilitation and support services thus enhancing recovery and social inclusion outcomes.
- Investment in the development of CMHA and the community managed mental health sector will increase timely access to responsive and effective services and improve the mental health and well-being of Australia.
Australia’s National Mental Health Policy aspires to ‘a mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable (people) to participate fully in the community’.  

(National Mental Health Policy, 2008)
It is possible for people to recover from mental illness with access to the right mix of medical, psychosocial rehabilitation and support services. Most experts now agree that mental health services are optimally delivered in community settings and address more than just symptoms of illness. In light of the above, the Australian community managed mental health sector plays a crucial role in achieving the goals of the ‘National Mental Health Policy’, ‘National Mental Health Plan’ and ‘Ten Year Roadmap for National Mental Health Reform’ and achieving the aspirations of the recently established national Mental Health Commission.9,10

The community managed mental health psychosocial rehabilitation and support service types described in this publication are:

- Helpline and Counselling Services
- Accommodation Support and Outreach
- Self-help and Peer Support
- Employment and Education
- Family and Carer Support
- Information, Advocacy and Promotion
- Leisure and Recreation.

Figure 1 below illustrates one way of thinking about the ideal mix and location of mental health services. As with general health care, optimal service access and health and social outcomes for people affected by mental illness need a ‘continuum of care’ — a variety of flexible options that meet diverse needs and make the best use of resources. To illustrate this, the World Health Organisation (WHO) has created a ‘Service Organisation Pyramid for an Optimal Mix of Services for Mental Health’.11

Figure 1: WHO Service Organisation Pyramid for an Optimal Mix of Services for Mental Health

The WHO model works on the premise that no single type of service can meet an entire population’s mental health needs. The various levels of care work in partnership — with support, supervision, collaboration, information sharing, and education taking place throughout the system. The model also promotes the involvement of people with lived experience of mental illness in their own recovery and that self-care continues at all levels, which in turn promotes and encourages recovery and better mental health.

‘Informal community care’ services are typically provided by community organisations and address the social determinants of mental ill health including employment, housing and social connectedness. This is done in partnership with people affected by mental illness and public, private and primary healthcare service providers.

Mental health related services are provided in Australia in a variety of ways — from hospitals and other residential/bed-based care to hospital-based outpatient services, consultations with both specialists and general practitioners (GPs), through to community managed mental health services, including peer/consumer operated services and programs. Australia continues to move away from an historical model of institutional-based mental health care toward community-based models. Mental health policy continues to shift from a purely illness-oriented, medical model to a more balanced psychosocial and recovery-oriented approach.

Existing data tells us that the availability of community managed mental health services has grown substantially over the twenty years of the National Mental Health Strategy. Despite this, the availability of community managed psychosocial rehabilitation and support services is limited compared to other countries including the UK, USA and New Zealand. Continuing expansion of community managed mental health services is critical to achieving an optimal mix of mental health services in Australia.

The COAG ‘National Action Plan for Mental Health 2006-11’ supported a range of programs delivered by the community sector. These programs include:

- Day to Day Living
- Personal Helpers and Mentors (PhaMS)
- Mental Health Respite and Carer Support (formerly known as Mental Health Carer Respite)
- Family Mental Health Support Services (formerly known as Mental Health Community Based Activities).

In addition, each of the states and territories also funds a range of community managed mental health programs.

While the availability of community sector mental health service types and programs varies in each state and territory, they have more commonalities than differences with their consistent focus on achieving recovery outcomes through facilitating employment opportunities, stable accommodation and social connections. Differences mostly arise due to historical funding approaches and the commitments of respective state and territory governments that existed prior to COAG mental health reform.

The history of the community managed mental health sector in Australia has not been well documented and predates the emergence of deinstitutionalisation and advent of psychiatric medication. Appendix 2 provides a brief history of the development and contributions of the sector over the past 100 years.

Increased funding for community managed mental health services has led to more recovery oriented services, with an increased focus on psychosocial rehabilitation and support service provision. Over the next five years planned funding includes: further increases to COAG community managed mental health service programs ($288M); the introduction of the new $549M ‘Partners in Recovery’ program to provide increased and improved coordinated support to 24,000 Australians living with mental illness that also have severe psychosocial disability as a result of mental illness; and the rollout of new community-based programs aimed to reduce homelessness and unnecessary hospitalization through the ‘National Partnership Agreement Supporting National Mental Health Reform’ ($400M).

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Mental illness has significant health, social, and economic effects on individuals, families and friends, and Australian society. Therefore, Australia’s mental health policy must be more than just words on a page. Community managed mental health services are increasingly recognised to demonstrate efficiency, effectiveness, value for money and measurable outcomes in supporting people — and communities — in their recovery from the effects of mental health problems. CMHA’s leadership has been critical to this growing recognition.

The Australian government recognises the value of, and is investing in, community managed mental health services.

Important activities and commitments have recently been undertaken at the national level in partnership with CMHA to better understand the community managed mental health sector, the services they provide, the staff that deliver them and future sector development needs.

The National Mental Health NGO Workforce Scoping Study confirmed the size of the sector to be about 800 organisations and its workforce was estimated to range between 15,000 to 26,000 employees (CMHA conservatively estimate this to be about 12,000 FTE). By way of comparison, the public mental health service direct care FTE is about 21,000. 42% of responding organisations have been delivering services for more than 20 years. 43% of workers identified as having health qualifications — mostly in social work, psychology or nursing — and 34% of workers had a vocational qualification with the majority of these being at the Certificate IV and Diploma levels. The Landscape Survey of the Workforce Scoping Study struggled to categorise the diversity of services being provided.

The Mental Health NGO Data Development Project has been undertaken to develop a national ‘taxonomy’ of community managed mental health service types. The taxonomy will be used to initiate routine data collections from community managed mental health services including: workforce (i.e. inputs); service delivery (i.e. outputs); and most importantly, the difference they make in the lives of people affected by mental illness (i.e. outcomes). It is broadly based on the service types used in this publication.

Both of the above projects have gathered a wealth of knowledge about the community managed mental health sector. Another project will soon commence to investigate the current use and potential standardisation of outcome measurement tools being used by community sector mental health services. The Outcome Measurement Project will be conducted by the Australian Mental Health Outcomes and Classification Network (AMHOCN).

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CMHA’s leadership is evidenced through the following achievements:

- Outcomes of participation on Mental Health Standing Committee working groups:
  
  CMHA chaired the working group that developed the National Mental Health Standards ‘Implementation Guidelines for Non-Government Community Services’ (National Safety and Quality Partnership Subcommittee/SQPS).  

  CMHA advocated to ensure inclusion of community sector, vocational education and training (VET) and peer workforce issues in the National Mental Health Workforce Strategy and Plan (Mental Health Workforce Advisory Committee/MHWAC).  

  CMHA contracted with the AIHW to negotiate national agreement regarding the taxonomy and minimum dataset for the community managed mental health sector (Mental Health Information Systems Subcommittee/MHISS).  

- The CMHA Day to Day Living (D2DL) Capacity Building Project facilitates the identification and dissemination of good practice among D2DL program providers. 95% of the 64 program sites attended forums held during 2011 and a web-based learning platform has been established.  

- The CMHA Building Capacity in Community Mental Health Family Support and Carer Respite Project provided a structure to bring people and organisations together to develop innovative support and services for families and carers of people with a mental illness. With the support of project coordinators in each state and territory, new partnership groups were formed and a number of networks established. Local area planning, identification of gaps and opportunities, and the needs of people with lived experience, provided the foundation for the development of a range of partnerships and initiatives.  

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People with psychosocial disabilities are amongst some of the most marginalised in the Australian community and many live with poverty, discrimination and social isolation as a normal part of their lives. We know that, due to a lack of community support, people with mental health conditions are more likely to become unwell and require acute services from the hospital sector.  

(National Mental Health Consumer and Carer Forum, 2011)
Community managed services provide a critical gateway for people affected by mental illness to live valued lives in the community. They have led the way in establishing a recovery-oriented mental health service delivery culture and to counter the stigma and discrimination that results in social exclusion. Social supports that result in safe and stable accommodation, meaningful engagement in the form of employment, education and training, and other peer based programs are particularly important to allow connection with, and participation in, the wider community.

Mental illness has enormous health and social impacts in Australia. Every year, one in five Australians experience some form of mental illness, which can encompass a wide variety of conditions; this figure is even higher for young people. Millions of other people are also affected: families and carers, co-workers and neighbours. Almost half of all Australians will experience mental illness at some point in their life. For individuals that experience psychotic illness the impacts are often particularly severe. In terms of national disease burden, mental illness ranks third at 13% among the major disease groups after cancer and cardiovascular disease. Alarmingly, mental illness — especially depression and anxiety — rates highest among the major disease groups for non-fatal disability burden (i.e. impacts on activities of daily living).

However, recovery from mental illness — including psychosis — is possible. An important study conducted over many years shows that more than half of people diagnosed with schizophrenia recover, with their experiences during the first two years of becoming unwell being especially important for good health and well-being outcomes. More recently, the second Australian survey of people living with psychotic illness shows marked increases in use of community managed rehabilitation and support programs with fewer people experiencing homelessness and unstable accommodation. However, people living with a psychotic illness still have substantially poorer physical health than the general population and remain at considerably greater risk of higher levels of obesity, smoking, alcohol and drug use. The results reinforce the Australian government's investments in early psychosis services and the new ‘Partners in Recovery’ program to better access and coordinate services for people with severe disability as a result of mental illness — especially as this relates to achieving greater physical health care.

Social inclusion is not just a lofty philosophical goal or human rights issue; it also makes good economic sense. People with well-established social networks and community connections are more likely to deal successfully with personal crises and other forms of adversity. This, in turn, helps to maintain housing and steady employment, and to reduce costs of health and other social services. Community managed mental health services work actively to improve people's ability to cope in difficult times; and actively combat the stigma and discrimination associated with mental illness, helping to foster the kind of social inclusion that is essential to the recovery journey.

The ‘United Nations Convention on the Rights of People with Disabilities’ and related implementation guide for people with psychosocial disability provide guidance on the importance of community managed psychosocial rehabilitation and support services in reducing stigma and discrimination and increasing opportunities for social inclusion and recovery.

Access to community managed, recovery oriented services that understand the impacts of stigma and discrimination and promote social inclusion is very important. This is where people come to understand that they are not alone in their experience of disadvantage and also to obtain information about, and support in relation to, their rights and related opportunities.

Recovery oriented service provision emphasises the importance of hope, healing, empowerment, connection, choice, responsibility and citizenship. It is based on minimising difficulty while maximising individual potential. This applies equally to all ages and ethnicities and to all those involved: the person living with mental illness, their family and carers, and service providers.

To help people affected by mental illness live valued lives and participate in society, all aspects of treatment, psychosocial rehabilitation, and support service delivery must focus on the goal of recovery. Ensuring sufficient access to well-coordinated medical, psychological (i.e. ‘talking therapy’) and psychosocial services is important but will not alone promote social inclusion and recovery outcomes. This requires a community integration and development approach — including recognition of the knowledge and skills that constitute psychosocial rehabilitation and support competencies — where all the aspects of ‘community living’ that are valued and enjoyed by most Australians are equally available to people living with mental illness.

A CMHA model for thinking about the social inclusion approach to integrated service delivery that recognises the value of psychosocial rehabilitation and support services and makes recovery a reality is illustrated in Figure 2 below and elaborated upon throughout this publication.

![Figure 2: Social Inclusion Approach to Integrated Service Delivery](image)

Many people recover from mental illness and enjoy active, productive lives. However, recovery is not always synonymous with cure. The recovery process refers to both internal and external conditions that facilitate recovery, including implementation of human rights. The value of the services provided by the community sector lie in achieving person-centred and integrated approaches to supporting people with mental health problems in ways that are chosen by them and that include consideration of social support, employment and housing (i.e. mates, jobs and homes).

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Community managed mental health services are an important and foundational part of the range of services responsive to individual need that must be available to achieve social inclusion and recovery outcomes. The lived experience of mental illness must drive mental health service reform; including the development of community managed mental health services. The experiences of people that have recovered are the best evidence that community managed mental health services work. However, community managed mental health services also have a strong and growing evidence base in addition to people’s lived experience of recovery. Some of this evidence is highlighted throughout this document. As greater recognition of the positive outcomes for people affected by mental illness through involvement with CMOs occurs, there are indications that research into community managed practices including program evaluation is emerging as a key area for sector development.

While funding for biomedical research has been available for mental health treatment interventions, especially as this relates to medications, research into psychosocial and recovery oriented approaches has been very inadequate. It is important to note that virtually every review or policy paper calls for more research into mental health services, particularly those offered outside of the hospital setting and related to improving quality of life, not just reducing symptoms and illness.

The range of important talking therapy and psychosocial rehabilitation and support services provided by community managed mental health services are further illustrated next in this ‘Taking Our Place’ publication.

Community managed mental health services promote social inclusion and recovery by:

- Providing consistent social, emotional and practical support to help people manage problematic areas of their lives better.
- Reconnecting people and strengthen relationships with friends and family.
- Supporting people to access and stay engaged with education and employment opportunities.
- Supporting individuals to maintain stable housing options resulting in reduced need for hospital admissions.
- Facilitating access to physical healthcare services and providing support to achieve physical health.
- Contributing to a sense of connection, belongingness and hope for a valued future for people living with mental illness.
- Promoting relationships between services, people affected by mental illness and the community.

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37 Mental Health Coordinating Council (MHCC, 2007). Working on Strengths … The Evidence So Far: Models of assistance by mental health community organisations and evidence of their effectiveness. Sydney: MHCC.
Mental illness is not a ‘minority’ issue: up to half of all Australians will experience some form of disabling mental distress in their lifetime. 43

(National Survey of Mental Health and Wellbeing, 2007)
Australian mental health policy increasingly recognises the importance of coordinated, integrated services that are delivered by community managed, public, private and primary healthcare service providers, and in partnership with people affected by mental illness using person-centred and self-directed care approaches.

The diverse range of offerings across the community managed mental health sector, and within organisations, contributes to the social inclusiveness of care as services more flexibly address individual’s holistic needs across both the health and social domains. The social model of health and/or disability takes a broad, ‘whole of person’ approach. This social model recognises that people with mental health issues must move beyond being ‘patients’ and become people living their life in the community.

Innovation and consumer-driven development has led to a broad range of practical, relevant community managed mental health services being offered. Figure 3 below shows the diversity and availability of the services provided by one state’s community managed mental health sector. The following information about the philosophy and evidence base underlying the community managed mental health sector is organised against these seven service types.

Figure 3:
Community Managed Mental Health Sector Service Types

It should be noted that service types may but do not necessarily align with particular programs — especially as this relates to the provision of holistic and individualised services. For example, the Personal Helpers and Mentors Service (PHAMS) may have service elements that address people’s employment/education, accommodation, and leisure and recreational needs. The PHAMS program would also provide support to ensure that people’s physical healthcare needs are being identified and responded to.

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In addition, three categories of community organizations were identified as providing mental health services and programs:

- Only mental health specific programs (least frequent) — those organisations providing mental health programs only
- Some mental health specific programs — those providing mental health programs in addition to other programs
- No mental health specific programs (most frequent) — those providing considerable mental health support services but no specific mental health programs.

The community managed mental health sector is generally agreed to consist of organisations that provide mental health specific programs only (i.e. the first two categories above). However, the impacts and corresponding infrastructure needs of organisations providing no mental health programs and yet still addressing the needs of people affected by mental illness must not be underestimated (e.g. employment, housing, youth, aged substance misuse services, etc.).

Importantly, the community managed sector has seen and experienced the advantage of peer-directed models of support across all organisational and service types. Consumers of mental health services have consistently highlighted the acceptance and benefit they feel with having support from ‘someone who’s walked in their shoes’ with life experience of mental illness. The hope and acceptance instilled by the peer-led model is essential in promoting a recovery culture and focus.

**Examples of services and emerging evidence**

This next section provides examples of Australian community managed mental health services for each of the following service types:

- Helpline and Counselling Services
- Accommodation Support and Outreach
- Self-help and Peer Support
- Employment and Education
- Family and Carer Support
- Information, Advocacy and Promotion
- Leisure and Recreation.

While each of the seven service areas is examined separately, many organisations offer a range of service types and programs, allowing them to more flexibly address the holistic health and social needs of consumers, carers and communities. The emerging evidence base for each service type is also considered.
Helpline and Counselling Services

Letter to Lifeline:
I am suffering from severe post-natal depression and anxiety. I have always benefited so much from talking to your volunteers and have always ended the call feeling refreshed and relaxed. I spoke to a young man today about my feelings and current situation and he helped me understand why I was feeling the way I did and ways to overcome these obstacles. I now feel so much better...I now know that I have a place I can turn to for help and not be judged. 45

Community managed organisations provide a wide variety of helpline and counselling services. Services such as Lifeline are well known and valued within Australia. While some services respond to people in crisis, others support people through life's difficult times to prevent an emergency from occurring. Helpline and counselling services might be provided over the telephone or in-person and are also increasingly internet and other computer/IT application based (e.g. mobile phone, e-health, telepsychology). 46 The later can be helpful for people in regional or rural areas where service access is problematic and are also especially appealing to young people. Services can be offered to individuals or groups and are particularly helpful when they include family and/or other social supports.

A large number of organisations replying to the national Mental Health NGO Workforce Project survey said they provide individual and group ‘therapeutic’ services and these were mostly ‘talking therapies’ which include:

- Strengths based approaches
- Motivational interviewing
- Cognitive behavioural therapy/CBT
- Acceptance and commitment therapy/ACT
- Interpersonal psychotherapy. 47

These were mostly helpline and counselling services. However, most workers in the community managed mental health sector have interpersonal, relationship and counselling skills that are used to deliver a range of community managed mental health services. The skills to achieve this are gained both on-the-job and through the attainment of educational qualifications mostly at a:

- University level (e.g. psychologists, social workers, occupational therapists) or
- Vocational education and training/VET level (e.g. Certificate IV in Mental Health, Diploma in Mental Health and/or Alcohol and Other Drugs). 48

A number of community managed mental health sector workers and volunteers also have lived experience of mental illness as consumers and/or carers and this is valued by their workplaces and contributes to the effectiveness of helpline and counselling services. For peer (i.e. consumer and carer) work roles, where lived experience of mental illness and recovery is required as an essential criteria for employment, this is the critical part of the effectiveness of the support offered and this is further discussed later (see ‘Self-help and Peer Support’). These important and emerging roles will soon be nationally recognised through introduction of the Certificate IV in Mental Health Peer Work qualification.

In recent years, the Australian Government has increased access to talking therapies through the introduction of Medicare reimbursable mental health services provided by GPs and private allied health professionals, most notably psychologists (e.g. Better Outcomes in Mental Health Care, Access to Allied Psychological Services, etc.). This has resulted in increased opportunities for community organisations to enter partnerships with private providers to strengthen client access to talking therapies. However, it is likely that there will never be enough mental health workers in the health and community service industry to provide sufficient talking therapies to meet our population’s needs, especially given the large number of Australians that experience depression, anxiety and substance use issues.

46 Campos, B. (2009). Telepsychology & Telehealth: Counselling conducted in a technology environment, Counselling, Psychotherapy, and Health, 5(1), The Use of Technology in Mental Health Special Issue, 26-59.
48 Ibid.
The role that both telehealth and community organisations play in providing talking therapies needs to be better understood. Alternative approaches to meeting the population's need for psychological support must be considered. One approach is the UK 'Improving Access to Psychological Therapies' (also known as the 'Doncaster Model'). A similar talking therapies approach is now being implemented in New Zealand and both involve consideration of existing and emerging community sector and vocationally qualified work roles for both psychological and social support.

Building the evidence base

Helplines
A large number of organisations (e.g. Lifeline, National Association of Loss and Grief/NALAG, Consumer Action Network NSW Inc.) run helplines which can serve a variety of purposes including: information services; service locators; telephone counselling and crisis/suicide prevention. Helplines Australia research exploring the effectiveness of e-health counselling found that the main technology used is the telephone. Workers providing these services have the same basic skills as those providing counselling and psychotherapy services and these are based on the Egan 'skilled helper' model (i.e. supportive relationships). An Australian National University systemic review of telephone-based services found them to benefit people with mental illness. However, the study recommends that further large scale research is needed to inform about the efficacy of telephone interventions.

Phone counselling has been established as an effective treatment for diagnoses ranging from depression to agoraphobia. Studies of helpline services indicate that callers often find them to be beneficial — 68% of callers in the case of one new study. A 2002 study found that phone counselling clients rate their counselling relationship similarly to in-person counselling clients. In addition, helplines are a cost-effective method of providing support to people affected by mental health problems. A crisis hotline is a phone number people can call to get immediate over-the-phone emergency counselling, usually by trained volunteers. There is some evidence that peoples’ thoughts of suicide decrease during a call to a crisis line and are lessened for several weeks after their call.

Counselling
Counselling is a psychological service that gives individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well-being. Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through conflict or improving relationships with others. Counsellors practise within a variety of approaches which may include psychodynamic counselling, CBT, family/systemic counselling, etc.
There is extensive evidence that CBT is effective for the treatment of a variety of problems including mood, anxiety, personality, eating, substance abuse, and psychotic disorders. CBT has been proven as an effective treatment for depression. For some problems, such as anxiety and depression, CBT is as effective as medication and can also enhance the effects of medication.

Additionally, there is evidence that counselling is effective for mixed anxiety/depression and that it is most effective when used with specified client groups (e.g. post-natal mothers, bereaved groups).

Motivational interviewing is a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (i.e. lack of motivation). Compared with nondirective counselling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose and the counsellor is intentionally directive in pursuing this goal. Motivational interviewing has been shown to be effective with a range of populations and problems including substance abuse, health-promotion, medical adherence and mental health issues. It is an important tool for supporting behaviour change in a wide range of service delivery settings toward achieving effective person-centred communication and engaging consumers in self-directed care.

The Importance of Relationship
A full discussion of the similarities and differences between, evidence base for, and outcomes achieved through use of the extensive range of in-person and e-health helpline, counselling and psychotherapy psychological services is beyond the scope of this publication. However, we note that it is the relationship — or alliance — between the service provider and person needing help that is of central importance to all approaches, along with a focus on what the person wants help with and continual review as to whether what is being provided is helping or not. Recovery oriented and person-centred approaches to working with people with complex health and social problems that also facilitate self-care rely on good communication and strong relationships that support service provider/client, and also systemic, approaches to integrated and coordinated care. However, the skills needed to achieve this are not optimally embedded in Australian education and training. This skills gap was also noted to include knowledge about community support services; ability to identify and harness people's strengths; collaborative care behaviours; and the psychosocial skills required to understand, value and utilise lived experience. In addition, recent research highlights some of the strengths and the challenges faced by counsellors in emerging e-health relationships, particularly relating to the counsellors ability to develop new interpersonal skills when using interactive mediums.

Examples of Australian services

Lifeline
Lifeline is a community service organisation that has been saving lives and supporting Australians in need for nearly 50 years. From the beginning, Lifeline has been committed to reaching out to those in crisis — offering an immediate response when difficulties seem overwhelming. Lifeline was founded in 1963 by the late Reverend Dr Sir Alan Walker when he took a call from a distressed man who later took his own life. Determined not to let isolation and lack of support be the cause of more deaths, Sir Alan launched a 24-hour crisis support line. Lifeline talks to 1,250 callers a...
day through their national 13 11 14 service, with around 50 calls from people at imminent risk of suicide. Lifeline
understands that a person can experience crisis as a result of many events: a relationship breakdown, loss of a job,
the onset of mental health issues, caring for another, violence and trauma in the home, pressures from work and
study, an accident or the loss of a loved one. Every day, Lifeline is contacted by people in crisis. Lifeline believes that
crisis support saves lives — it breaks the onset of suicidality, it prevents unsafe and damaging reactions to difficulties,
and it builds opportunities for personal growth and change — creating enhanced resilience and coping capabilities
for future crisis.

Lifeline’s numerous crisis support and suicide prevention services are made possible through the efforts of around
1,000 staff and 11,000 volunteers, operating from over 60 locations nationwide. Services and resources are now
provided through phone, face-to-face and online mediums.

Lifeline also provides national services and campaigns that promote emotional well-being, encourage help seeking,
and address suicide prevention and awareness.

NALAG (NSW) Inc.
The NALAG Centre for Loss and Grief provides loss, grief, trauma support and counselling. NALAG stands for
the National Association for Loss and Grief. NALAG (NSW) Inc. aims to enhance the capacity of individuals,
organisations and communities in order to enhance well-being following loss, grief, bereavement and trauma. The
NALAG Centre in Dubbo offers individual grief support and counselling together with psychoeducation in the area
of depression, stress and anxiety. The NALAG Centre outreaches to remote areas of NSW including Bourke,
Brewarrina, Walgett, Lightning Ridge, Goodooga, Parkes and Narramine.

NALAG (NSW) Inc. is one of the peak providers of education and training in the area of loss, grief and trauma.
NALAG (NSW) Inc. also provides a Telephone Grief Support Service for rural and remote communities that may
not have services for face to face support. Based in Sydney, the Telephone Grief Support service is managed by
dedicated volunteers.

One of NALAG’s programs, the Blue Healers Program, is a psychoeducation program designed to teach people
experiencing depression, stress and anxiety strategies for coping. A 2010 evaluation of the Blue Healers Program
found that participants who completed the program had a 40% mood improvement from pre to post as measured
by the Depression Anxiety Stress Scale (DASS).

Carers ACT
Carers ACT runs the Culturally and Linguistically Diverse (CALD) Carers program to provide support and facilitate
access to services for carers from non-English speaking backgrounds. CALD carers look after a family member or
friend who has a chronic illness, disability, mental health issue, a drug or alcohol problem or is frail aged. CALD carers
share many of the same experiences as other carers, including stress, burnout, isolation and lack of assistance.
However, cultural issues and conflicts may have an additional influence on this demanding role.

Although some CALD Carers may have very strong English language skills, they may still have very different cultural
values which could make mainstream support mechanisms incompatible with their needs. The CALD Carers program
aims to assist CALD carers to break down the barriers and ensure they have access to the services they are
entitled to.

Support groups are available for 12 ethnic groups and allow CALD carers to meet and talk to other carers who
share the same language and culture. Groups meet monthly and include: Chinese; Greek; Hungarian; Indian; Italian;
Japanese; Polish; Samoan; Spanish; Tamil; Tongan; and Vietnamese.

These support groups are facilitated by a bilingual group facilitator who speaks the language of the group,
understands the culture and can interpret if required. Carers ACT provide training and support for the group
leaders to assist them in their role.

CALD Carers also have access to the mainstream one-on-one support facilitated by Carers ACT including: counselling
services; referral to respite services; information and resources; special, individual support as required; and access to
other Carers ACT groups and events.
Accommodation Support and Outreach

Raymond’s story:
The starting of my troubles was alcohol abuse. I was living my life to drink alcohol and neglecting family responsibilities. It was causing mental breakdown for myself and my family. I knew I had to stop but couldn’t. My family tried to help but I couldn’t stop. With living in boarding houses feeling lonely, it gave me a long time to think about the way I was going to live my life. Neami helped me choose the right path and gave me the skills to keep on this path; gradually it gave me contact with family again, which was the start of a new life. 77

A lack of appropriate supported accommodation has long been declared the most significant obstacle to effective recovery and rehabilitation for people living with mental illness. 78 Consumers themselves repeatedly identify stable housing as critical to their quality of life.

Safe housing is a basic human right but this is not the reality for far too many people with mental illness. The recent survey on adults living with a psychotic illness found that 5% were homeless at the time of interview, 13% had experienced homelessness over the past year, 20% were living in a family residence that was not their own (with 10% not happy with this arrangement), and 27% had changed accommodation at least once over the past year. 79 While improved since the 1997/98 survey, largely due to the increase availability of supported accommodation, these statistics do not capture the trauma of transitional homelessness where people cycle through different forms of tenuous housing and/or homelessness. 80

A recent survey conducted by the Schizophrenia Fellowships of Australia found that around two-thirds of people mentioned housing and housing support as the most important issues in their lives. 81 As the Queensland Office of the Public Advocate summarised in their submission to the Senate Select Committee Inquiry into Australian Mental Health Services:

“Housing is one of the critical factors in a person’s recovery process. A wealth of empirical evidence now attests to the fact that poor, unsuitable, substandard, and/or unaffordable housing has a direct impact on the emotional and social well-being of mental health consumers. Simply put, good mental health requires good housing.”

Building the evidence base

Because of its centrality to recovery and social inclusion, accommodation and housing support is an important component of many programs in the community managed mental health sector. There is strong evidence both internationally and in Australia demonstrating that where housing needs are addressed people experience improved mental health outcomes. The World Health Organization (WHO) has shown clear benefits by comparing supported accommodation in the community with institutional care for consumers in recovery. The results are as follows:

- 73% of studies found significantly better outcomes in functioning and psychosocial adjustment
- 64% of studies found significant reductions in hospital admissions/re-admissions. 82

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Closer to home, the **Housing and Accommodation Support Initiative (HASI)** is an innovative NSW Government funded program that has yielded excellent results from commencement in 2003. It ensures stable housing linked to a range of levels of specialist support for people with a mental illness. HASI is based on a three-way partnership between Housing NSW, NSW Health (providing clinical services), and the community sector (providing rehabilitation and support services). HASI has been a prominent success story for the provision of a stable, consistent and integrated hospital-to-community-care system for people with a mental illness and associated psychiatric disability. For this group of people, HASI is helping to avert homelessness and to reduce the need for hospitalisation.

HASI won the 2006 NSW Premier’s Public Sector Gold Award and a summary of the program evaluation is below:

- The overwhelming majority of people maintained their secure housing since entering the program (90%) and of those ending tenancy most did so for planned reasons (86% of the remaining 10%).
- There are statistically significant decreases in hospital use, measured by:
  - the average number of hospital admissions each year (24% decrease)
  - the average number of days spent in hospital per person per year (60% decrease)
  - the average number of days hospitalised per admission after entering the HASI program (68% decrease)
  - hospital use continued to decrease the longer the person was supported through HASI
- There are group improvements in mental health across a variety of outcome measures including:
  - Kessler Psychological Distress Scale (K-10)
  - Health of the Nation Outcome Scale (HONOS)
  - Life Skills Profile (LSP-16)
  - Activity and Participation Questionnaire (APQ-6)
- There are high levels of social inclusion indicators such as:
  - a high degree of independence in daily living skills (e.g. personal hygiene, cooking, medication, transport) with over 60% of people being completely independent or needing support less than half the time
  - 83% were participating in at least one community social and recreational activity and more than half (54%) were independently participating in community activities
  - 86% had regular social contact with family and friends
  - 31% were participating in paid or unpaid work
  - 19% were involved with education and training
  - 96% were engaged with health, mental health and/or allied health services at least once over the past year
- More than half were seen to have excellent, very good or good physical health and improved identification and management of poor physical health.\(^{83}\)

A final report on the longitudinal evaluation of HASI is nearing completion and will be available in 2012. It will assess the cost of HASI against the outcomes experienced by the people receiving support.

Another effective permanent housing partnership model that has been evaluated in Australia is Queensland’s **Housing and Support Program (HASP)**.\(^{84}\) The service model was established in 2006 and is similar to HASI. It also demonstrates improved well-being for people with significant disability by showing that clinical, housing and disability support services can be brought together to meet the needs of this population. The cost of keeping a person in HASP is half the cost of a non-acute hospital setting and one quarter the cost of an acute hospital setting.

In Victoria, **Prevention and Recovery Care (PARC)** services offer time limited accommodation support in a home-like environment that is not a person’s home (i.e. it is a community-based ‘step-up/step-down’ or ‘sub-acute’ service and offers an alternative to hospitalisation).\(^{85}\) PARC is well regarded and provides strong support for people either leaving hospital or at risk of experiencing a crisis that may lead to hospitalisation. Among its strengths are the collaboration of clinical and community support providers (the ‘blended provider model’) and the fact that, as a community service, it can more easily maintain links with family and carers. It also fosters strong peer support through educational, social and recreational activities for residents.

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85 CMHA acknowledges that PARC services in Victoria are not seen as an accommodation support service type but as a distinct step-up and step-down sub-acute service type (i.e. the stays are far too short to be accommodation).
Evaluation shows that:

- Consumers have provided feedback that they prefer this service to being in hospital-based care.
- The ‘step-up’ component of the PARC model is designed as an early intervention strategy. The service guidelines for PARC state that PARC “…offers an important alternative for early intervention with those consumers in the early phase of relapse.”
- According to the Manager for Adult Mental Health Services with the Victorian Department of Human Services, the cost per person per day in the PARC model is $339. The daily cost per person in hospital is $590.  

There are several community managed organisations involved in the delivery of PARC services and also other sub-acute service models including ‘Time Out’ in Queensland which has strong linkages with private clinical service providers. The Transition to Recovery Program (TREC) in the ACT is another sub-acute residential service.

Examples of Australian services

**Neami**

Neami offers specialist rehabilitation and recovery services to people with serious mental illness who require assistance with skill development, social contact and housing. Neami first expanded out of Victoria in 2003 when it was successful in tendering for the NSW HASI initiative. Approximately 2500 people in Victoria, NSW, SA, WA and Queensland are now supported by Neami each year through a wide range of programs including: PARC; home based outreach and care coordination; group programs; the Personal Helpers and Mentors Service; Day to Day Living; Complex Care Services; and arts-based practice. Health Promotion Officers in each state support an integrated approach to health and well-being.

In Sydney, Neami collaborates with the St Vincent’s Health Outreach Team in Way2Home, a holistic response to people sleeping rough in the inner city area. This program has exceeded expectations in supporting people to move from the streets into permanent housing. An Aboriginal Assertive Outreach team works specifically with Aboriginal people sleeping rough or at risk of homelessness in the inner urban area of Sydney. Both of these programs employ people with lived experience of homelessness to support consumer engagement. All Neami programs use the Collaborative Recovery Model, a strengths-based approach to individual service planning, and many sites offer the peer facilitated Flourish program.

Central to the success of all of Neami’s programs are partnerships and in particular those with clinical services and community housing. Neami establishes formal service level agreements informed by our belief that most people are capable of living in the community if they have the right type of housing and coordinated support. These agreements clearly identify the roles of the partners and articulate protocols for enacting these roles. The overall aim is to support social inclusion, enhance quality of life, and build capacity for independent living and autonomy.

**SOLAS**

SOLAS (Supported Options in Lifestyle and Access Services Inc.) is a specialist mental health service providing lifestyle support services to adults in the Townsville and North Queensland communities. Their mission is to provide collaborative engagement with people in mental health recovery to promote meaningful inclusion in communities. Their vision is for communities where belonging, inclusion and engagement create opportunities for life. SOLAS offers a range of support services based on the needs of each person. The services focus on hope, choice, motivation and inclusive processes using the strengths based perspective to support recovery in communities.

SOLAS provides a wide range of services to people affected by mental illness including the Mental Health Housing and Support Program (HASP). HASP is a collaborative interagency project involving Department of Communities (Housing and Homeless Services and Disability and Community Care Services) funded non-government service providers and Queensland Health. The program provides for comprehensive supports including clinical support, non-clinical support and social housing to assist people with a psychiatric disability to move from Queensland Health extended treatment or acute mental health facilities towards sustained community living.

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Mind

Mind is a leading provider of a comprehensive range of services for over 5000 people with mental health issues and their families and friends across Victoria and South Australia. The organisational focus is on supporting personal recovery and promoting well-being. Services are individually tailored, person focused and responsive to the changing needs of people over time. Service models and practice are informed by evidence and an understanding of social models of health. Evidence includes feedback from people with a lived experience of mental health issues and recovery, their families and carers. In partnership with the University of Melbourne, a Director of Research has been appointed to develop a research and evaluation program.

Many clients experience significant disadvantage and marginalisation, and have experienced homelessness and institutionalisation. Services focus on issues of concern to the individual such as relationships, housing, employment, practical skill or self-confidence. Mind seeks to engage proactively and purposefully with clients as trusting and respectful relationships are developed.

The organisation has established a wide range of accommodation and support options to meet the needs and preferences of individuals. These include short-term crisis support, residential rehabilitation, long-term accommodation support and outreach. Services targeting people with particular needs such as women, young people and people with a dual disability have also been developed. Mind also works with clients to source stable and affordable housing.

Mind services acknowledge the needs of the families and friends of clients, and support is available to meet their individual needs. Specialist family services and short term targeted support is provided by the organisation.

All services are provided in the context of partnership and collaboration with other health professionals and community organisations. Specialist mental health services are key partners, and where appropriate, Mind works to develop an effective partnership with the treatment mental health professional to support access to effective treatment.
Self-Help and Peer Support

Winifred's story:
My life has been transformed by GROW. I could overcome the fear of embarrassing myself and better organise myself and start to go out again. A great sense of freedom comes from being helped out of the rut of life. Freedom to be who we are meant to be and realise our own true potential! My life continues to present challenges and changes, but I have continued with GROW, working on myself and encouraging others. “Each person’s recovery or growth aids the transformation of the world”. 87

Self-help and peer support is central to recovery oriented service provision. Both the self-help (i.e. mutual aid) peer support movement and community managed organisations have grown from a shared history of responding to unmet individual, group and/or community needs. The community sector values the benefits of self-help/peer-directed models of support. The inspiration of hope and feelings of acceptance instilled by the peer-led model is essential in promoting recovery. Mental health consumers and carers have consistently highlighted the importance of having support from ‘someone who’s walked in their shoes’, that is, someone with lived experience of mental illness and/or recovery.

There are many different self-help movements and each has its own focus, techniques, associated beliefs, advocates and in some cases, leaders. Self-help uses publicly available information and/or support groups where people in similar situations join together and learn from one another. Self-help groups for mental health often begin as voluntary associations of people who share a common desire to overcome mental illness or otherwise increase their level of cognitive or emotional well-being. 88 Many have evolved to become mature organisations that may or may not be consumer operated and delivered.

Peer support occurs when people provide knowledge, experience, emotional, social or practical help to each other. 89 It commonly refers to an initiative consisting of trained supporters and can take a number of forms such as peer mentoring, listening or counselling. Peer support is also used to refer to initiatives where colleagues, members of self-help organisations and others meet as equals to give each other support on a reciprocal basis. Peer, in this case, is taken to imply that each person has no more expertise as a supporter than the other and the relationship is one of equality. A peer has ‘been there, done that’ and can relate to others who are now in a similar situation.

Australia’s National Mental Health Plan defines peer support as:

Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems to others sharing a similar mental health condition. Peer support aims to bring about a desired social or personal change and may be provided on a financial or unpaid basis. 90

Building the evidence base

Self-help
Self-help groups are effective for helping people cope with, and recover from, a wide variety of problems. 91 92 The therapeutic effects are often attributed to increased social support, a sense of community, education, and personal empowerment. 93 94 The benefits for participants can include increased self-esteem, reduced stigma, accelerated

Peer support

Peer support is an important part of a holistic approach to mental health care. The evidence base for the effectiveness of a continuum of peer support services — from voluntary self-help through to consumer operated services (COS) — has recently been consolidated into an evidence based practice implementation ‘KIT’ (Knowledge Informing Transformation) by the US Substance Abuse and Mental Health Services Administration (SAMHSA). This includes an extensive literature review of the strong evidence base for self-help and peer support services and development of a fidelity scale so that services can audit peer support participation against the known evidence base for achieving recovery outcomes.

The largest and most rigorous study of COS conducted to date is the US Consumer-Operated Services Programs (COSP) Multisite Research Initiative (1998–2006) with 1,827 individuals participating from eight sites. Their outcomes were compared to those for programs in traditional mental health service organisations. Findings are that participation in COS leads to significant increases in both well-being and subjective aspects of empowerment when compared with results achieved through participation in traditional mental health services alone. The variations in strength of effect across sites were related to levels of consumer participation rather than to types of COS.

Other examples of the growing evidence base supporting the effectiveness of peer support and COS approaches are:

- New Zealand has found that participation in peer support programs reduces psychiatric symptoms and hospitalisation, improves psychological and social adjustment and encourages goal advancement.
- A South Korean study of people with co-occurring mental health and substance abuse problems compared hospitalisation rates for consumers participating in a peer support program called ‘The Friends Connection’. Compared with a control group, they found that significantly fewer participants in ‘The Friends Connection’ were hospitalised within a three-year period.
- A further study showed that, for those re-entering the community under a Transitional Discharge Model, re-hospitalisation was reduced. Peer support was one of the discharge program’s core components.

Australian evidence regarding the effectiveness of peer support includes a pilot evaluation of the first 3 months of a hospital avoidance and early discharge service demonstrating significantly reduced hospital bed days and associated cost savings, as well as reduced rates of post-support relapse. The benefits of Peer Support Workers’ lived experience on influencing recovery culture within acute services were also noted. Australian research also demonstrates challenges associated with the introduction of peer work including consumer and service provider understanding of these important work roles, with recommendations made for education to overcome this evidence based practice implementation barrier.

Peer support and COS approaches also have the added benefit of providing supportive employment opportunities and career pathways for people with lived experience of mental illness and recovery, which is in itself an evidence-based practice that supports recovery.

Examples of Australian services

**GROW Australia**

GROW was founded in Sydney as Recovery Inc. more than 50 years ago and is now an international mental health self-help organisation. In 2010/11 around 4,000 people regularly accessed Grow services.

Grow provides a peer supported program for growth and personal development to people with a mental illness and those people experiencing difficulty in coping with life’s challenges. The program is designed for people to take back control of their lives, overcome obstacles and start living a life full of meaning, hope and optimism. Grow groups offer the opportunity for people to share challenges and solutions for recovery in a supportive and structured way. Participants are also able to attend education and training sessions and participate in a range of social activities. Grow is free to join and there is no eligibility criteria. There is no need for a referral or diagnosis.

Grow has weekly meetings where small groups of people who have experienced a range of mental health issues including depression, anxiety, panic attacks as well as diagnosed mental illness, come together to support each other. Groups vary in size from 3 to 10 members and are run by experienced ‘Growers’ who have taken a voluntary leadership role with the group.

A recent nation-wide research of the Grow Program found that “Grow’s major advantage is that it offers a ‘real life’ mini-community where people develop new skills. The benefits are concrete in terms of developing communication, social, life management and problem solving skills. But there are also improvements in the less tangible ‘quality of life’ arena which come via gradual identity transformation in terms of development of a sense of being useful, valuable and belonging.”

The evaluation of GROW also showed that there is a statistically significant link between the length of time of Grow membership and reduced hospitalisation, medication usage and sustained recovery.

**Red Cross**

The Personal Helpers and Mentors Service (PHaMS) is available across Australia through a number of community organisations that together support about 7000 people at risk for or recovering from mental illness. The program requires the use of Peer Support Workers and 87% of PHaMS programs have at least one and about half employ more than one. A Peer Support Worker is a person in a paid staff role who has lived experience of mental illness and recovery. In June 2010, PHaMS programs employed about 240 Peer Support Workers making this the largest mental health peer workforce in Australia.

In Rockhampton, far north Queensland, the service is offered through the Red Cross. The service began in late 2007, following a successful submission for funding to the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). Since then, Rockhampton PHaMS Support Workers — both peer and non-peer — have helped more than 300 clients to get their lives on track.

The PHaMS team in Rockhampton addresses three priority areas: Aboriginal and Torres Strait Islander disadvantage; overcoming social exclusion by providing bridges back into the community; and tackling entrenched locational disadvantage. PHaMS is shaped by FaHCSIA guidelines which include requirements for a strengths-based recovery approach.

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111 Personal communication with FaHCSIA on 4 February 2011.
The thriving peer support program helps guide workers and ensures relevant input from consumers. The Peer Support Worker’s role involves:

- Advocating on behalf of service users and influencing service delivery
- Influencing policy and protocol development
- Promoting the identification of options and solutions when working with clients
- Providing practical support to other workers under direction of the Team Leader
- Acknowledging the rights and responsibilities of clients
- Helping other workers to develop, put into practice, and evaluate clients’ recovery plans
- Promoting mental health literacy within the program and the broader community
- Encouraging a peer support and recovery approach in other projects within the wider Red Cross organisation.

Centre of Excellence in Peer Support
The Centre of Excellence in Peer Support provides a centralised specialist clearinghouse and online resource centre for mental health peer support. It has been set up in response to the growing interest in and recognition of peer support work, for both consumers and families/carers. A collaborative project, it aims to support a sustainable peer support sector by providing linkage, service mapping and information-sharing. It is intended for use by consumers, families/carers, peer support workers, community mental health organisations, NGOs and individuals who provide or want to provide peer support.

Individualised information and support are also available by telephone or email. Business planning, in-house training and mentoring can be provided to individuals or services wanting to implement new peer support projects or enhance existing ones.

The Centre aims to: reduce the burden on existing peer support agencies of responding to requests; increase the capacity of individuals and services to utilise best practice in the development, implementation, ongoing management, evaluation and review of peer support services; promote sustainable practice and encourage community participation in responding to mental health issues; reduce ad hoc and unsupported service development; increase potential peer support network linkages to assist planned service development; and provide practical information and support.
Employment and Education

Daniel's story:
The Fellowship has done wonders for me. I came to Pioneer Clubhouse in February 2009, where I attended for 2 and half years before I got my first full time job as a Business Support Officer at QBE processing applications for builders warranty insurance. I have had the opportunity to attend the 15th International Clubhouse Seminar in Florida in 2009. I also attended the 9th Australasian Conference in Queensland in September 2010. 112

In 2011, mental illness surpassed physical problems for the first time as the prime reason for receiving the Disability Support Pension (DSP). 113 With a steady increase since 2001, this translates to 241,335 Australian’s (i.e. 29.5% of DSP recipients with mental illness) — many of whom want work and are unable to access employment and education programs to help them get, and keep, jobs. More than half of these are over the age of 45.

Employment and education are basic human rights and therefore meeting these core needs is central to a person’s sense of purpose and fulfillment. 114 Mental illness and psychiatric disability at an individual level disrupt schooling, school to work transitions, employment, and pathways to a career — both directly and indirectly. 115

Activities in the areas of employment and education provide the most compelling evidence linking social inclusiveness with improved mental health and the community managed mental health sector is a significant provider of education and employment support. This is in line with its overall focus on helping individuals address their life goals and work to their strengths, as opposed to only focusing on the symptoms of mental illness alone.

Whilst employment is not an option for everybody, the evidence still points to strong links between having a vocation in life, a sense of purpose, and recovery. 116 Employment can also reduce the stigma associated with mental illness as more people with mental illness enter the workforce and interact with society as a whole.

Many people affected by mental illness want to work and with the right individual support can do so. Yet they are significantly under-represented in employment statistics in Australia. A 2005 Australian survey of 134 disability employment service providers assisting 3,025 jobseekers found that people with mental health conditions represented the largest category at 30%, and fared worse than any other category in both getting and keeping employment. 117

Ongoing support for this group is a requirement to achieve successful employment. Barriers to employment include:

- A lack of support to overcome disability/impairments
- Systemic barriers resulting from community and workplace stigma
- The way health and vocational services are organised in Australia.

The benefits of employment for people living with severe mental illness are well documented. It is well established that unemployment degrades a person’s sense of purpose, structure, social status and sense of identity. 118 It is not surprising then, that paid work is associated with reduced psychiatric symptoms, higher functioning, an improved sense of self-worth, and significant improvement in social skills. 119

Building the evidence base

There are a many studies linking the benefits of employment support programs with improved outcomes for people with mental illness: 120 121

- A USA study found that adults with severe and persistent mental illness who received employment services through mental health and/or vocational rehabilitation programs had higher employment rates than individuals who did not receive any employment services. Individuals who received services from both programs had significantly higher employment rates than individuals who received services from only one program. 122

- Another study, looking at the 10-year outcomes of clients who participated in supported employment in the early 1990s, found that the benefits of supported employment lasted for the longer term, with participants reporting successful competitive employment and substantial improvements in self-esteem, feelings of hope, relationships, and control of substance abuse. 123

- Research has also found that consumers who retained competitive employment for a sustained period demonstrated benefits such as improved self-esteem and control of symptoms. 124

Current evidence based practice in this area integrates employment job seeking services with mental health services. This approach is known as ‘supported employment’ and draws on the Individual Placement and Support (IPS) model. 125 The evidence of effectiveness of IPS is strong. A meta-analysis of 11 RCTs found an overall employment rate of 61% for those people receiving IPS compared to 23% for controls. 126

The original IPS model was developed around a set of seven core principles with another four operational principles added later:

1. The goal of the service is competitive employment
2. Zero-exclusion policy, eligibility is based solely on desire to work
3. Rapid job search, excluding lengthy pre-vocational training
4. Integration of vocational and clinical services
5. Attention to consumer preferences
6. Time-unlimited and individualised support
7. Personalised ‘benefits counselling’, that is, advice regarding income entitlements are their interaction with paid work
8. Continuous availability of intensive onsite workplace support
9. Multidisciplinary teams to coordinate treatment and vocational interventions
10. Alliances between staff and consumers in rehabilitation
11. Strategies to counter workplace stigma.

Other approaches to employment and education that have been recognised as complimentary include:

- Clubhouses (perhaps the first integrated employment and mental health service)
- Consumer operated services (COS, as previously discussed under ‘Self-help and Peer Support’)
- Social enterprises (also known as the ‘fourth sector’).

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120 Ibid. VICSERV (2008b).
Social enterprise organisations involve a blend of community sector/NGO and private-for-profit values and legal structures. They address economic, social, cultural or environmental issues consistent with a public or community benefit, often through employment of socially excluded people such as those that are homeless and/or have mental illness. Social enterprise employment cooperatives are a key feature of the hugely successful mental health sector in Trieste, Italy, and are now gaining traction in Australia. Part of the strength of social enterprise models lies in their commitment to making reasonable accommodations for employees with complex health and/or social problems.

Examples of Australian services

**Schizophrenia Fellowship of NSW**
The Schizophrenia Fellowship of NSW (SFNSW) Ostara Disability Employment Service (DES) program has a number of sites across Sydney which have been rated by the Department of Employment, Education and Workplace Relations (DEEWR) as a ‘5 Star’ DES provider. Services are provided in eighteen locations across NSW including one based at the Pioneer Clubhouse at Balgowlah, which was established in 1995. Much more than simply a program, or a social service, the Clubhouse is most importantly a community of people with a common goal to support individuals living with the effects of mental illness. Clubhouse participation gives people opportunities for friendship, family, important work, employment, education, and to access the services and supports they may individually need.

Clubhouses revolve around a work-ordered day and help give meaning and structure to the lives of members. The work-ordered day, together with the employment program, provides an invaluable stepping-stone into employment and the community. The Clubhouse provides a range of employment and education programs including the Transitional Employment Program (open employment) and Supported Employment. The latter uses the evidence based ISP approach with its emphasis on integrated service delivery with public and private mental health treatment services. Pioneer also provides support to members once they find employment. SFNSW’s inclusive and holistic approach has been fundamental to the outstanding success of their Ostara program.

More recently, an Early School Leavers program has been developed for school leavers (15 to 17 years) who have been identified as having mental health issues but may not be diagnosed. This provides employment, training and where possible accredited education outcomes including apprenticeships and traineeships and up to two years post-employment support. 70% of the young participants have obtained jobs.

**Freight Gallery & Studio**
The Freight Gallery is auspiced by Disability in the Arts, Disadvantage in the Arts, Australia (DADAA) which is based in Fremantle and offers targeted cultural development programs in over 46 Western Australian communities. DADAA has been a catalyst for the development of an inclusive approach to the arts and culture for more than 20 years and creates opportunities and significant beneficial social change for people who have a disability or mental illness. Programs cater to the artistic development and social and cultural participation needs of more than 2000 people annually. The arts programs offer individualised and group arts practices that assist in the development of a wide range of artistic, social and functional skills that enhance self-confidence and enable participants to enter into activities and roles that are essential to a fulfilling, productive and participative life. Services are a result of partnerships encompassing disability and health; community cultural development; the arts; training and education; and the corporate sector. Freight Gallery offers people living with a mental illness the opportunity to develop new skills or expand on existing skills in the visual arts. Freight artists work in various mediums: painting, photography, ceramics, digital media, sculpture or textiles. Participants also receive professional development and training in arts administration, curation and installation. Artists are encouraged to exhibit their work for sale, generating income and new employment opportunities for its members and increasing well-being.

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128 Ostara Australia is a national consortium of mental health Disability Employment Service providers: www.ostara.org.au.
Mental Illness Fellowship Victoria

The Mental Illness Fellowship Victoria (MI Fellowship) offers a wide range of community managed rehabilitation and support services to people with mental illness, their carers and families — last year working with close to 5,000 people. MI Fellowship’s focus is to enable people to manage their mental health and pursue personal goals such as building a home and supportive relationships and participating in education and work.

MI Fellowship is a significant provider of disability employment services for people with severe and persistent mental illness. They have been delivering international best practice employment services since 2005, applying the Individual Placement and Support (IPS) model that:

- Closely integrates mental health treatment and co-located employment services
- Supports jobseekers into employment as quickly as possible
- Provides ongoing support to encourage and train individuals as they participate in paid employment.

Consistent with the principles that underpin the IPS model, MI Fellowship has established 10 co-located employment services in Area Mental Health Service clinics in Melbourne. MI Fellowship’s long term experience is that the IPS model works best when there is a close working relationship but clear and agreed separation of roles between employment consultants and mental health service providers. In collaborating with public mental health services they establish clear protocols detailing the expectations of respective service providers and support these with close liaison, information exchange and including the participation of consultants in people’s service review meetings. This close integration enables job seeking and placement goals to be integrated with overall treatment and recovery plans and facilitates links into other MI Fellowship services.

Another key program is Well Ways, an evidence-based peer-delivered family educational intervention that helps families of people with a mental illness better manage the impact of mental illness in their lives. The program is delivered nationally through a range of organisations and has been evaluated as being effective in reducing the negative care giving consequences frequently experienced by families and caregivers. 129

Family and Carer Support

My story:
Mum would just lie in bed and not do anything; she didn’t want to have anything to do with the world. She looked sad and I would feel sad too. At this time my little sister was about six years old, I had to cook meals for her, I had to wash the dishes and do other chores as well. I also used to cook for Mum and take her meals to her in bed.
(Male aged 14)130

A key component of the social inclusion approach taken by the community managed mental health sector is providing support to carers, family and friends. People rarely choose to become carers and are often thrown in at the deep end with little or no formal training in dealing with mental illness. Family and carers play a central role in the recovery process for many people with a mental illness. While this role can have many fulfilling aspects, it often places significant stress on the person providing care and places them at great risk of also developing a mental illness.

For the first time, Australia has a National Carer Strategy — the second element of the Australian Government’s National Carer Recognition Framework. 131 Along with the Carer Recognition Act 2010, the National Carer Strategy strengthens our commitment to recognise and respond to the needs of carers so that they have rights, choices, opportunities and capabilities to participate in economic, social and community life. 132 133 The National Carer Strategy contains six important priority areas for action: recognition and respect; information and access; economic security; services for carers; education and training; and health and well-being. Collectively, these priority areas outline how the contribution of Australia’s carers will be better valued, supported and shared and this must include increasing availability of family support and carer services.

Carers are often overlooked by services — both for their contribution to the recovery process and in terms of their own personal needs. Carers have been found to contribute, on average, over 100 hours per week caring for those with mental illness. 134 They are at risk of both health and mental health problems themselves as they may experience anxiety, guilt, helplessness and, in some situations, fear for their own well-being or that of those around them. The rates of depression and anxiety disorders amongst carers are particularly high. 135 136

Support for carers can include providing information and practical assistance, providing respite care (this is a break from caring responsibilities) and helping them to feel more confident and satisfied in their caring role.

Building the evidence base

The evidence on the needs of carers
There is ample evidence both in Australia and internationally which attests to the needs and difficulties experienced by carers. The Mental Health Council of Australia (MHCA) conducted a series of workshops with 1,500 carers across Australia and they consistently brought up the lack of respect and recognition that others had for their experience and significance. They spoke of discrimination not only against those they care for but also against themselves, owing to their relationship to a person with mental illness, which is often highly stigmatised. 137

The National Survey of Carer Health and Wellbeing received information from 1,449 carers and found reduced physical, mental and emotional health and well-being for most carers because of their caring responsibilities. As a result of caring:

- Two-thirds of carers felt their mental and emotional health had been affected by providing care
- Over half of all carers were experiencing mild to moderate depression
- Over half of all carers experienced a decline in physical health
- Constant pressure of caring, stress, disturbed or lost sleep, and physical aspects of care such as lifting to assist mobility were the most common reasons reported for negative effects on health.

This is compounded by the fact that around one-third of carers reported their caring duties caused difficulties or delays in seeking their own health care (including GP visits, hospital treatments, operations, and treatments such as physiotherapy).

Similar figures emerge from the international literature. For example, a 2005 Commonwealth Fund survey of family carers aged 19-64 found that 60% reported only fair or poor health, one or more chronic conditions or a disability, compared with only one-third of non-caregivers. It is crucial for carers to feel that they can take a break or have some respite, that they are not alone and that their social support is effective. Likewise, it is important that other aspects of their lives are not completely overshadowed by their caring duties.

The evidence on the effectiveness of carer interventions

The benefits of providing support for carers are far-reaching — not just to the carers themselves but to the consumer, family and others involved in service delivery.

A systematic review of carer needs and interventions in Australia found evidence to support the effectiveness of many types of support interventions for carers. Caregiver interventions, as a whole, produced a significant improvement in carer burden, depression, subjective well-being, satisfaction, ability, knowledge and care receiver competence:

- Education and counselling had a significant effect on all outcome variables
- Multi-component interventions had significant effects on burden, well-being and knowledge
- Respite was effective for reducing burden and depression and enhancing well-being.
- Individual interventions had stronger effects on burden and well-being, while group-based interventions had larger effects on care receiver competence.

Although the above studies were not specific to mental health carers, there is no reason to believe there would be significant differences in the results.

In addition to strong evidence supporting respite care and counselling, it has also been found that for carers looking after those with dementia, disability or schizophrenia, there is a reasonable evidence base for other interventions not usually funded or provided by mainstream health services including carer support groups and the provision of information/education.

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Participants in carer support groups repeatedly commented on how much they appreciated talking to others who understood their situation, as they had been unable to get this level of understanding from their own relatives and friends. It has been suggested that the caring role tends to fall on one individual within a family while the rest of the family may distance themselves from the situation. Support groups for primary carers can play a vital role in reducing feelings of isolation.

The value of group information/education for families and carers as a brief intervention, evidence based practice has been understood for years. However, as is the case with many known evidence based approaches there have been considerable challenges in implementing these services in acute care settings. Research now demonstrates the many benefits of peer, as a compliment to service provider, delivered family education and support groups — in terms of both the focus on carer outcomes, prevention of mental health problems and in overcoming implementation barriers.

Peer delivered family education programs have been delivered in Australia for more than 20 years and the recent large-scale, longitudinal, national evaluation of the Well Ways program demonstrated significant reductions in negative care giving consequences including worrying, tension, urging and distress. These gains were sustained at 3 and 6-month follow-up and were also greater for carers of people with a psychotic illness.

Examples of Australian services

**COPMI**

Children of Parents with Mental Illness (COPMI) is a national service based in Adelaide, South Australia, that provides information for family members across Australia where a parent has a mental illness and for the people who care for and work with them. It is estimated that there are between 21% and 23% of children living in Australian households where at least one parent has a mental illness, equating to just over a million children. These children may face many challenges. A range of factors associated with families where a parent experiences mental illness can have a negative impact on a child’s development and well-being. In stating this, it is also acknowledged that many parents living with mental illness are very capable.

With these families and children in mind, COPMI develops information for parents, their partners, carers, family and friends in support of these children. This information complements training resources developed by COPMI for professionals to support families either individually or through community services and programs. Their website is the primary way that COPMI information is accessed. They also work with health care providers, community support groups, educators, service organisations and the media.

COPMI’s resources are designed to foster better mental health outcomes for children of parents with a mental illness, reduce stigma associated with parental mental illness and help friends, family and workers in a range of settings identify and respond to the needs of the children and their families where parental mental illness exists. Resources are developed under the guidance of people who share the experience of living in families where mental illness is a part of family life, and of leading researchers and service providers in the mental health field.

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The COPMI initiative was established in 2002 and is being undertaken by the Australian Infant Child Adolescent and Family Mental Health Association (AICAFMHA).

**ARAFEMI**

The ARAFEMI Family Support Program recognises the important role that families, friends and carers play in the ongoing recovery from mental illness. As a leader in peer support for carers in Victoria, ARAFEMI listens and supports the voice of families towards better mental health through a helpline, support groups and online services. Over the past three years ARAFEMI has developed and implemented an independent, service neutral, state-wide Carer Advocacy Program in Victoria.

A new Carer Advocate position has been developed to primarily assist carers in the mental health system with complex advocacy issues, the outcome of which will be to improve mental health services provided to carers and consumers. The Carer Advocate would provide one-to-one support to carers and services across Victoria including individualised face-to-face and telephone support to assist carers with complex advocacy issues and, where appropriate, walk with them when needed.

The seeds of this program originated from direct consultation with mental health carers and ARAFEMI continues to consult with carers and other key stakeholders in relation to this program to provide a ‘best practice’ service to carers, with a view to improving the responsiveness of the mental health system to carers and mental health consumers alike. A key finding of the consultation was “…even carers who are trained, experienced and skilled in advocacy felt there were times when they could advocate and times when it was just too hard …”. 156

ARAFEMI is a member of Mental Health Carers Arafmi Australia (MHCAA), a federation of the six ARAFEMI member organisations in each state and territory and the national voice of mental health carers.

**Frontier Services**

CMHA’s Building Capacity in Community Mental Health Family Support and Carer Respite Project, funded by the Australian Government under the COAG Mental Health Respite Program, provided a structure to bring people and organisations together to develop new and innovative support and services for families and carers of people with a mental illness and resulted in the establishment of numerous new services across Australia. 157

For mental health professionals working in larger metropolitan centres, it’s hard to imagine the remoteness of Western Australia’s Pilbara and Kimberley regions. Dirt roads, often impassable during the wet season, the sheer vastness of space, the travel time from one town to the next. Add to that cross-cultural issues associated with working with Aboriginal and Torres Strait Islander (ATSI) communities plus a high incidence of comorbidities such as alcohol and drug issues and a picture emerges of life for mental health carers in the Pilbara and Kimberley.

Frontier Services — the major provider of aged care, health, community services and pastoral support to people in outback Australia for the past 100 years — applied for funds for four projects under round two of the National Respite Development Fund component of the Mental Health Respite Program and were successful with all applications. One of these applications was to develop the Kimberley Mental Health Respite Service.

The region had a clear and significant unmet need for respite for carers of people with mental illness. Where a service did exist, carers were often anxious about leaving the care recipient. Due to high staff turnover in the region, the staff was rarely familiar to carers or care recipients. Frontier Services engaged a specialist Indigenous consultancy to scope the project. Despite many challenges, Frontier Services established a town-based service in Fitzroy Crossing which is serving the needs of carers in the Fitzroy Valley. Known locally as the ‘Fitzroy Valley Respite Service’, it is available to the 46 communities living in the Fitzroy Valley.

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Information, Advocacy and Promotion

Our stories:
Our stories are a valuable resource for making meaning out of ‘madness’, for changing perceptions and for educating the community and mental health professionals. How and whether you tell your story is entirely up to you. It is your story. For example, the idea of ‘mental illness’ is not something that all consumers identify with – some will express sophisticated intellectual, political or spiritual critiques of this concept. Others find it profoundly useful. 158

Information, advocacy and promotion are activities towards increasing mental health literacy and self-directed care, and reducing stigma and discrimination. Mental health literacy has been defined as ‘knowledge and beliefs about mental disorders which aid their recognition, management or prevention’. Poor mental health literacy limits the implementation of evidence-based care and the degree of community support for people affected by mental disorders. Studies show that although Australians believe mental health is a significant issue, they are not well informed about the services available. 159

Poor mental health literacy was first demonstrated in Australia in a large national survey in 1995 with 90% of people reporting that they lack a clear understanding of mental illness and the services that are available to address it. 160 While recognition of mental health problems has since vastly improved, awareness of the services that are available to address it have not. 161 Despite growing mental health literacy, stigma surrounding people with lived experience of mental illness continues to be a major problem, both in the general community and amongst mental health and other health service providers. 162

Information and education are the most frequently used approach to reduce the stigma associated with mental illness. Australia is leading the world in mental health education through national programs such as beyondblue and Mental Health First Aid.

The overarching goals of public education are to:

• Improve the public’s ability to recognise the signs of mental illness
• Increase knowledge about treatment supports and services
• Increase willingness to proactively seek out professional services, and
• Build the capacity of carers to provide support. 163

The National Mental Health Strategy defines advocacy as ‘representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support so they (people affected by mental illness) can represent themselves’. 164 Many others have a view that advocacy should never include speaking on another’s behalf, but always supporting people to use their own voice including shared and supported decision-making practices. The Fourth National Mental Health Plan states that service development should include support for advocacy and self-determination to the greatest extent possible.

162 Mental Health Council of Australia (2011). Consumer and Carer Experiences of Stigma from Mental Health and Other Health Professionals. Canberra: MHCA.
Mental health promotion is a multidisciplinary approach to achieving positive mental health and is part of a broader health promotion agenda. It looks beyond individual disease prevention and towards the steps that people and communities can take to encourage mental health.\footnote{165} Mental health promotion encompasses a variety of activities that work towards the ultimate outcomes of:

- People having a better understanding and recognition of mental health problems and mental illness
- People being supported to develop resilience and coping skills
- People being better prepared to seek help for themselves and to support others to prevent or intervene early in the onset or recurrence of mental illness
- Greater recognition and response to co-occurring alcohol and other drug problems, physical health issues, and suicidal behaviour.\footnote{166}

The Australian community managed mental health sector is actively engaged in information, advocacy and promotion activities. The continuation and extension of these programs, supported by emerging evidence, is in line with the National Mental Health Plan.

### Building the evidence base

There is an emerging evidence base showing that an investment in mental health information, advocacy and promotion can positively impact on consumers, carers and society as a whole. Research undertaken by the University of Melbourne has demonstrated an increase in awareness of depression and the issues associated with it (e.g. discrimination) between 1995 and 2004, which were most pronounced in states and territories that contributed funding to beyondblue.\footnote{167}

The community managed mental health sector is well-placed to offer best practice initiatives in this area due to our holistic approach. Research shows that education is particularly effective when it is aimed at a specific audience, involves one or more forms of media, and the messages are tailored to the target audience (i.e. police, medical students). Information, education and advocacy activities can be especially effective when people with a lived experience of recovery share their stories and experiences. Education that is multi-faceted and confronts common myths (dangerousness, incompetence, impulsivity) improves public attitudes.\footnote{168}\footnote{169}\footnote{170}\footnote{171}

There are also a number of reports that make the economic case for mental health promotion and prevention.\footnote{172}\footnote{173} Early and preventive interventions show promise in reducing the burden of mental illness particularly in young people.\footnote{174} In one study, mainstream treatments were found to avert only 13% of the burden of mental illness and even best practice treatment, if applied to 100% of the population with mental illness, would still only avert an estimated 40% of the burden of disease.\footnote{175} Therefore, prevention and early intervention — for example, to help prevent relapse and reduce severity of mental illness — can significantly reduce costs.\footnote{176}

\footnote{176} Access Economics (2009). The economic impact of youth mental illness and the cost effectiveness of early intervention.
Examples of Australian services

Our Consumer Place

Our Consumer Place is a resource centre run by people diagnosed with ‘mental illness’. They provide information, training, support and advice to consumer developed initiatives. They also support the ‘consumer perspective’ recognising that the lived experience of ‘mental illness’ provides a crucial source of insight that is of value and must be respected. Our Consumer Place is part of an important cultural shift towards valuing and respecting the lived experience of ‘mental illness’ as people diagnosed with mental illness have a unique perspective to offer. Lived experience is rich and varied — some people experience madness, psyche-ache, emotional distress, hearing voices, mental breakdown or ‘mental illness’ — not all people make meaning from their experiences in the same way.

Many people have experienced prejudice, exclusion and trauma. Many have used or survived mental health services, others have not. Many people have hidden their experiences, and some share their experiences in various ways. All people with lived experience share the ability to reflect on their lives, communities and the ‘mental health system’ from the perspective of having been through these experiences. Our Consumer Place is a resource for the voices of people with lived experience to come together and become stronger.

Our Consumer Place is based in Melbourne and auspiced by Our Community. Our Community is a world-leading for-profit social enterprise that provides advice and tools for Australia’s 600,000 not-for-profit community groups and state, private and independent schools, as well as practical linkages between the community sector and the general public, business and government. Our Consumer Place is unique in Australia but there are many similar services in Europe and the United States.

Mental Health Association of Central Australia

The Mental Health Association of Central Australia (MHACA) is located in Alice Springs. They have a vision to enhance mental health and well-being for people living in Central Australia. They offer a diverse range of individual psychosocial support that is recovery-oriented including:

- A drop-in centre, with a regular program of activities including a peer support program
- Short-term care around relapse to minimise hospitalisation
- Suicide prevention and research
- Training in mental health first aid and suicide intervention
- Independent housing support that is affordable and secure
- Mental health promotion to raise community awareness
- Opportunities for participant collaboration and participation
- Advocacy and participation at local, state and national levels.

MHACA first formed in 1992. A small group of carers wanted more than just the medical services available – they wanted rehabilitation services and to explore accommodation options. Originally developed as a Clubhouse model, MHACA has since evolved into a ‘one stop shop’.

MHACA’s longest running service, the Life Promotion Program, works to develop strategies to reduce suicide and suicidal behaviour in Central Australia by applying the principles of the LIFE Framework of the National Suicide Prevention Strategy. This includes: delivery of ASIST (Applied Suicide Intervention Skills Training); raising awareness and reducing stigma around suicide; supporting communities after a suicide; developing culturally appropriate resources; supporting a Mental Health Promotion Officer in Tennant Creek; data collection on completed suicides; and organising World Suicide Prevention Day events.

Current projects include ‘Suicide Story’, an indigenous-specific training tool to help create suicide safer communities and families, and the ‘Yarning About Suicide’ audio project.
beyondblue

*beyondblue* is a national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related disorders in Australia. Where possible, it draws on evidence-based research, works in partnership with health services, schools, workplaces, universities and community organisations, as well as people living with depression/anxiety and their carers, to bring together their expertise. *beyondblue’s* main aims are to raise awareness of depression, anxiety and related disorders to help reduce the associated stigma and encourage people to seek help in the Australian community.

Underpinning *beyondblue’s* mission is a series of five priority areas for action:

1. Increasing community awareness of depression, anxiety and related disorders and addressing the associated stigma
2. Providing people living with depression and anxiety and their carers with information on the illness and effective treatment options, and promoting their needs and experiences with policy makers and healthcare service providers
3. Developing depression prevention and early intervention programs
4. Improving training and support for General Practitioners and other healthcare professionals on depression/anxiety
5. Initiating and supporting depression-related research.

A 2009 independent evaluation of *beyondblue* concluded that:

- It is clear that *beyondblue* has established itself over the past decade as a major force in shaping public policy and in introducing new programs in mental health in Australia
- It is likely that *beyondblue* has, at least partially, increased the capacity of the broader Australian community to prevent and respond effectively to depression
- The breadth and depth of its activities across its five priority areas is impressive. Its activities are well distributed between innovation (funding of new programs), further development of more established programs, and preparation for wider dissemination of existing programs through planning and workforce development. 177

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Leisure and Recreation

Sallyanne’s story:
I’ve lost 60 kilograms! My feet have gone down two shoe sizes. I’ve got a lot more going on socially now than I ever did before and I am very happy to be buying new clothes. My financial management skills have really come along too. I am more confident and energetic and I am not sitting at home alone. I have more of a social life than I had before. I was a borderline diabetic and was going to be insulin dependent. I made the choice to change. 178

Leisure and recreation activities are an important component of the social inclusion approach taken by the community managed mental health sector. This is not simply a matter of ‘finding something to do’; it is providing meaningful engagement with other individuals, and with the broader community, which are very important to recovery.

It is well documented that leisure activities increase one’s physical, social, and mental health as well as being “health-sustaining, self-actualising, and re-creative”. 179 Like anyone else, people living with mental illnesses need a sense of belonging and a feeling of satisfaction with their lives. Efforts to help people feel a part of their communities and have a good quality of life usually focus on helping them get decent housing, meaningful employment, education and health care, as well as fostering self-determination and social support. However, recreational and leisure activities are also central to feeling connected to community life.

Research has consistently indicated that physically and socially active recreation and leisure activities are related to a higher quality of life in the general population, as well as in people with various disabilities. This is especially true of activities that help people feel a part of neighbourhood life including such simple activities as eating in a restaurant, visiting a library or walking in a park. But research has also found strong relationships between physical activity and physical health as well as between physical activity and mental health. Yet individuals with serious mental illnesses are significantly less active than the general population and their leisure involvement tends to be much more passive.

Building the evidence base

The negative impacts of mental illness can affect almost everything that is connected to satisfaction and well-being in everyday life. In terms of social support and social networks, problems created by inter-personal issues can have a large impact on quality of life and are probably more pervasive than the illness itself. 180

Therefore, programs which seek to increase a person’s self-esteem, self-efficacy and social functioning can significantly aid in the recovery process and contribute to a feeling of social inclusion. Consumers and carers value improved functioning very highly and one study found that they value this more highly than improvement in symptoms. 181

There is also a link between access to leisure and recreation, and housing. The links between ‘staying housed’ and the various forms, levels and sources of support are quite broad. These forms of support can be directly associated with housing, such as financial assistance or practical assistance with daily activities and household tasks; or indirectly as in the case of more intangible factors that can improve a person’s mental health and emotional well-being, for example:

- Social and community connectedness
- Stable and supportive environments
- Leisure and physical activities
- Access to social and supportive relationships
- Physical security

• Opportunity for self-determination and control over one’s life
• Access to work or meaningful engagement
• Access to money. 182

Support indirectly linked to housing such as access to leisure or recreational activities can help someone with a mental illness cope with the day-to-day demands of life. In turn, this makes it more likely that people can sustain housing. 183 184

Examples of Australian services

PRA
Psychiatric Rehabilitation Australia (PRA) currently supports 2800 people living with persistent mental illness and their families/carers with a range of community-based, work-based and home-based initiatives in 32 locations across NSW. PRA is one of four community organisations in NSW delivering the Recovery and Resources Services Program (RRSP). RRSP is a service to support people with a mental illness by providing improved access to community social, leisure, and recreational opportunities and vocational services. RRSP has focused on establishing services in regional and rural areas with a limited existing range of community managed mental health services. PRA is currently providing RRSP services in Cootamundra, Tumut/Young, Temora/Junee, West Wyalong, Moree, Armidale, Taree/Foster, Maitland/Cessnock and Blacktown.

The RRSP has a recovery approach and is based on principles of psychosocial rehabilitation. This approach and the psychosocial principles are the foundations of service delivery for people with a mental illness, which means that the practice of psychosocial rehabilitation begins at the first point of contact. The aim of the RRSP is to reduce social isolation through access to community-based activities, as well as to promote access to public and private healthcare services.

People receiving PRA’s RRSP services also benefit from the opportunity to participate in the Back On Track Health (BOTH) program which provides opportunities for clients to address or prevent physical health problems that they may be struggling with including poor nutrition, obesity, diabetes, smoking, cardiovascular disease, substance use and metabolic syndrome.

Club Haven
Anglicare Tasmania currently provides fourteen mental health programs across the state. Club Haven is one of these programs and is based in Devonport in Tasmania’s north-west. It is a social and support network for people recovering from mental illness and is quite unique in its history, development and progressiveness. It is a comfortable place where people can meet and develop skills through activities like computer training, cooking, art and craft, first aid training and exercise. It offers a friendly, supportive environment in which to build self-esteem, independence and confidence. Club Haven receives no external funding and is currently funded by Anglicare Tasmania Inc., both through its Mental Health Services stream and broader organisational support.

Club Haven is a consumer-led program currently operating two days a week, providing social and recreational activities for people with mental illness, as well as opportunities for people to develop skills and participate in the community. Club Haven is increasingly being recognised for its contribution to broader developments regarding consumer participation and increasing clients’ capacity to cope with everyday life.

This included consumer representation on the recent Department of Health and Human Services (DHHS) Consumer and Carer Participation Review Implementation Advisory Committee. Club Haven also has consumer representation on a number of other working groups and steering committees and is actively involved in promoting the benefits of recovery-based peer support.

Anglicare reports receiving extremely positive feedback from other NGO service providers and clients about the day-to-day difference the program makes in the lives of its members.

Aspire, A Pathway to Mental Health (Aspire), was established in 1989 and operates across southwest Victoria and Tasmania. Aspire provides a range of community managed mental health services for consumers, carers and the wider community. These services include rehabilitation and recovery for adults with a serious mental illness and psychiatric disability, carer support and advocacy, respite, volunteering and mental health promotion and education.

Aspire delivers rehabilitation and recovery services within a framework of practice known as the ‘Boston Model of Recovery’. The Boston Model is a strengths-based approach that recognises each individual’s skills and interests and supports recovery in a holistic way to reflect the person’s occupation, communication and connection. This is achieved across life domains including social and recreational activities.

As an organisation driven by the mission to enhance the mental health and overall quality of life of every individual in our community and one that specialises in service delivery in regional and remote regions, Aspire appreciates and promotes the importance of community connection and collaboration. In isolated communities it is essential to integrate services with normal everyday activities and interests of the community such as sporting associations, schools, farming co-ops etc. This integration promotes acceptance and reduces stigma around mental health issues, provides an opportunity for mental health promotion and ill health prevention education and increases physical and social activity and engagement. The connection between physical and psychological health is well documented and now incorporated in to best practice in rehabilitation and recovery. At Aspire, all activities are considered within the context of this connection and ranges from physical activities instead of traditional day programs through to healthy eating programs and nutritional advice.
A key gap is in relation to accountability and Australia’s capacity to demonstrate clearly the real impact services have on the lives of people with mental illness.

*(International Journal of Mental Health, 2011)*

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The community managed mental health sector has the necessary experience and expertise to provide real recovery and social inclusion opportunities for people affected by mental illness — tailoring or adjusting psychosocial rehabilitation and support services where necessary for greater impact.

Recent policy and funding directions have seen considerable growth of the community managed mental health sector but in the main this has not included funding for infrastructure development. A coordinated national sector research and development strategy is urgently needed to address:

- Data collection and outcome monitoring
- Workforce development and learning
- Quality improvement
- Coordinated and integrated service delivery.

Both the Commonwealth and state/territory governments have a considerable investment to see that a national community managed mental health sector development strategy occurs. Progressing the national Data Development Project, including investment in data systems information technology, is seen to be an important first priority. Improved data systems and standardised outcomes monitoring will increase the sector's capacity to demonstrate its efficiency and effectiveness, as well as the positive health and social benefits and outcomes for people affected by mental illness and their communities.

The evidence increasingly shows that accommodation, employment and social connection services are central components of the mental health recovery journey. And it’s not just about service delivery — it’s also the recovery philosophy and relationship skills that mental health workers bring to their roles that helps instil a sense of belonging, connection, empowerment, and hope in those experiencing mental illness.

In order to highlight and build on the effectiveness of this approach, more research must be done. People consulted in the development of this publication strongly highlighted this need. Through the use of standardised data reporting and recovery-based outcome measures, the contributions of the community managed mental health sector to the recovery of people with mental health problems and their families and carers is becoming increasingly evident. CMHA obtained legal status as an incorporated association in December 2011. This was preceded by three years of intensive relationship development work including the development of a Memorandum of Understanding to formalise the alliance. A National Leadership Committee developed strategic directions for CMHA and other management, governance and operational functions and processes, including CMHA’s Constitution. Incorporated association status provides CMHA with additional opportunities to pursue its role (i.e. goal, purpose and objectives) and to expedite future directions.

The role of CMHA

CMHA has been established as the national peak body to provide leadership and direction in promoting the benefits of community managed mental health and recovery services across Australia. The journey to establish CMHA brought together the various concerns and priorities of eight separately constituted organisations. All of whom work alongside numerous departments of state, territory and federal governments who have diverse perspectives on the appropriate role and function of the community mental health sector.
The strength of the coalition lies in over 800 community managed non-government organisations who are members of, or affiliated with, the coalition members. CMHA draws on the expertise and skills of the state and territory member organisations to support and coordinate national level advocacy and representation, research, and policy and sector development services.

**CMHA Goals**
The primary goals of CMHA are to:

- Build a viable and sustainable community managed mental health sector across Australia
- Promote the value and outcomes delivered by community managed mental health services based on a philosophy of recovery and social inclusion.

**CMHA Purpose**
The purpose of CMHA is to:

- Provide a voice and represent the community managed mental health sector in national initiatives related to mental health and social inclusion initiatives
- Enhance the capacity of coalition members to represent, support and strengthen the non-government community mental health sector
- Collaborate to develop joint policy and advocacy papers that promote community mental health at national and state/territory levels.

**CMHA Objectives**
CMHA's objectives are to work at the national, state and local levels to:

- Increase understanding of the value of community mental health programs
- Establish a better understanding of community mental health programs, recovery services and consumer and carer groups supported by not-for-profit and non-government agencies
- Expand recovery options within the community
- Expand the range of options available to enable people with a mental illness to recover in their own homes and communities
- Influence government decision-making
- Influence government decision-making related to mental health and other key social justice and social inclusion issues
- Improve funding for community-managed mental health services
- Increase the ratio of mental health funding allocated to support quality community-managed mental health services and recovery programs
- Improve capacity of the community mental health sector
- Promote and strengthen the capacity of the community mental health sector across Australia
- Foster effective partnerships to achieve shared goals
- Establish effective partnerships with stakeholders to achieve shared mental health reform goals
- Share knowledge and resources more effectively
- Share the combined knowledge, resources and capacities of the State and Territory community mental health services
- Drive innovation, based on recovery and inclusion
- Drive innovation and promote new models and programs based on recovery and social inclusion
- Work together to provide leadership and advocacy
- Work together to build unity and enable coalition members to be effective in their individual and collective leadership and advocacy roles.

**The future of CMHA**
CMHA is committed to working in collaboration with consumers, families and carers, communities, all levels of government and other health and community sector service providers and peak bodies to better address the needs of people affected by mental illness and to promote mental — and social and emotional — well-being in Australia. With appropriate financial and structural support, CMHA will provide a unified voice representing, supporting and developing community managed mental health organisations and services.
Four strategic directions have been identified:

1. **Sector and coalition capacity development**
   Support and develop the sector’s growing and innovative workforce as part of the rollout of the National Standards for Mental Health Services and achieving the social inclusion objectives of the Fourth National Mental Health Plan.

2. **Build and disseminating of the evidence base**
   Oversee data consistency and information management, implementation and evaluation of research and – through these activities – increase the evidence base for recovery oriented service provision that results in more effective outcomes for consumers, carers and communities affected by mental illness.

3. **National leadership and advocacy**
   Increase understanding of the importance of person-centred and self-directed recovery, rehabilitation and social inclusion health and community (i.e. psychosocial) services as necessary and natural adjuncts to medical treatments and advise on the best ways to strengthen access to these.

4. **Enhance our capacity and governance**
   Continue to grow CMHA’s ability to consult and communicate to better respond to people living with and/or recovering from mental health problems about the best ways to address their needs.

An overview of CMHA’s current strategic directions is provided below:

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**CMHA STRATEGIC DIRECTIONS**

**Goal 1: Sector and coalition capacity development**

<table>
<thead>
<tr>
<th>Objective 1.1</th>
<th>Promote diversity and innovation, quality and standards</th>
</tr>
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<tbody>
<tr>
<td>Objective 1.2</td>
<td>Build a skilled and competent workforce</td>
</tr>
<tr>
<td>Objective 1.3</td>
<td>Support and collaborate on national projects</td>
</tr>
</tbody>
</table>

**Goal 2: Building and disseminating the evidence base**

<table>
<thead>
<tr>
<th>Objective 2.1</th>
<th>Foster and develop a national approach to community mental health recovery and outcome measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 2.2</td>
<td>Contribute to the evidence for community-based mental health recovery, rehabilitation and social inclusion models</td>
</tr>
<tr>
<td>Objective 2.3</td>
<td>Disseminate good practice models nationally and through coalition members</td>
</tr>
</tbody>
</table>

**Goal 3: National leadership and advocacy**

<table>
<thead>
<tr>
<th>Objective 3.1</th>
<th>Promote a unified and unique voice regarding community based mental health, recovery and social inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 3.2</td>
<td>Contribute to national debate and policy development related to mental health recovery, rehabilitation and social inclusion</td>
</tr>
<tr>
<td>Objective 3.3</td>
<td>Facilitate collaborative partnerships and relationships across the non-government, business, private and public mental health and government sectors</td>
</tr>
</tbody>
</table>

**Goal 4: Enhancing our capacity and governance**

<table>
<thead>
<tr>
<th>Objective 4.1</th>
<th>Develop on-going robust consultation and communication mechanisms</th>
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</thead>
<tbody>
<tr>
<td>Objective 4.2</td>
<td>Support governance and policy capacity</td>
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<tr>
<td>Objective 4.3</td>
<td>Pursue sustainability in infrastructure and funding</td>
</tr>
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</table>
CMHA’s wide-ranging national network affords opportunity for discussion, consideration and review of good service delivery models, leading to improved outcomes and collaborations with our public, private, primary healthcare and community sector service delivery partners. CMHA has a record of achieving excellent representation for people affected by mental illness, our members and other organisations.

As a national coalition CMHA also offer the following:

• Understanding of the variation in needs, barriers, and reporting requirements across 22 funding bodies nationally
• A streamlined and independent voice for the community managed sector in national and cross-agency policy advice
• Deep understanding of the community managed mental health sector through the eight state/territory community sector mental health peak bodies
• A mechanism to deliver consistent, high quality organisational support to the community managed mental health sector.

CMHA supports its members and their affiliates to continue the vital work of mental health recovery and social inclusion. Through supporting the work of CMHA and its affiliates, the ultimate goal of mental health recovery, stigma reduction and a more inclusive Australia for individuals, families, and carers will be closer to being achieved.

At a national, state and local level, CMHA aims to:

• Build on the evidence base for community mental health programs, recovery services and consumer and carer groups supported by not-for-profit and non-government agencies
• Expand the options available to enable people with a mental illness to recover in their own homes and communities
• Influence government decision-making related to mental health and other key social justice and social inclusion issues
• Increase the ratio of mental health funding allocated to support quality community managed mental health services
• Promote and strengthen the capacity of the community mental health sector across Australia
• Establish effective partnerships with stakeholders to achieve shared mental health reform goals
• Share the knowledge, resources and capacities of state/ territory community mental health services
• Drive innovation and promote new models and programs based on recovery and social inclusion
• Work together to build unity and enable coalition members to be effective in their individual and collective leadership and advocacy roles.
Appendix 1: Contact Details for CMHA Coalition Members

Appendix 2: Brief History of the Community Managed Mental Health Sector

Appendix 3: Glossary
## Appendix I  Contact Details for CMHA Coalition Members

<table>
<thead>
<tr>
<th>Region</th>
<th>Name</th>
<th>Position</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>ACT</td>
<td>Ian Rentsch</td>
<td>CEO</td>
<td>Mental Health Community Coalition ACT</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td><a href="mailto:ian.rentsch@mhccact.org.au">ian.rentsch@mhccact.org.au</a></td>
</tr>
<tr>
<td>NSW</td>
<td>Jenna Bateman</td>
<td>CEO</td>
<td>Mental Health Coordinating Council</td>
</tr>
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<td></td>
<td></td>
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<td><a href="mailto:jenna@mhcc.org.au">jenna@mhcc.org.au</a></td>
</tr>
<tr>
<td>NT</td>
<td>Nfanwy Welsh</td>
<td>Executive Officer</td>
<td>NT Mental Health Coalition</td>
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<td></td>
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<td><a href="mailto:nfanwy@ntmhc.org.au">nfanwy@ntmhc.org.au</a></td>
</tr>
<tr>
<td>QLD</td>
<td>Richard Nelson</td>
<td>CEO</td>
<td>Queensland Alliance for Mental Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="mailto:rnelson@qldalliance.org.au">rnelson@qldalliance.org.au</a></td>
</tr>
<tr>
<td>SA</td>
<td>Geoff Harris</td>
<td>Executive Director</td>
<td>Mental Health Coalition South Australia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="mailto:geoff@mhcsa.org.au">geoff@mhcsa.org.au</a></td>
</tr>
<tr>
<td>TAS</td>
<td>Darren Carr</td>
<td>Executive Officer</td>
<td>Mental Health Council of Tasmania</td>
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<tr>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>VIC</td>
<td>Kim Koop</td>
<td>CEO</td>
<td>Psychiatric Disability Services of Victoria (VICSERV)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="mailto:k.koop@vicserv.org.au">k.koop@vicserv.org.au</a></td>
</tr>
<tr>
<td>WA</td>
<td>Rod Astbury</td>
<td>Executive Director</td>
<td>WA Association for Mental Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="mailto:rastbury@waamh.org.au">rastbury@waamh.org.au</a></td>
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</tbody>
</table>

**Note:** The CMHA secretariat can be contacted at admin@cmha.org.au.
Appendix 2

Brief History of the Community Managed Mental Health Sector

Community managed organisations have extensive expertise and a long history of supporting social inclusion and recovery from mental illness for over 100 years. Unfortunately, the history of the sector has not been well documented. The following content on the history of the sector is adapted from a presentation made at the 2008 VICSERV Conference as an important step towards documenting that history.  

In the early 1900s, the rights of the mentally ill were championed by what was then known as the Lunacy Reform League. The first documented community managed mental health service in Australia was the Aftercare Association which was established in 1907 to provide discharged psychiatric patients with residential care. The return of traumatised war veterans hastened the call for mental health services in the community and the NSW Association for Mental Health was established in 1932 and set about lobbying for a broader range of both treatment and support services. Similar associations were established in other states and territories in the latter half of the twentieth century.

In the 1940’s in Victoria, Prahran Mission established a voluntary drop-in centre which was increasingly used by people discharged from mental institutions. The 1950’s saw the establishment of what is now known as Psychiatric Rehabilitation Australia (PRA) reflecting a shift from charitable to more professional approaches within the sector including the use of self-help and peer support approaches. PRA was one of the first community managed organisations (CMOs) to receive government funding and did so reluctantly fearing loss of independence and ability to speak out and, if necessary, criticise government mental health policy (a realistic fear that continues for many government-funded CMOs to this day).

Many other CMOs and peak bodies emerged during the 1960s, 70s and 80s coinciding with large scale deinstitutionalisation including: GROW (originally known as Recovery); the Richmond Fellowship; the Association of Relatives and Friends of the Mentally Ill (ARAFMI); and, the Schizophrenia Fellowship. These organisations provided an increasingly diverse range of services which characterise the sector to this day. In this era, optimism was growing about the capacity for recovery and participation in the community but medical models which focused on diagnosis and treatment rather than functional strengths and participation continued to hold sway in both policy and practice. Government acknowledgement and support for the developing community mental health sector was severely limited in both vision and financial commitment and community organisations were mostly seen to function as a complimentary but non-essential and cheaper alternative to professional services. This policy context perhaps explains the failure of governments to transfer resources both during the early phases of deinstitutionalisation and some might argue, still.

Peak mental health organisations formed in the mid-1980s in NSW and Victoria (with the Mental Health Coordinating Council and VICSERV respectively) and now exist in every state and territory and speak collectively through the Community Mental Health Australia (CMHA) coalition.

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What's in a name …

A number of terms are used — both historically and currently — to describe the community managed mental health sector, including:

- Not-for-profit (NFP) sector
- Community sector mental health services
- Mental health non-government organisations (NGOs)
- Mental health community managed organisations (CMOs)
- In Victoria, Psychiatric Disability Rehabilitation and Support Services (PDRSS)
- The Third Sector — as defined by Lyons and as utilised in the National Compact 187

The defining characteristic of these organisations and their services are that they form in response to unmet need in communities and are innovative, flexible and responsive in finding person-centred solutions to what are often complex and diverse health and social problems.

Access  Ability of consumers or potential consumers to obtain required or available services when needed or within an appropriate time.

Advocacy  Consumers and carers speaking on their own behalf or being represented by others where this support may be required.

Advocates  People who have been chosen by, and are accountable to, people affected by mental health problems to seek the outcomes preferred by consumers and/or carers.

Appropriate  Services provided relevant to consumer needs and based on relevant standards.

Available  Information and services present in the area where a person lives.

Care  Services provided to a person with a mental health problem.

(Mental Health) Carer  A person with lived experience of caring for someone with a mental health problem. This can be a family member, friend or service provider — either in a paid or unpaid role.

Consumer  Used respectfully in this publication to refer to a person with lived experience of mental illness and/or recovery who uses — or has used — treatment, rehabilitation and/or support services. ‘Person-first’ language is preferred, however, the terms ‘consumer’, ‘client’, etc. are also used. What is most important is that we recognise and express that we are all people — sometimes being helped by, and at other times helping other people. It is not ‘them and us’ — it is ‘all of us’.

Coordinate  To bring together in a common or harmonious action or effort.

Community Based Mental Health Services  Mental health services that are based in the community; they may be public, private or community managed.

Community Managed Mental Health Service  A health or community service provided to people affected by mental illness by a community managed organisation.

Community Managed Organisation  Private, not-for-profit organisations that flexibly respond to the identified, unmet needs of communities and are managed by a board of representative and elected community members.

Community Mental Health Sector  Mental health services delivered in a community setting; these may be provided by organisations operating in the public, private and/or non-government community managed sectors.

The CMHA 'Taking Our Place' glossary was derived following a review of terms relevant to this publication used in: the National Mental Health Strategy publication glossaries; the 2011 NMHCCF 'Unravelling Psychosocial Disability' publication; and the Our Consumer Place (2011) 'Psychobabble' publication.
Community Managed Mental Health Sector
The collective of all community managed organisations delivering programs and services to people affected by mental illness, and their families and friends.

Disability
The umbrella term for any or all of an impairment of body structure or function, a limitation in activities or a restriction in participation.

Disability Discrimination
Any distinction, exclusion or restriction on the basis of a disability that has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise — on an equal basis with others — of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Effective
Producing the intended or expected result.

Evaluation
Judging the value of something by gathering information about it in a systematic way and making a comparison.

Evidence Based Practice
The term used where a service provider systematically finds, appraises, and uses the most current and valid research/evaluation findings as the basis for service delivery (i.e. practice) while also being mindful of people’s choices and preferences for services.

Families and Carers
People who have lived experience of caring for people with mental illness; the degree of unpaid support provided can vary and they may or may not be biologically related.

Human Rights
The basic rights and freedoms to which all humans are entitled, often held to include the right to life and liberty, freedom of thought and expression, and equality before the law.

Integration
The act of combining or adding parts to make a unified whole — in this case, health and community services to address the complex and diverse health and social needs of people affected by mental health problems.

Lived Experience (of mental illness/recovery)
The condition of having or having had, a mental health problem and obtaining help and services to address this.

Medical Model
Focused on the physical and biological aspects of specific diseases and conditions.

Mental Health
A state of complete physical, mental and social well-being and is not merely the absence of disease (in Aboriginal communities this incorporates community managed approaches to ‘social and emotional’ well-being).
Mental Health Problem
This includes a broad range of health and social features that characterise a ‘mental illness’, whether diagnosed or not.

Mental Health Services
Provide community support, rehabilitation or treatment for people affected by mental illness/psychosocial disability, and their families and carers. Mental health services may be provided by organisations operating in the public, private and non-government community managed sector.

Mental Illness
A diagnosable disorder that significantly interferes with an individual’s cognitive, emotional or social abilities, whether diagnosed or not.

Mental Health Worker
A broad, generic term that encompasses people who work in mental health service delivery, regardless of role, training or qualifications.

Non Government Organisation
Private organisations that may or may not be not-for-profit.

Peer
A person who has equal standing with another or others.

Peer Worker
A person with lived experience of mental illness that provides services to others affected by mental health problems; lived experience of recovery is an essential criteria of this job role.

Peer Support
Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems to others sharing a similar mental health condition.

Program
A structural component of an organisation’s activities, usually managed with specific resources, funding and funding sources.

Psychosocial Disability
Disability associated with a person’s psychosocial experiences.

Psychosocial Rehabilitation
The process of restoration of community functioning and well-being of an individual who has a psychosocial disability; it seeks to effect changes in a person’s environment and in a person’s ability to deal with his/her environment. 189

Research
An original investigation undertaken to gain knowledge, understanding and insight.

Recovery
A deeply personal, unique process of changing one’s attitudes, values and feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability. 190

189 This is also sometimes referred to as psychiatric rehabilitation.
190 The terms psychosocial/psychiatric disability are often used interchangeably.
Recovery Oriented Service Provision
Acknowledges that the person with lived experience of mental illness is the expert in their unique recovery journey and this is the organising principle for service delivery.

Service/s
Work done for others as an occupation or business.

Service Provider
A person, usually with professional qualifications, who receives remuneration for providing services.

Service Taxonomy
A formal classification list of identified and named organisation activities. Taxonomies tend to be formalised lists used for evaluation and planning of services and are usually devised with clear classification principles (e.g. hierarchies, mutual exclusivity, equivalent measurement units, etc.).

Service Typology
An informal classification list of identified and named organisation activities. Typologies can be any quantitatively or qualitatively constructed set of activities based on declared assumptions.

Social Inclusion
Having the resources, opportunities and capability to learn, work, engage in the community and have a voice.

Social Model
Recognises the effect of social, economic, cultural and political factors and conditions on health and well-being.

Stigma
A distinguishing personal trait that is perceived as or actually is physically, socially, or psychologically disadvantageous (i.e. discriminatory).

Support
Services provided to reduce disability and promote community participation.

Talking Therapies
An alternative name used to describe a variety of psychotherapy and counselling approaches.

Trauma
A distressing emotional experience that can create significant and lasting damage to a person’s mental, physical and emotional growth.

Trauma Informed
To take into account knowledge about trauma — its impact, interpersonal dynamic, and paths to recovery — and incorporate this knowledge into all aspects of service delivery.

Treatment
Specific physical, psychological and social interventions provided by health professionals aimed at the reduction of impairment and disability and/or the maintenance of current level of functioning.