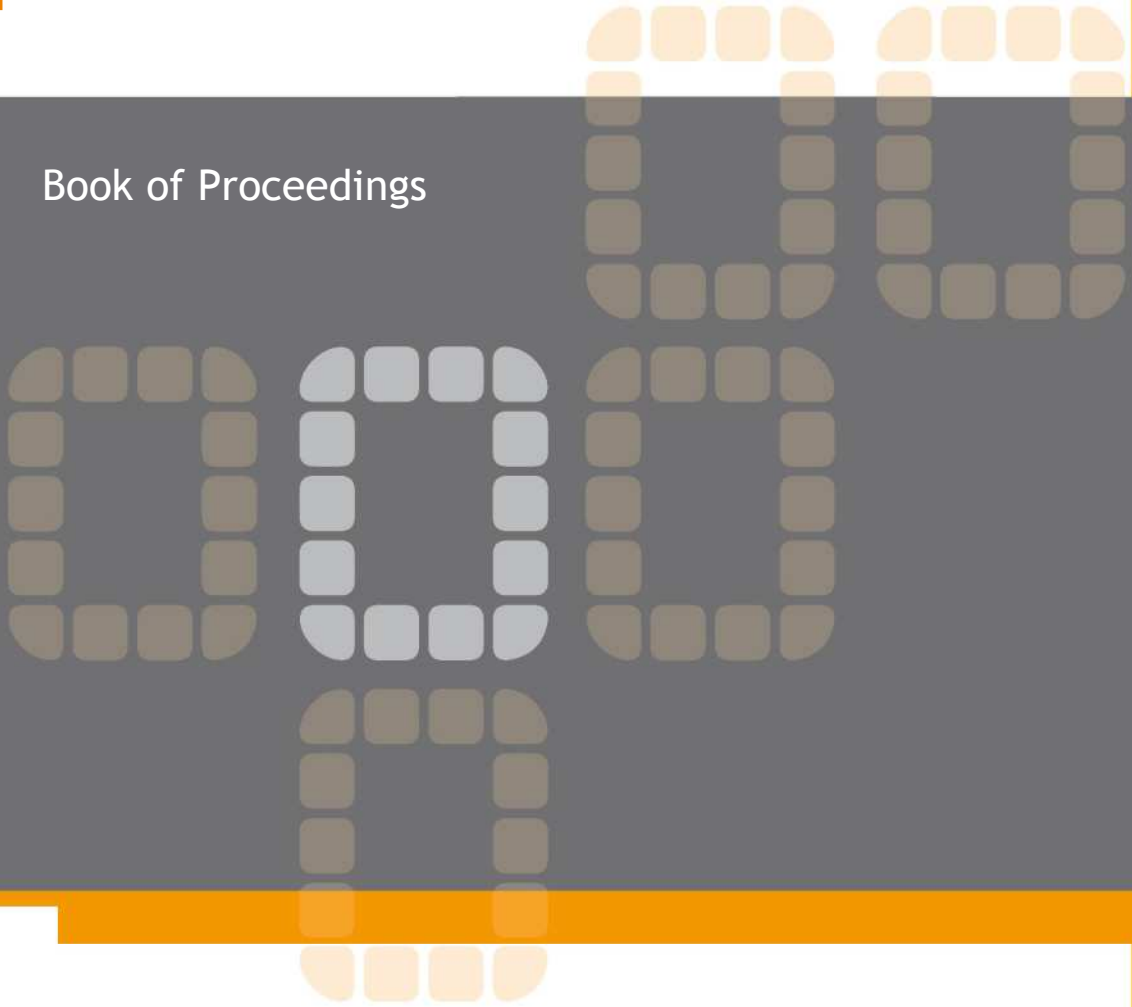
Mental Health Community Network
Open Space Forum
4 April 2008

Book of Proceedings



the question?

What can we ALL do to better the mental health of ALL West Australians?

Department of Health

Disclaimer:

This Book of Proceedings is provided as a record of the discussions which took place on 4 April 2008 at the Mental Health Community Network Forum in Perth.

The records of each discussion, made by the participants, have been presented here in their original form, with amendments being avoided except where necessary to clarify meaning. If participants feel that this record does not accurately reflect the discussion, that vital information was omitted or was incorrect, it is recommended that they contact the Mental Health Division on 9222 4099 to make a record of this.

The views and opinions represented in this document do not necessarily reflect the views of the Department of Health WA.

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TOGETHER WE CAN SHAPE THE FUTURE

Help shape the vision for mental health in Western Australia

Do you feel passionate about mental health?

Do you want to be part of a lively, open and inclusive discussion regarding mental health in Western Australia?

Then come along and share your passion, ideas and thoughts over the question:

What can we ALL do to better the mental health of ALL West Australians?

The WA Mental Health Community Network will soon host the first of a series of Open Space forums. The forums will facilitate community input into WA mental health planning and public policy development. Health Minister, Jim McGinty, will give the opening address at the inaugural forum.

Forum discussion groups will follow the method of Open Space Technology, "a philosophy, practice and process that enables groups of any size to come together around complex, important issues and accomplish something meaningful." (Peggy Holman, Founder of The Open Circle Company)

- YOU will create the agenda.
- YOU will be able to move freely from group to group and contribute as you consider best.
- All discussion will be captured in a Book of Proceedings that will be made available to the public.

Date: Friday 4 April 2008
Time: 8.30am - 4:30pm
Venue: Boundary Room, WACA, Gate 2, Nelson Crescent, East Perth
Bookings: by 28 March 2008 on (08) 9222 4099 or mentalhealthreception.royalst@health.wa.gov.au

All are welcome, including community members, consumers, carers, health professionals and service providers. Lunch and refreshments are provided. Bookings are essential.

Mental health Open Space forums will be held over the next two years throughout WA.

We look forward to your participation.

Dr Steve Patchett
Executive Director
Mental Health

What happened?

On Friday 4 April 2008, a forum was held to address the question:

What can we ALL do to better the mental health of ALL West Australians?

Community members, consumers, carers, health professionals, policy makers, Non-Government Organisation representatives and service providers gathered to consider this question using the method of Open Space Technology.

Together, they created the agenda for the day at the Market Place and were free to attend, move between and contribute to discussions as they wished. A summary of each discussion was recorded on the day, which have all now been compiled to form this Book of Proceedings.

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* NDR – No Discussion Recorded

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* NDR – No Discussion Recorded

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* NDR – No Discussion Recorded

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Session Code:	**1A**
Session Title:	**Child, Adolescent & Youth Mental Health Services**
Initiator:	**Barry Nurcombe**
Recorder:	**Patrick Marwick**
Participants (initials):	**MC, PM, LL1, BN, EO, JL1, MW2, DH2, GW, AF2, WS2, JT, MJ1, PS2, AW3, DF, JF4, JM, DT1, RL, PF**

- Under funded, limited advocacy, benign neglect; demoralisation of services
- Children & adolescents 25% of population, 10.8% of mental health services budget
- Poor representation in decision making
- Inpatient beds inadequate – need 15 beds in North Metro area
- Less than 1% have access to mental health services; priority to acute adolescent presentation; no dedicated infant mental health services
- Lack of equity – prioritisation needs to be carefully determined – children in care, ATSI, homeless young people
- Parents view – need for appropriate inpatient services and specialist community services for young people
- Continuity of care across inpatient and community services - Community responsiveness not just clinic based.
- Adult inpatient facilities not appropriate for young people
- Community sector poorly resourced.
- Lack of investment in children – need for a coordinated plan for children
- Young people discouraged from accessing adult mental health services
- Need for preventative mental health first aid: need for greater understanding in emergency depts.
- Lack of capacity for responding to emergency presentations in the community
- Children are our present - need for parenting training programs
- Need to focus on prevention and early intervention.
- Lack of tier 1 and 2 services
- Need for partnerships with consumers and carers e.g. family Advisory Council
- Well supported consumer/carer infrastructure
- Consumer/youth council supported with dedicated staff
- Prevention based on early intervention with services to infants
- Good evidence to support intervention with preschool aged children
- Need for interagency coordination at DG level – co-location of services for children
- Solo structures problematic.
- Need population needs based planning to know what the needs in the community are.

Session Code: **1B**

Session Title: **The Future Development of Mental Health Nursing**

Initiator: **Jan Price**

Recorder:

Participants (initials): **JP, MT, JB, PA, AJ2, UL, LH, TB, MZ, ZZ, DB, SH, DP, RE, PO, KH, JD, DC**

Concerns regarding attraction and retention of mental health nurses

- System not supporting the promotion of nurses
  - Require they change their award although they require the qualification (for management)
- No training facility for MH nurses
- UK nurses better trained - empower current WA MH nurses - access to training.
- Specific course for MH Nursing not associated with general nursing.
- No experience required for working within mental health hostels.
- Perceive increased needs as a training provider to increase competency – hands on!
- Stand alone course for mental health nursing – only enrolled nurses.
- RMHN too paperwork associated practice.
- MH Nursing need to make a stand. Prominence of mental health nursing.
- Risk issues – MH Nurses not taking responsibility for risk.
- Acknowledge fabulous work that nurses do – they do make a difference. Nurses not given information on outside resources – how well equipped are they!
- Huge variety of skills in nurses – cultural issues. All nurses in office. Seclusion misused. Culture needs changing in locked wards. Not sufficient OT. Risk issues for nurses. Increase staff, lower morale. Lack of support. Quality of nurses is a problem.
- MH Nurses – more political forum, nursing needs to be hands on – decrease paperwork.
- Shortage of nurses – recruitment and retention. Work practice flexibility. No specialist training for MH nursing.
- Not a clinical career structure for recognition of expertise.
- Nurse practitioner preparation by appropriate persons.
- Quality of teaching in university is poor.
- Undergraduate program in nursing is insufficient. Glamorisation of general side vs mental health - frightening without support.
- Specialised MH areas – community, CAMHS
- Credentialed MH Nursing, private practice, special interest group. Direction and definition of MH Nurses.
- Other disciplines specialising in mental health. E.g. SW, OT – no solid base for MH
- Best outcome for client.

- What is support and treatment for client?
- Identify care pathways - consistency.
- University programs – relevant, well prepared, knowledge about models in MH nursing. Work with people - not just about Acts.

Key Messages

- Mental health is specialised and every person should have mental health knowledge that works with a patient
- Adequate training to equip nurses to be deliverers of comprehensive treatment
- MH college have higher profile
- Forum on adequate training of MH nursing does it need to be university based or TAFE?
- Self efficacy with patient care.
- Practice MH nurses recruitment. Incentive program. Credentialing is a convoluted cumbersome process.
- Retention of MH nurses (20 yrs on) - alignment of general nurses i.e. hours in patient day as a "restorative Unit"
- Understaffed.
- Drugs - ? Mental Health? As individual people vs diagnoses.
- Nurses not supported
- Not just about nurses it is also about everyone else in the community and taking responsibility.
- How do MH Nurses control their practice (in whatever setting)
    - Autonomy – MAGNET hospitals – a system which provides autonomy in these 12 hospitals.
    - Cost of professional MH education i.e. ability to attend due to work setting needs.
    - Coordinated approach to provide professional development and incentive to become "transformed".
- No adequate compensation for people to develop themselves as MH nurses. (coordinated industry/education approach)
- Too hard to do professional development as a MH Nurse.
- Development of practitioners who do untold good – change the system to provide role models for the future MH nurses (benchmarking i.e. KPI's important standard development tools).
- Two models of care
    - Continuum of care for all patients –(seamless service)
    - Silos (patients must fit service criteria)
- Creativity as MH nurses produce results for clients.

CONCLUSION:

A definitive need to have Training (as in higher education) and practice forum, called 'Training & Practice Forum' ASAP.

Session Code:	**1C**
Session Title:	**Barriers of Confidentiality for parental carers & Care Plan Management**
Initiator:	**Idoia Mosterin & Donald**
Recorder:	**Penny Thomas**
Participants (initials):	**MB1, CS2, BK1, SV, AG, AB3, BC1, KR, WS1, PM3, LL2, ZZ**

- Frustration with lack of communication with family to ask for background information
- Care should follow people throughout the state (i.e. not just changing clinics as they move suburb)
- Consumers are able to pull wool over the eyes of clinicians and therefore don't get treatment = "stock-standard" answers
- Family know better than anyone how the person is functioning
- Carers' Act. Carers' charter. Clinicians are not recognising the act. Clinicians need to be provided with education regarding this. Updated contact numbers need to be included in the Act Information (one carer tried to phone up about their rights and the numbers had been changed).
- Could Carer organisations please update the contact details to make the acts more accessible
- Provide information regarding the acts to carers on wards
- When people are discharged from hospital – sometimes hard to follow-up especially if the client is moving to a regional area where NGOs are not necessarily given discharge plans etc.
- All care plans need to follow the person from hospital -> clinics -> NGOs etc. Consumers and Carers should receive a copy.
- Care-plan in hospital that the consumer needs to agree to before discharge from hospital and they should be returned to hospital if they don't comply at home.
- Discussion re PSOLIS as a statewide database
- Discussion re National standards etc set up to protect rights of carers
- People are escaping from hospital because they can.
- Patient's minds are not being kept active in hospital (TV, zombies)
- Care-plans should include not just medication but activities
- "We bandy around the term recovery but we don't know what it means"
- Need for individualised Occupational Therapy (i.e. what the person likes)
- Nothing for them on weekends. Nothing for them when they get out of hospital.
- Too much time to think about illness/ suicide
- **"People in prison get more rehabilitation than people with a mental illness."**
- We don't do rehabilitation well in WA
- Too much focus on medication. Not enough psychological treatments.
- People should be forced to do occupational therapy
- Law should allow people to be forced into psychological treatments
- People are not getting referred enough to rehab services and NGO's. Clinicians need to follow-up more with referring on.
- Case workers are only seeing people for medication

- Need to be more people on involuntary treatment until their illness is better managed
- Look at other states re ability to force patient into treatment
- Families are frustrated by not enough involuntary treatment options
- Develop specific treatment plans/ management plans
- NGOs need compulsory sharing of information – for the safety of consumers, carers and staff. Background info on discharge.
- People who are over 18 don't necessarily have the ability to provide informed consent – just because they are over 18. (Illness)
- WA doesn't have a strong enough lobby group to allow changes to be made.
- The only time anyone will intervene sometimes is if there is a risk to the person or their family. Sometimes we would be better off if our son/ daughter was unsafe – at least we would get treatment.
- Everything in the system is "reactive" – only dealing with the most unwell and the tip of the iceberg.
- Alternative mental health treatments/ workers
- Too many talk fests, too many project officers, not enough $ on the ground
- Its polarised towards the patient – there are too many rights for the patient and not enough for the family
- Human Rights of the family and client should be equal/ balanced.
- Participation from all involved.
- Instead of an "or" state we need an "and" state (i.e. it's about the rights of both parties, not family at expense of client or vice versa.)
- Needs to be a complete review of funding in the system
- Needs to be more $ in the community (not hospitals)
- Care-plans need to be an ongoing conversation
- Consumers report they have never seen a care-plan
- Staff are under tremendous pressure; staff aren't able to work they way they want to. Lobby for more staff
- People need to take responsibility for their own recovery. Not everyone can!
- People could write their own personalised care-plans
- No discharge planning. Clinicians & family are not advised when a person is discharged from hospital
- Wellness Recovery Action Plans (like run by RUAH) need to be introduced in all services
- NGOs seem to be providing better service than government services
- Services are not being creative enough
- More $ on MH services – HOW???
- NGO's aren't getting enough $ to keep good staff. Why would a psychologist work for small pay when they can get 2-3 x more in public/ govt.?
- Educate teachers etc re prevention/ early intervention/ promotion
- Discussed wasted money on Neale Fong's office.

Main points:

- Carers are frustrated at not having enough rights with regard to their family member's treatment
- Families would like services to enforce treatment more, especially until the person is recovered and better able to make informed decisions

What can we ALL do to better the mental health of ALL West Australians?

- Needs to be more services available – esp. non-medical (i.e. Occupational Therapy, psychology, alternative therapies)
- Care-plans need to be developed with all consumers – and developed in collaboration with all parties (family, consumer, NGO's, clinics etc)
- Care-plans and treatments need to follow people wherever they go rather than change by suburb

Session Code:	**1D**
Session Title:	**Preventative Mental Health Strategies**
Initiator:	**Lavinia Scott-Sellars**
Recorder:	**Sally McCallum**
Participants (initials):	**LS2, DL1, SM4, PC2, JS1, PO1, ID, AS, LS1, KM3, JB2, AB3, JP2, SB2, AH2, KS2, VP1, CT**

CONSUMER VIEW

- A mental health consumer in the group wishes for a drug free therapy to help maintain mental health
- Also wishes for alternative therapies to be available to mental health patients and outpatients.

PREVENTATIVE MENTAL HEALTH STRATEGY

Lavinia Scott-Sellars from the International Association for Human Values (MOB: 0411 614 900 or iahvaustralia@iinet.net.au) initiated the discussion from her typed notes, which included the following points:

- Preventative health strategies are in place for the body and anti-social behaviours
- But few sustainable mental health strategies are in place in schools or communities
- The mind and how it works is largely unknown to citizens and professionals alike
- Global foundations (www.iahv.org) and are currently introducing deeper knowledge of the mind, tools to re-balance the body mind complex and relieve stress to governments, educators and communities – some 40 million people have benefited in 150 countries.
- There are rhythms in nature and in human beings. Through trauma, accidents, ill health or stress, the rhythms in our physical, emotional and mental bodies become out of sync and the body mind complex gets stressed. Mental or physical ill health may follow.
- The mental health technique **'SUDARSHAN KRIYA'** (www.aol.research.org) resets the inner rhythms each time it is practices, returning the body mind to equilibrium.
- The technique cleanses the mind from stress, bad memories of the past and anxiety about the future.
- It is a drug free therapy which supports other mental health therapies and treatments.
- SUDARSHAN KRIYA practice boosts the resilience factors which mediate tendencies towards violence, addictions, self farm, depression and traumatic flashbacks, post traumatic stress disorder.
- It can be learned at any age and education and socio economic status, language, culture or faith is no barrier.

- Beneficial in diverse situations – prisons, veterans, conflict areas, youth empowerment, personal well being and community renewal.

DISCUSSION FROM THE FLOOR

Openness required from Health and Education Departments

- The SUDARSHAN KRIYA breathing technique is a suggestion only as a supportive therapy and is not suggested as a universal panacea for mental ill health.
- A wide range of strategies could be introduced to reduce stress levels across the life span.
- The Education and Health Departments should open themselves to assistance from community groups who can provide this input kind of input to mental health programs.
- Some preventative activities are available in schools -like sport - but this encourages competitiveness, leaving less capable students out. Care should be taken to decrease and not increase stress.

Gender Specific vs Generic Programs

- There is too much emphasis on 'one size fits all' programs with little regard to gender issues. For example, most successful suicides are males and males are conditioned to not to ask for help.

Funding

- However, it was acknowledged that prevention programs should ideally be both generic and gender specific.
- The group was concerned that funding cuts have removed many school based life and wellness programs
- Some school programs are insufficiently funded with only 1 or 2 professionals assigned to the entire WA.

Mental Health Units for Schools

- These units should be introduced to the education system.
- Reintroduce programs which have lost funding.
- Schools need to be a place where mental health is promoted and discussed as integral to the school environment and culture.

Community Involvement

- Communities should accept responsibility for keeping themselves strong and looking after people in the community.
- There should be greater community connectedness – neighbours.
- Nowhere are we taught, except a little by our parents maybe, how to handle life experiences – stress, parenting, relationships, our emotions.
- Parenting skills should improve and parenting programs funded.

Research

- Research should be undertaken to explore **WELLNESS** rather than **ILLNESS.**

Drugs

- Drugs seem a logical self medication for some people who cannot handle stress.

- Drug abuse may seem like a logical solution to a problem – but the critical question is … what is the problem? Let's address the problem itself.

Emotional Issues

- Sharing emotional issues is an important preventative factor for mental health.
- We need to investigate why this happens more easily for women than for men, and what can be done to help men in this regard.
- Often people are treated for anger management when the real problem is depression. If the depression goes, the anger goes.
- Bigger issue is the emotional aspect of our being is integral and normal.
- How can we help people to understand their emotions and express their sensitive side? How can we encourage an alternative healthy expression?

Bringing the message to the masses

- Work at grass roots level, doing the ordinary things we are all doing.
- Work at all levels (state and local government, schools)
- Break down the barriers in schools, communities, shopping centres, community centres and through art shows, discussions etc.
- Normalise and de-stigmatise mental illness by bringing it to the people.

Recognition at Government Level

- Responsibility at state and local government is required
- Government to understand the link between mental and physical health
- Also the impact of environment on mental and physical health – town planners take note!
- Cooperation and collaboration is vital between those with the knowledge and experience and those with the money and power.

Session Code:	**1E**
Session Title:	**Possibilities (Not Limitations) of Health and consciousness in a crazy world**
Initiator:	**Josephine Wright**
Recorder:	**Josephine Wright**
Participants (initials):	**DC, KB1, CM1, JC3, JP4**

POSITIVE NOTIONS
Life is expansion
Life is a gift / fun
Life is exciting
Labels are a limitation, sentence.
Why do we believe other people's opinions when my own opinion is just as valid?
What is mental illness? What is energy?
What is wellness?
We live in an unconscious / insane world – fighting for peace (and loosing peace).
So what is the place of consciousness?
What is the place of what is called God, or high consciousness, or Holy Spirit, or earth intelligence in our lives?
How do we access change in our lives?
Three requisites:

1. desire for change
2. perseverance
3. a facilitator (type of wise person, holy spirit)

If our 'sane', 'logical' minds are so good, why do we have all these problems? A mind working differently could be an asset.
Why is a person labelled 'insane'? Because of labels like 'stupid', or self judgements, self hate, and unworthiness. Or emotions of anger, loneliness, disappointment.
Jesus talked about people as:

1. infinite beings
2. being released from their prison
3. as incredible gifts
4. life being great joy

Are these pillars relevant in today's world? Emphatically YES.
Whether I use the name of Jesus or not I can use the language of quantum biophysics.
I, who have seen very smart people lose their mind, and be labelled mentally ill.
My awareness is that these can be facilitated into a different reality / life. A tool bag for life. The keys to self healing – the only healing.
Need to look/approach mental health holistically.
Staff lack nurtured society so fragmenting not integrating.
Why do 'experts' never listen to Mum?

My work called Access Consciousness is working with subtle energy to uncover the power of the sub-conscious mind and belief systems. The availability of CHOICE and

the power to uncreate the dysfunctional mind and life and create differently. It is just the thought and then the deed. A thought is an energy pulse. Learn to use energy and have it work for you. The rules of logic do not work the same way in the MIND. Mine fields of energy and consciousness – the REAL WORLD.

Session Code:	**1F**
Session Title:	**Mental Health for those from Different Cultural Backgrounds**
Initiator	**Dr Rosie Rooney**
Recorder	**Dr Rosie Rooney**
Participants (initials):	**RR, SH, GB, PB, PS, and various others (total 14)**

Summary ideas:

1. **Mental health services are lacking** for those from Culturally and Linguistically Diverse Backgrounds (CALD).

2. **Some areas in urgent need** include Alzheimer's, Parkinson's and Depression
    a. **Professionals want to assess** these problems and there is one test, Feldstein's Mini Mental, which is culturally inappropriate for Non-English Speaking people as it was developed on White Anglo-Saxons. For example you need to spell WORLD backwards which is not phonetically spelled so anyone from a Non-English-Speaking-Background is automatically at a disadvantage. It makes it very hard to pass this item rendering the score inaccurate. One test that had been created in Australia which has been designed specifically for CALD is the RUDAS and this measure needs to be promoted for wide-spread use in Western Australia. In summary, there is a need for specific culturally validated tests in Western Australia. A further consequence of this is that people receive access to medication based on an unscientific invalid measurement.

3. **Access to interpreting services is reduced** across the board for those from CALD backgrounds. In the past, interpreting services were free. The department of Immigration started to introduce costs with cost recovery. Now interpreting is managed through private enterprise which means interpreters are underpaid so it is not possible to make a living and consequently, people from ethnic groups don't get this much needed service. Although interpreting over the phone can be more easily accessed, it doesn't work as it is not sensitive enough to deal with issues that emerge in this very vulnerable population, e.g., being informed that they need to be committed or have a breast removal over the phone is inappropriate. People who are interpreting need to be in the room with people from CALD backgrounds with mental health issues.
    a. **A multicultural mental health grant** obtained by one attendee from a North Perth Community centre who said that they are hoping to provide non-professional interpreters as support for CALD who are mentally ill in crisis etc.

4. **Substantive Equality Policy needs to be applied to government policy for mental health services in Western Australia**: Substantive Equality Policy is a policy that emerged as a result of anti-racism and discrimination issues. It

includes the central idea that services need to be culturally sensitive and specific.

a. Transcultural mental healthcare services need to be where people from CALD backgrounds live, in the community and it should involve whatever is right for their community, it would be up to each community to assess and decide.
b. It takes time to determine who the ethnic leaders are for each community which is one important reason why cultural informants need to be used.

Action: Adopt substantive equality policy in WA.

5. **Children from CALD backgrounds and those with a parent with a mental illness** are at high risk and less likely to be identified and therefore helped or have a chance of accessing services. They will have a variety of different issues;
    a. There are some community and family structures that can help, we need more work on contacting cultural groups and building bridges between the government and cultural groups.

6. **Aboriginal mental health** needs more representatives to attend forums, need more forums on Aboriginal mental health.

7. **GP's and health professionals** in general need to be far more culturally aware and sensitive. For example, hearing voices may be normal in children in a variety of cultures including Aboriginal cultures

    a. Too much prescription of medications such as anti-depressants which has not been assessed in a thorough culturally sensitive fashion;
    b. Psychological or supportive or culturally sensitive therapy from the person's explanatory model can be more helpful than therapy

Action: Need comprehensive cultural management training across professionals in Western Australia.

8. **Migrants are particularly at risk** of mental health problems as they have re-located which is a highly stressful process and research shows that stress is associated with a higher incidence of mental illness.

9. **Culturally specific mental health professionals** are needed. We need to get culturally specific professionals (e.g., Polish social workers) to be brought out of mainstream services and better utilised in supporting CALD Polish services.
    a. A directory and network needed for those from CALD backgrounds, can be mentors etc.

10. There are some great centres and services , e.g., Ethnic Community Council, ISHAR, ASSETTS, Transcultural Mental Health Centre, Fremantle migrant resource centre (example given 20 years ago) who really helped on attendee with mentoring, getting a job etc which made all the differences. These services need to be supported.

Action: What we need is to make an **inventory** of services available and **coordinate** services at a multi level, e.g., English proficiency, getting a job, finding a house as these things are all stressors that can trigger mental illness, a preventative approach. Integrated services centre in Parkwood, funded by the office of multicultural interests, if found to be effective after evaluation could be used as a model of multicultural mental health service provision.

11. **Getting into CALD women's homes** can be a problem as they have young children and are very isolated. Many basic needs can be lacking, housing, English classes, child care.

Action: Centrelink could be used to help get information and access by assigning women to ethnic specific workers who speak their language and can coordinate the competing needs.

12. **Policy /guidelines** about how professionals **behave** towards those with a mental illness. Simple things like when you press a button to enter, there needs to be a button available to press in your own language. More translated materials and brochures available at all areas of service delivery, GP's included.

Action: There needs to guidelines/policy about behaviour towards CALD clients with a mental illness, e.g., Graylands example given where a man with schizophrenia was not treated with respect and was asked to do things that were beyond him in his mental state and appointments were not announced.

13. **Need more forums** with representatives from additional groups such as **African** communities as their needs are not being represented today.

14. A lack of focus at the preventative end: Need more prevention programs in communities, particularly with children, e.g., prevention of depression and anxiety etc.

15. The stigma of mental illness is a problem in people accessing services.

Action: reduce stigma and bring access into communities.

Recommendations:

1. Adopt Substantive Equality Policy;
2. Have more culturally sensitive assessments for problems such as Alzheimer's;
3. Have community based CALD mental health centres based on each communities' needs;
4. Better paid and trained interpreters and access face to face should be free;
5. Routine cultural sensitivity and CALD mental health management training for GP's and other health professionals;
6. Further forums to represent the needs of additional communities not represented in larger numbers here today such as Aboriginal and African communities;
7. There needs to guidelines/policy about behaviour towards CALD clients with a mental illness;

8. Make an inventory of CALD mental health services available and coordinate services at a multi level, e.g., English proficiency;
9. Centrelink could be used to help get information and access by assigning women or CALD people in need to ethnic specific workers who speak their language and can coordinate the competing needs;
10. More preventative approaches needed in communities to help build resilience and connectedness as support is very important;
11. Support existing services;
12. Reduce the stigma of mental illness in CALD and the general community.
13. Culturally specific mental health professionals are needed and should be streamlined into CALD mental health and taken out of mainstream mental health services so they can be better utilized;
14. More translated materials and brochures available at all areas of service delivery, GP's included.
15. Reduce stigma of mental illness in CALD communities and bring access to services into communities; build bridges between communities and government.

Session Code: **1G**

Session Title: **Treatment for Co-morbid MH & AOD**

Initiator: **Graeme Lamont**

Recorder:

Participants (initials): **JF, LG, CR, IW, PB, JG, LE, SM, AB, RM**

- Issues associated with co-morbidity are complex
- See more in NGO's
- Government services seen to fetter them (clients/patients) out
- Close the gap – provide seamless service to prevent clients to be bounced around
- Meds put on weight – clients self esteem suffers go back to using drugs to lose weight.
- MH clients treatment in prison not always appropriate i.e. prescription meds
- How drugs interact with prescription drugs
- Issues with clients keeping appointments with different agencies – risk lose touch with services including supported accommodation
- Issues of stigma/labelling – addict, mentally ill, mad or bad
- Treatment to follow medical models – drug treatment – money seems to be directed to medical programmes set up.
- Recommend government MH services see client as whole take holistic approach to address complexities. Including substance use, seamless service provision – fully integrated
- Alternative treatments
- Greater collaboration between services especially in crisis
- GP's first point of contact – appropriate knowledge, support, follow up.
- Consider/value client as expert over their own life
- Services adopt open door policy - available when needed – client centred care
- Take care of basic needs first
- Support to families – families, including children, needing more info in after care of family member once discharged
- Ongoing care and follow up even if difficult to engage client
- Funding bodies need to think holistically
- Consider in holistic approach who else is the expert of their client – parent, partner, child friend
- More vigilant assessment
- Acknowledge cost benefits of keeping people well employed, out of prison etc

Summary

- Holistic
- Systemic
- Person centred
- Combined drug and alcohol and MH clinic

- Equality of funding resources for service provision across government and NGO's (include time for programmes to be developed and evolve)
- Consider the impact of the stigma labels MAD, BAD, SAD that comes from lack of awareness
- Strategies to reduce 'burn out' in field – improved job satisfaction
- Client/consumer self worth therefore value increased
- Collaborative practice i.e. strong family forum.

Session Code:	**1H**
Session Title:	**Looking at Mental Health Holistically within Aboriginal Communities**
Initiator:	**Charmaine Derschow, Kerry-Ann Winmar, Dena Gower**
Recorder:	**Dena Gower**
Participants (initials):	**AL3, DG, PB, CD1, JB4, RH1, MM4, SM1, RD1, AL3, AF1, RM2, MC2, PB, JL3, KAW**

Discussion points:

- Lack of knowledge
- Services available
- Report on what's available in mainstream and the community
- Statewide Indigenous services
- Services and networks providing the support for all Aboriginal staff within the Health Department
- Functioning of appointments
- Health workers need to go out to the clients
- Mainstream not working for Aboriginal people
- Alice Springs workers go out to the clients
- Holistic care
- Who's responsible? State OR Federal?
- Remote elders aren't considered when it comes to their cultural background
- Interventions put in place for WA, NT and boarder regions by Michael Mitchell
- Community issues – where do we go? Who do we talk to?
- The Government sectors need to make and act on the changes and the recommendations
- Too many Aboriginal people in the prison system who do have mental health issues
- Major issues in WA, and across the 7 regions
- Local qualified people to be a part of the solution
- Lack of education on Mental Health within the Aboriginal communities?
- Inter-generation of trauma
- WHAM – Mission Statements, Aboriginal Medical Health
- WAACCA – Western Australian Aboriginal Community Control Health Association - don't even touch on Mental Health issues

RECOMMENDATIONS

- Set up Aboriginal workforce
- Set up a network of Aboriginal agencies
- Train Aboriginal people from their own areas/countries/regions to service their own people
- Provide support for Aboriginal workers/people in the communities

- Cultural Awareness security consultants and training for non-Aboriginal workers
- Establish career pathways for Aboriginal workers, support systems / cross agencies
- Fast track Aboriginal staff into certificates in Mental Health
- Educate about Mental Health across sections – both Government /non-Government & Communities
- Respect collaboration across Government agencies
- Get rid of the word or title "Mental" as if frightens Aboriginal people away.

Session Code: **1I**

Session Title: **Financial Abuse of the Mentally Ill**

Initiator: **Kate Malkovic (Public Trustee 9222 6543)**

Recorder: **Kate Malkovic**

Participants (initials): **KM, ID, ST, IP, LH**

General discussion on legally sanctioned financial abuse both through use of Enduring Powers of Attorney by family members/others and informal arrangements between family members/friends/neighbours

Examples discussed

1. Great nephew who obtains EPA from great aunt on the promise of "looking after" and then proceeds to withdraw $400K leaving great aunt in care facility (dementia) without funds; and
2. Bipolar sufferers who spend wildly and inappropriately during manic phase and then suffer financially the rest of the time – are use of EPAs/trustees seen as an alternative to penury?

Department of Veterans Affairs uses financial advisors and has strong support and advocacy for veterans and their families so financial abuse is not seen as an issue.

Recommendations for greater awareness/education of:

1. Inadequacies of EPAs (and ability for abuse);
2. Financial abuse and the forms it may take; with special reference to migrant/refugee groups
3. Introduction of family agreements (in writing);
4. Greater powers of restitution (and ease in obtaining) in cases where financial abuse is evident

Session Code:	**1J**
Session Title:	**Community Mental Health Education**
Initiator:	**Trudi Cooper**
Recorder:	**Various**
Participants (initials):	**JC3, KS1, DK1, AB3, PF1, BN, MP3, RD2, AP1, JC5, CS, DT1, plus various others**

Background

- There is a shortage of mental health workers. Challenge: how to equip people in the sector.
- Country Services pick the right person and then want to train them. Would welcome a degree program available online.
- Opportunity to provide dual qualification to other professionals, youth workers family support workers, counsellors, psychologists
- Consumers want peer support workers, role models of 'well consumers', hope, information, support for choices, flexible support packages

Skills required

- Community mental health requires the ability to work collaboratively across different agencies.
- Boundaries of mental health worker role are blurred.
- Education programs to support wellness and mental wellbeing in the community would be welcomed.
- Should include some content on physical health and links between physical health and metal health and wellbeing.
- Community capacity building strategies are necessary to effectively address the full extent of mental health issues in the community.
- Mental health workers need a particular set of skills. The curriculum should be developed by starting from the tasks they need to do and then establishing what skills they need.

Qualification and registration

- Needs to be recognition from government to employ people with appropriate skill sets measured against benchmarks rather than specific qualification
- Qualifications and membership of professional associations provides quality assurance for the sector.
- A view was expressed that Psychology and Nursing registration do not equip mental health workers with the practical skills that are required to support holistic rehabilitation, recovery and wellness. For example, the emphasis on medical skills (such as the ability to give injections) has meant that other very important parts of the role are marginalised.

- Intelligent training required to ensure workers have skills required to support wellness, and to promote community connection and to support maximal function in the community in everyday life.
- Need respect between professionals with different backgrounds, question the need for discipline specific training and current primacy arrangements of hierarchy between professions
- Need more diverse skills and different paradigms
- Whole of life care needs complementary roles, medical support, community based practical help with housing, work, activities in the community
- Professionals need to be able trained to negotiate, develop and implement holistic care plans.

Session Code:	**1K**
Session Title:	**How do we Better Care for the Carers?**
Initiator:	**Kristine McConnell**
Recorder:	**Kristine McConnell**
Participants (initials):	**KM2, SR3, TL, PC1, LW2, AH3, KS1, DB1, JP4, PG, FM, LO3, LW1, ST, AH1, MP2, AG, OP, MB2, SH2**

Discussion involved a mixture of Carers, consumers and Service Providers.

We should aim for a "Positive Caring Culture throughout WA"

"I think we should all be Carers"

Often Carers are Consumers too.

No one seems to be taking a holistic approach to supporting families. Each situation is individual and should be treated as such. The Carers are the experts and have the best understanding of their own reality.

Respite does not necessarily mean time apart from the Care Recipient. This may be impossible e.g. the Care Recipient does not acknowledge their mental health issue; separation from the Carer may increase the stress and status of the Care Recipients mental health. Older teens or young adults do not want another 'Mum'. Some Care Recipients do not acknowledge their mental health issue – "I'm OK" "There is nothing wrong with me".

It is hard to relax when you are constantly worried about the state of the Care Recipient and what issues will be worst when they get home.

A break away with the whole family can be very positive for everyone. It is a change of scenery and provides opportunities for new experiences and growth. All important in psycho-social development.

It doesn't have to be fancy – just a basic holiday. Holiday Respite House for the whole family would be good.

If a Carer is eligible for respite funding, why can't they decide what is done with the funding? Rather than a 'top down' approach – should acknowledge the individual expertise for what will work for each situation.

In Ravensthorpe and Norseman there have been changes due to mining industry. Families have moved there for lower rental homes but there are no support services available. The pressure on services such as Education are huge. Suggestion is for local Carers to be trained to be able to provide respite to each other which will also develop work-force skills for the Carers.

In Kalbarri there was a meeting for Carers but with no respite services available, many could not attend.

Diagnosis hit hard. It was difficult to access information particularly positive information. Needed someone to provide basic info and hope that this wasn't the end of life.

Carelink is good information point but may be more professionally focused with a need for compassion. It is hard to get information when you don't know what you are asking for.

Information needs to be delivered in a variety of mediums.

Carer allowances and pensions need to be revised. They are living in poverty. They provide 24/7 care. If they all decided they could not keep doing their role and took their Care Recipients to the local hospital etc the system would collapse.

What do you think is being done for you as a Carer?

- Not much
- Nothing
- What little I get isn't enough. With HACC domestic services, I get a fortnightly service but need weekly. Coordinating service sometimes seems just too hard on top of all the caring work.

Interagency approach beneficial – Commonwealth Respite and Carelink Centre can fund alternative care for Care Recipient and ARAFMI has funding for Carer respite. (Will meet and send info to all WA Commonwealth Respite and Carelink Centres and Carers WA).

Carers WA made application for funding for Carers to become involved in policy development in mental health. It was not successful. It is important Carers are given the opportunity to be involved without financial burden.

FINAL STATEMENTS

- **Family should be at the forefront of all care. They should not be taken for granted. They should have a voice systemically and practically.**

- **Respite means different things to different people. They are the experts in their own individual situations.**

- **Carer support must be flexible to meet diverse needs.**

Session Code: **1M**

Session Title: **Adaptive Leadership**

Initiator: **Edward Nieman**

Recorder: **Edward Nieman**

Participants (initials): **RS1, AP3, AP4, AW1, AW2, SH2**

Please Google – The Dilemma of Foundation Leadership' by Ronald A. Heifetz, John V. Kania and Mark R. Kramer

- The distinction between exercising leadership and mis-using authority is a constant source of concern for the health industry.
- When stakeholders take the necessary responsibility themselves for tackling tough problems and derive answers more adaptive to the politics, culture, and history of the situation; this approach is known as adaptive leadership.
- A distinction was made between the technical leader and the adaptive leader:
    - The technical leader is good at solving complicated problems, but not complex problems.
    - The adaptive leader works with the stakeholders to solve the problem because they are the problem and need to alter some of their values and behaviours
- Comment – a leader is able to take a lot of things and quality what is there, so people believe in it.
    - Need to be offering something different. How do we provide the (different) services?
    - How to manage change
    - Funding has gone from poor to good
    - Use NGO's to create change
    - Someone comes up with a planned proposal
    - There has been change and the consumers and carers have created the change
    - There was some disappointment to how this change has come about
- Relating the above comments to the adaptive leadership process:
    - The leader does not come up with the proposal, but all the stakeholders over time come up with the proposal. The NGO's don't create change alone; they are part of the long running conversation 'facilitated' by the adaptive leader that eventually comes up with a solution.
    - A real problem for the mental health field that can only be resolved by adaptive leadership is the move to current knowledge and understandings coming out of the '2nd generation cognitive psychology' and away from traditional 'faculty psychology' which people such as Lakoff & Johnson consider as just plain wrong!
    - E.g. Language is a Fixed Action Pattern (FAP), so today is a FAP Fest
    - To sum up: to keep doing the same thing over and over again and expecting change is simply insanity

Session Code: **1N**

Session Title: **Accommodation Services – Somebody's Home**

Initiator: **Lee Roberts**

Recorder: **Lee Roberts**

Participants (initials): **MN, DH, PM, EC, LJ, AP, plus various others (total 15)**

- With in the policy framework the concept of / definition of home needs to be central and embedded to then inform the development of appropriate models – one size does not fit all.
    - There needs to be a range of models to meet various levels of need but all should have the "sense of home" embedded in the model and have the **appropriate level of support** to address this (in cluster/ step down residential rehabilitation/ individual homes)
    - Without an agreed model with the concept of home embedded in the policy we will continue to do more of the same or nothing
    - A key issue is that people in choosing their accommodation should have a sense of safety in their home environment
- Appropriate levels of support are required – other wise the individual can be set up to fail. (Sometimes someone moving into housing is seen as the outcome has been achieved and services are then withdrawn – prematurely)
- A person's home can often include their family and they may also need support as well as the individual with a mental illness to ensure the ongoing capacity of the family to survive. This is not currently addressed in funding the level of support required by the family unit, especially those with children
- This is a social justice/rights issue where people with a mental illness should not be offered "second best" options. Maintain standards – not to accept second best or "cast offs".
- There are people already in public housing that require mental health support to maintain their tenancy who are not receiving support – unmet need
- Lack of coordination between housing and range of support services – psycho- social / clinical etc- issue of confidentiality used as an excuse not to coordinate. Real coordinated services need to involve and obtain "agreement to disclose" by the individual for services to talk to each other in timely manner.
    - DCP project on care coordination mentioned- worth investigating
- Accommodation support service hours are not flexible enough – not a 9-5 job
- Refer to NSW HASI Report $70,000 pa for high level support with excellent outcomes
- Difficulty in finding support staff for accommodation services due to pay rate
- Minimal recognition of the needs of youth with a mental illness and accommodation support services (15 -18)

Session Code:	**1O**
Session Title:	**Treatment of Patients with a Mental Illness in Emergency Department (ED) when they present with a Physical Illness**
Initiator:	**Kay De'Brett**
Recorder:	**Various**
Participants (initials):	**KDB, MP, IW, MS, EM, MJ2, IM**

Maureen: client went to ED by ambulance to Fremantle. Client distressed and anxious and mild intellectual disability. Never used the service previously. Told to "go home"

Kay De Brett: My concern is the ED becoming too anxious when patient labelled with mental illness present with physical illness.

Solutions: Promote the carers recognition act. Education of All ED staff that patients with a psychiatric diagnosis have physical illness.

Cultural change in health requires more practical solutions. Spend a day with a consumer as part of an annual competency.

All staff in hospitals should have professional development in managing mental health consumers. It is not just the province of 'experts' but needs to have a level of understanding to be demonstrated by everyone concerned with health.

Session Code:	**1P**
Session Title:	**Forensic**
Initiator:	**Ken Steele**
Recorder:	**Ken Steele**
Participants (initials):	**KS, AP, AP2, PW1, JP1, EW, AB2, B, SW2, VP2, DC, TW, PB, AS3**

1. MH in prison should be health not corrective services.
2. Early intervention, diversion to appropriate service and police education and assistance at an appropriate level.
3. Work towards a combined (service?)
4. Same Act and Agencies for mental health and intellectually disabled
5. Housing - lack of liaison on court reports from psychiatrists and inadequate follow up
6. Community changing perceptions
7. Promotion of MH First Aid – to reduce number of calls to police / police escorts
8. TOMS vs PSOLIS – don't interact, so upon leaving correctional facility no record in PSOLIS (only in TOMS)
9. Correctional service education
10. Support to the family of the person in correctional facility

Session Code: **1Q**

Session Title: **Information About the 'Grow Movement'**

Initiator: **David Tehr**

Recorder: **David Tehr**

Participants (initials): **DT2, BP, BN, JB3, CT, AC**

The GROW Movement in WA have a number of excellent and informative speakers available to give presentations to groups of people (consumers, health professionals, NGO's, government departments, specialist or social clubs, etc.) about the 50 years of success GROW is celebrating with its 12 step recovery-focused program for mental health.

GROW mutual self-help groups meet weekly at various locations across Australia (and currently in three other countries!) The groups are anonymous (first names only), confidential and open to all. There are NO FEES OR DUES (although voluntary donations at the end of each group are sometimes offered).

The GROW "program" is a layman's CBT (cognitive behavioural therapy) built up over 50 years from sufferers of mental health breakdown who have found a way up and out of their distress. Social skills and leadership are fostered through participation in the Movement by:

- attendance at weekly meetings
- regular phone calls between meetings
- occasionally chairing the weekly meeting
- taking on leadership roles (one year at a time)
- monthly leadership meetings (for seasoned GROWers)
- monthly branch social activities (organised and open to all, including family & friends)
- occasional group social activities (as ad-hoc organised by each autonomous group)
- live-in training weekends (four per year)

It has been noted that with 50 years of experience GROW must be doing something right! Recent PhD research by Dr. Lizzie Finn confirmed this by documenting how successful GROW has been in reducing medication and hospital admittances, plus increasing a sense of wellbeing and confidence. Over a large number of parameters, membership in a weekly GROW group helped 98% of people across a range of demographics to lead more fulfilling and harmonious lives.

To book a speaker to come and give an entertaining & informative presentation to your group, please contact the GROW WA Office on **(08) 9315 1666** or check out the website at **www.grow.net.au** for further info. GROW is the perfect support network.

GROW WISDOMS: ***Friendship is the special key to mental health***
Mental health can't be taught, it has to be learned together
A friend is as near as the nearest phone
Carry the message, not the person

Session Code: 1S

Session Title: Support Minority Groups

Initiator: Anne Jeavons

Recorder:

Participants (initials):

Hearing Impaired
- No services available in the inpatient settings
- Cannot bring their dogs into the hospital

Post-traumatic Stress Disorder – diagnosed
- No support from the Govt (person previously a police officer) – doesn't come under disability or mental health.

Minority Groups
- Break down the mentality that one service fits all. A system flexible enough to cater to the individual.
- See a system where there is support for the different mental problems can be dealt with.

Migrants/Refugees
- No friends or family supports
- Come from zones of war
- Difficulty acculturating
- Families are not diagnosed
- No mental health facilities available
- No education programs – afraid to verbalise their needs for fear of being deported
- No awareness of their own needs

Regional – Narrogin
- Groups of people who don't have the skills to verbalise their needs.
- Social isolation – does not allow them to advocate for their needs
- No awareness of symptoms of mental health illness
- Need education programs – need to educate the committee
- No services available
- Clients in the rural areas have to travel very far to receive services
- Clients have to be transported to the city for services, creates another problem, adaptability from country to city & cultural needs
- Youth mental health issues
- When carers not available after parents are deceased a person with mental illness will end up on the street.

Session Code: **1T**

Session Title: **Infant Mental Health**

Initiator: **Mindy Horseman**

Recorder:

Participants (initials): **CB1, Rick, Lorraine, Mandy**

WA Perinatal mental health unit. State Child Development Centre.

Creating 'circles of security' in community to support early attachment relationships e.g.:

- Free, accessible attachment focused programs for all new families
- Consistent availability across state - as different from pockets of services (e.g. programs like: attach, Best Beginnings…only in certain areas)
- Umbrella scoping exercise to manage overlaps and gaps
- Normalising of services in this group
- Increasing numbers + resources of child health nurses
- Mother baby unit to support attachment relationships
- ↑ home based services "volunteers have to go back to work + give up after a while"
- Issues for 18months – 2 years – PND may not start just at birth
- Broader capacity to recognise PND
- More accommodation support for families
- Tapping into corporate sector for early intervention e.g. Mining corporations to support fly in fly out family programs
- Specifics of services
    - In home respite
    - Settling and establishing routines
    - Contact
    - Connecting in playgroups
- Promotional and educational materials for fathers – put out by places of employment (e.g. mining companies – pamphlets sent out with pay slips) – sell this on the basis of loss of hours and loss of income if there are family difficulties
- Professional development and supervision to follow from training

Session Code:	**2A**
Session Title:	**What can the Media do to Reduce the Stigma Associated with Mental Illness?**
Initiator:	**Sonia Vinci**
Recorder:	**Bronwen Kelly**
Participants (initials):	**TB1, MS2, AW2, RK, AW1, SM4, KS3, AC1, CH, PO, KD, DP, MB1, LD, LT, PC2, EW, WS1, HW**

A series of programs representing people with mental illness living in the community.

Media needs to find courage to engage in conversations about mental health issues – starting the dialogue.

How do we sensitively speak about issues like suicide – need to position it sensibly.

Need people to come forward to tell their stories.

Let's not call people a diagnosis and put labels on people with mental illness.

Talked about Geoff Gallops contribution – high profile people can tell their stories and help break down barriers.

Do we do enough to educate the media about mental illness – give them the confidence and competence to report the issues?

Go into each media workplace and talk to journalists. Ask the union to issue a statement reminding of responsibilities – media needs refresher training.

Look at opportunities through the arts – use creativity to create a conversation.

How do we support the media to be comfortable reporting issues?

Engage journalists in education sessions.

How are we going to get the message out about average people who have experienced a mental illness?

Need to challenge people's belief – get ordinary people to tell their stories and consider how to use the multi media.

Need to talk about mental health, not just to have a mental illness. Think prevention.

Report on how people stay well and healthy.

Programs to provide advice – how do they get help – suitable for radio? Advertise referral services or run pubic health campaigns which break down stigma.

Talk to media about possibility of doing something on mental health as part of their community service responsibilities.

Australian Standards Bureau and various ethical codes.

Meet with News Directors and tell them about what the community wants and expects.

Have breakfast with News Editors, and put them together with people who can tell their stories.

One base where everything that could be a public story goes – one base, one race.

Need people to tell their stories. To talk about issues that affect them.

Need young people to talk about the issues. Need to offer support and debriefing to consumers who come forward.

Session Code:	**2B**
Session Title:	**Regional Issues**
Initiator:	**Audrey Parnell**
Recorder:	**Anthony Bourne**
Participants (initials):	**AP, KS2, LL, KB, RD, KL, PS, DT, AP2, DG, plus various others**

Main issues

- Distance
- Centralisation
- Lack of funding for regional services
- Population growth
- Prevalence of lower socio-economic groups
- Staffing
- Farming families and mental health
- Infrastructure – housing competition with resource boom

Description of Baptist care services based in Narrogin and the huge workload faced.

Description of service Esperance region – same issues + OHS + stress + housing issues

Opportunities

- More access to Commonwealth funds
- Change service model – from one size fits all
- Break down metro-centric bias
- Rural placements
- Incentives for workers bonded to stay in town
- Proper, effective consultation
- More attention to attitude from staff
- Auditing of where the money goes

More issues

- Busselton no increase in core funding though population ↑ 500%. Clients more than that. Increasing costs. Remuneration is very poor.
- Example of Headspace (Commonwealth funded). Take workers away because can pay more.
- Where is the money going?
- Poor communication, especially concerning discharged patients from metro treatment services to back to rural areas.
- No GPs in small towns. Cannot attract COAG funding.
- Escalating costs – fuel, housing
- Too busy to look up – strategic planning
- Poorly targeted money provision

Session Code:	**2C**
Session Title:	**How do we do Mental Health Prevention and Promotion better across the Population**
Initiator:	**Carolyn Ngan**
Recorder:	**Carolyn Ngan**
Participants (initials):	**AH, BP, CN, FT, GW, KR, LE, LW1, LW2, NG, PF1, PT, WS2, JM, BH, SM, ZZ, PT, HM**

- Issues around the strategies across all age groups
- Mental health P&P not coordinated, high priority or sustainable
- MH First Aid should be provided across the population – make it everyone's business
- Need more education to break down the stigma
- There are already a number of MHP&P across the state – however inconsistent and no auditing
- Duplication in some areas and none in others
- Look at VIC Health – managed, strategic and budgeted public mental health campaign
- Triple P – consistent, recognized, funded but not ongoing service delivery to support this program. Regions do not always see it as a priority – does it need to be mandatory and audited?
- Give Managers authority to use evidenced based programs – not just local programs that are not consistent and based on the 'interest' of the local provider/clinician
- Managers have to juggle resources – resources dedicated to MHP&P
- Programs such as Mind matters, Triple P – collaboration required across agencies who have prime responsibility for implementing
- MHP&P seen as similar to the Domestic Violence agenda – drops off the priority and attention every so often. Nothing changed until the review of State services that went to national priorities with resources for each state to implement
- Stock take required – what is happening in WA for MHP&P?? Who is doing what/when and how? Mapping process to determine the status quo
- Programs that are local based connecting communities – difficult to gain sustainable funding to keep going e.g. United Care Rainbow Program – that connects thousands of people across the metro but will fall through when current project officer retires – program has many volunteers but still needs paid employees to drive the program (currently short term funding is used and donations)
- Build on what we have got – do not reinvent the wheel. What is working well?
- Get government to commit at Commonwealth and State to separate funding for MHP&P
- Use 'appreciative inquiry' technique to see what works well and why, across the mental health and NGO sector
- Most vulnerable people e.g. Homeless also need to have MHP&P, early intervention programs – many homeless have mental health and AOD issues.

- Health Promotion strategies such as Healthright program needs higher profile – program with peer support workers to give responsibility to look after own health
- Recognition that best investment in MHP&P is in the early years – tier the investment across the continuum of care – main investment in infants/children and parents (long term gain into the future
- Mental health starts with 'you' and 'us'
- Need for a political champion (look at Jeff Kennett) and what he did for Victoria
- WA has MH Prevention and Promotion Policy – review of policy required – what has been implemented? What else needs to be done?
- Current MHP&P network in WA email: mhpalwa@yahoo.com.au - a good network already exists
- GP WA Network – has put in funding application for Train the Trainer for GPs to understand and recognize MHP&P and early intervention strategies when dealing with their patients.
- MHP&P is everyone's business – all agencies, individuals to take responsibility
- Need to better coordination
- Look at Beyondblue – look at their factors of success (both National, State, Regional and local input) – framework, priority strategies, utilising localized knowledge and skills – perhaps we need a national based program?
- Need to look at Mining Industry – impact of separated families and new 'group' in community that need support with long absences of mothers/fathers
- Need to include consumers/carers in the MHP&P – good for consumers and carers to learn from each other as a MHP&P strategy.

RECOMMENDATONS/PLAN FOR ACTION:

- Funding for public mental health campaign e.g. VIC Health – what are the outcomes of Act-Belong-Commit – is this enough?
- Specified budget for MHP&P programs – evaluated and monitored
- Mapping exercise for MHP&P across WA – do a stock –take – what is happening now – where/what/how?
- Build on what we have – better coordinated services on a regional level
- MHP&P Policy for WA – review policy – what has been implemented? Where can we go from here?
- Look at the success factors for 'Beyondblue' and VicHealth – Together We Do Better Campaign – learn from this experience

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Session Code: **2D**

Session Title: **Holistic Care ADHD**

Initiator: **Pia McKay**

Recorder: **Karina Bateman**

Participants (initials): **HT, GL, MN, KB, PM2**

- Comprehensive planning
- Holistic support
- Who says medication is the right option
- More expansive investigation of families
- More comprehensive investigation before diagnosis
- More education for all involved with children taking ADD meds
- More conversation between Education Dep't and medical practitioners
- Neuroscience starts to treat and not only access
- Easier pathways to access services
- Use of audio/visual

Session Code:	**2E**
Session Title:	**Respect for Mental Health Consumers**
Initiator:	**June Prouse**
Recorder:	**June Prouse**
Participants (initials):	**DC, RD2, PC1, CB1, CS, TL, AP4, AG**

Issues

Workplace discrimination: including declaring mental illness, with consequent dismissal on another pretext, workplace bullying, and perceptions by other workers. Progress in terms of health and workplace advancement hampered. Instances of going to tribunal because of discrimination on mental health grounds proved very demanding and detrimental to the complainant. Value of Consumer Participation program emphasized. Need for financial help for employers and employees with the purpose of supporting people with mental illness in the workplace.

Language: need for campaign/publicity regarding language associated with mental health issues. The use of the word "consumer" has negative connotations. Sense of inequality perceived in that "consumers" have no choice in what they are called, but "service providers" can object to the term. Some professionals are aware that they sometimes use disrespectful or demeaning language, possibly because of stressful situations and as a way of coping. Use of the term "emotional" illness suggested. The UK cited as an example of where such language usage is not permitted. Language as a means of empowerment or disempowerment.

Culture of medical profession: Tendency to not listen well, and/or not communicate well. Insufficient acknowledgement of the consumer's skills, knowledge and experience. Practices become institutionalised and in general a clinical model predominantly is employed, rather than one which also acknowledges the softer and more obviously caring model.
Also the need for mutual respect is perceived, so that the medical professionals' genuine caring is acknowledged. The need for education and ongoing professional development is great.

Media: a very negative image of mental illness is portrayed in the media. This includes the unnecessary labelling of people, so that they are stamped with their diagnosis. Images of eating disorders and of schizophrenia were cited as specific examples, as was the links that are made, for examples between schizophrenia and violence, when the reality doesn't support this presentation. Adverse publicity and negative images in the media can have a drastic effect on consumers, sometimes retarding recovery or inducing a critical incident.

Lack of genuine involvement: little choice or say regarding possible treatments is provided to consumers. Strong sense of disempowerment felt by consumers and that

scant regard is given to their intelligence, qualifications, skills, knowledge or experience. They do not feel as thought they are give the same respect or regard as someone with a physical illness would be accorded.

Barriers: because of risk management/perceived safety issues barriers, often of a very visual nature, are put in place. These barriers tend to perpetuate and reinforce stigma.

Housing: the types of housing or accommodation available to people with a mental illness often tends to foster situations that do not encourage respect.

Recovery models: these must acknowledge that this is the consumer's own journey and must be with their full involvement.

Resourcing: the ultimate way of being respectful is through adequate resourcing. Resourcing must ensure that there is constancy and consistency in the provision of programs, in the provision of staff as far as is possible. Of particular concern are programs that are only funded for a short period of time, when in fact the maintenance of a program may be cost effective and much less than the setting up stage.

Linking to carers: support, respect for and knowledge of carers can be vital in being respectful to consumers and in ensuring their recovery.

Some solutions

1. Truly collaborative processes in which mutual respect is fostered.
2. Education – of health professionals, carers, consumers, the general public. Most importantly education must start with children.
3. Normalisation of mental health issues through education, integration, media and policy.
4. Emotional and caring aspects of treatments must be emphasized.
5. Flexibility in types of treatments must be available and funded (e.g. swimming as a therapy).
6. Genuine consultation must occur, not lip service. This should be applicable to all involved – the use of the term "shareholders" was suggested. This type of forum seen as a very positive step.
7. Media can play a significant role, particularly in not labelling people, in normalizing mental health issues, and in providing positive stories regarding recovery etc.
8. Greater language awareness and promotion of language that does not disempower people.

Session Code:	**2F**
Session Title:	**Services for Traumatised Children & Coordination Between Departments**
Initiator:	**Prue Stone**
Recorder:	**Barry Nurcombe**
Participants (initials):	**BN, MJ1, AF2, EO, JM, LL1, BP, AW3, MH2, MP1, DF2, MS, and various others**

Dr Stone: *The problem* – Increasing numbers of traumatised children are presenting in primary school age. Very difficult to contain. No adequate collaborative approach. Tendency of CAMHS to exclude them as "social problems". Buck-passing. Needs collaboration of DCP, CAMHS, Juvenile Justice and different Government services.

Responses:

- Silo approach and mentality. Needs an integrated approach. Co-location of DCP, CAMHS & collaboration required.
- Children in care need support and counselling. At present they do not get mental health assessment within 3-4 months, if at all. When they leave, they need care; they need a "leaving care plan" including mental health.
- Children in foster care with mental health problems. Some are too disorganised to respond to counselling. Structure and (?) mediation required.
- A specialist program for DCP from CAMHS is required.
- Traumatised children are difficult to manage in private practice.
- Exclusion from school is increasing in frequency.
- Service in New South Wales: a 24 hour / 7 days per week / 6 weeks in-home service built into a long-term plan for the family. Services are often too desk-bound.
- DCP Parent Support Team in WA approximate to this. Voluntary service accessed through schools. Each worker has 15 families.
- Foster parent support and training.
- Professionals get stuck in agencies. They should be seconded to different agencies rotationally, potentially building networks across the community. Workforce development, planning, and change.
- Need to support people to stay consistently.
- Jointly funded positions (e.g. DCP/MH) could be useful, to support a continuum of care.
- A balance of generalists and specialists.
- Collaboration is poor between public v private mental health.
- Strong Families is a collaborative model.
- Home-based services for serious behaviour problems: Homeless families will become more common. Waiting times are up to 2 years. Programs are often very small and isolated, as a result of Federal funding.
- No one can tell you what services exist. There is no central information service. Who is doing what?
- Co-location and memoranda of agreement between Departments.

- No longer do we have residential units.
- Art therapy. Creative expression centre that is child-friendly.
- DCP Hostels poorly resourced, the children need services + aren't getting them. BAS. Collaboration is piece-meal, not consistent.
- A policy is needed for traumatised children.
- Parent Support & Next Step (D&A) is currently working.

Session Code: **2G**

Session Title: **Service for People with Intellectual Disability/Cognitive Disability & Mental Health & Drug Use who Offend**

Initiator: **Amanda Perlinski**

Recorder:

Participants (initials): **AP2, PW1, TW, RH1, RM, SL, AS, SC2, PW, EN, DH**

Summary of Problem

- Housing crisis means people with above issues can no longer get any accommodation.
- Being incarcerated in prisons due to no options,
- Does give some access to funds (e.g. justice funding from DSC but difficulty is buying a service).
- Medication may help with managing behaviour & mental health problems.
- Need to commit crime to fund habit – often the ones to get caught. Very vulnerable.
- Additional programs needed for these people.
- Assumption is that these people can access generic services but are not able to due to cognitive ability.
- Compartmentalisation/boundaries between services – referred/shuffled between services – no coordination. Idea of primary disability.
- In UK specialised service for people with ID within MH services.
- SEPARATE DEPTS IS A PROBLEM!
- CBT needs to be specially modified for this population.
- Gone too far towards inclusion to recognise individual needs.
- Too separate from Eastern States.
- In country easier to work together & included history of institutionalisation contributes to MH problems.
- Trauma – use of alcohol/substance abuse to self soothe.
- Trauma often subtle & unknown.
- MH services need to look at literature on MH & ID assessments etc rather than just blaming the ID.
- Hard to treat people with social skills deficits.
- Can other means be used, e.g. online especially people with autism.
- Research/policy divide needs to change quicker.
- Research into Indigenous communities takes from community but they don't get anything back in terms of services.
- Children taken from Indigenous community.
- Deinstitutionalisation has left people with lack of support & socially isolated.
- But people are now more included in the community which is positive.
- Need for course on MH first aid needs to be more generally available in community.
- Different generations have different attitudes.
- Need to use new language to change the system.

- Intervention programs can be implemented on line for some people.
- Borderline people fall between services. Need to look at needs rather than diagnosis & include community as a whole including families & services.
- No coordination between services.
- DGs group looked at complex needs group - is a different group.
- Need to break down SILOS to provide coordinated services which might actually decrease costs.
- Needs much wider framework to provide services.
- We need adaptive leadership to deal with complexity.
- Need housing.
- Need paradigm shift between agencies, e.g. Strong Families model, but some people don't have friendships or families.
- People offend to get accommodation for the night (or longer).
- Drug use – MH services especially ICE use – aggressive people & often – permanent psychosis.
- Need to collect data.
- Needs will to make it happen.
- Professional links across agencies.
- Needs to be ground up in agencies.
- Now being managed by NGO who don't have experience & poor support.

ACTION

  - Need cross departmental groups – MH/DSC/DCS
  - Localised groups – but people are very mobile.
  - Needs overarching policy.
  - Lack of consistency in terms of what services are provided across the metro area.
- Middle management need to come on board.
- Service providers exhausted & burnt out. Need support & to be listened to.

Session Code: **2H**

Session Title: **COPMI - Children and Young People Whose Parents have a Mental Illness**

Initiator: **Jenny Terry**

Recorder: **Lyn Gleeson**

Participants (initials): **JT, MC, LG, SR3, SK, CD, LO1, HD, MM**

Discussion

- Education affected when living with parent with MI.
- Young people don't recognise themselves as carers.
- Importance of peer support
    - Mentoring
    - Community awareness/education – reduce stigma
- Difference in having people respond positively to MI – other disability or health issue.
- Limited funding for existing programs in schools.
- Need to address MH at much younger age.
- Mental illness in children of patients who also have MI
- Associated trauma for children exp of parents who also have MI
- Consumer "we tell/share stories" with family of their exp. Keeping light – communication – enabled us to be a very functional/dysfunctional family.
- How to tell children about illness – shame, stigma
- How to increase community awareness – reduce stigma
    - Positive media attention
    - Question what is normal – 'concept of normal' getting smaller – hard to be different

Suggestions

- Put children on the agenda.
- More to be done working with families/children.
- Parents supported to continue parenting role even during crisis, workers being/having expert knowledge of child – parents supported to keep child with them.
- Children able to have confidence in parent.
- Holistic/systematic approach to managing parent's illness.
- Biosocial assessment when people admitted.
- Respite care available – DCP not considered viable option for consumer.
- Mining companies to contribute funding to support families where parent works away.
- Adult services to ask "Do you have children etc? What is happening for them?" – Child friendly services.
- Family advisory council in MH to cover everything.
- Improved follow up services, referrals & outcomes.

- Long wait lists for children referred to available services – need more!!!
- Worker linked in with children prior to discharge.
- Children's worker within adult MH hospital.

Summary

- Useful to focus on children – keep them on agenda
- Importance of resources to support parents to continue caring role of children (include respite accommodation).
- Importance of stories – parents having courage to talk with children about illness.
- Assessment process.
- Child workers in hospitals – child friendly space to visit.

Session Code:	**2I**
Session Title:	**View of Mental Health Clients – What They Want**
Initiator:	**Mary Nolan**
Recorder:	**Pip Brennan**
Participants (initials):	**MN, CT, FM, PB, CB, LS, JP2, AJ, NS, RD, AH1, IM, DC, AH, CB1**

Introductory discussion:

1. Accessible, flexible complaints process to ensure that mental health client view is constantly fed back into the process of service delivery. The facility of Consumer Representative Training which is delivered by the Health Consumers' Council was mentioned (www.hconc.org.au) as a resource that already exists to facilitate this.
2. Longer available consultant hours outside of work hours – e.g. when someone starts work, they are not able to access appointments during work hours
3. Assistance may be needed after hours however the needs are not of a crisis nature. The only clinical assistance after hours is through MHERL or other 24 hour programs, which is a high level service for a lower level need. This is not a match between client need and service. An example

Mary Nolan sought feedback from clients at the June O'Connor Centre. This formed the basis of the discussions, with additions and recommendations added by participants.

1. More emphasis on exercise: e.g. one client attempted to attend Curves but found it difficult to sustain. The importance of exercise on client's overall health was discussed.
2. Recommendation: Some kind of partnership e.g. extra support from an OT staff member, working at Curves with clients in a supportive environment to promote exercise
3. Mentoring help with study e.g. TAFE courses can be difficult to sustain over the long haul.
4. Consider reviews every three months with a regular doctor, not a different doctor each time.
5. Ready referrals of chronic patients to psychologists, not psychiatrists. Make counselling readily available.
6. Where can you get help after hours? Client was told his mother had been given last rites, and needed emergency counselling and support. See also point 3 in Introductory discussion
   Recommendation: Support workers could provide mobile phone numbers on a roster system, to be available after hours for phone assistance so people can talk to someone they know. MHERL is crisis support but the distressed person would not know the counsellor. It is an issue like a family death you wouldn't want to talk to someone you don't know.
   Service Information: The DBT or Dialectic Behavioural Therapy programme run in NMAHS provides this level of support but is a very specific programme, with a weekly session with a case worker, group sessions and out of hours phone support.

7. Respect for clients. Subiaco CAG produced a booklet of information for clients which was sent to NMAHS and was lost, and never ultimately published. This does not indicate respect for the client.
8. Liaison with Government mental health services and NGOs. Services seem to be pretty poor at present.
9. More grass roots action and provision of services for mental health clients. Less talk and more action!
10. Listening by W.A. Government. The government does not want to listen on the issue of the ban on smoking. However there are genuine concerns about how, and how effectively this is being implemented on the ground. Some concerns centre on how the ban on smoking is pushing clients back into the streets. Also of concern is the civil liberty aspect – for some people the mental health facilities are their home. While most staff are no longer allowed to smoke on work premises, people can then exercise free choice at home. This is not the case for in-patients.
11. Database of mental health services – make a database which can be accessed at the State Library which lists absolutely every organization however big or small, private, public, voluntary etc which is involved in providing mental health support
    Service Information: Ruah, an NGO have an excellent and fairly comprehensive database of services on their website, www.ruah.org.au or Google on Ruah.
12. Change the name of Graylands. It is outdated – the suburb is now Mount Claremont (the local primary school has changed its name) plus for a mental health facility Graylands has awful connotations. Choose a new, inspiring name.
13. More courses for consumers related to the level of skill e.g. computer courses for beginners, separate group for more advanced – not everyone lumped in together
14. Discharge arrangements – when someone leaves hospital, a support person (OT?) should call in every day for 20 minutes or so to check if the patient is lonely, have they taken their medication, to they have food, do that have any problems etc, until things settle down.
    Recommendation: Institute a Hospital in the Home programme for discharged mental health patients. An EN or Allied Health staff member with mental health training could deliver this services, wit a delegator, and care planner overseeing service delivery. This could assist in reducing the "revolving door" of patients coming back into mental health services after discharge due to support. It would have to be cost effective long term.
15. Return Pharmacy to Avro Clinic. Pharmacy access was discussed at some length – it appears to be a state/ commonwealth funding issue. Now Avro patients are required to go to Graylands for their medication. There is also the option of obtaining meds from private pharmacists however there is not the specialisation in mental health where patients can ask the pharmacist for assistance or information regarding their discharge medications, nor is there adequate privacy for people to discuss their concerns.
    Recommendation Medication Discharge templates should be supplied when patients are discharged so that they have adequate information on their medications should queries arise after discharge
16. Admit the smoking ban at Graylands Hospital will never work – give the hospital dispensation (see point 10 above)
17. Psychiatrists do not spend enough time with patients, and prescribe increased medication, with very little knowledge of the patient
18. Accommodation is a huge issue. Clusters of 1 or 2 bedroom units with a "supervisor" on site 24/7 (a team of 3-4 could "supervise" 20 or so people. People who do not need any "supervision" need to have access to accommodation that is government owned so that there is stability and security.

19. What is the government going to do about the increasing problems of homelessness of which the short/long term consequences will be an increase in mental health problems?
20. Stop calling users of mental health facilities "consumers". That is supermarket jargon. Clients a better name. Any other suggestions?
21. Recommendation: Involvement of students (OTs, physios, social workers) to work with an organisation for a long term period, 1-2 years – practical experience
22. Support accommodation and transition into the community for mental health consumers. The need for more resources and funding for the transition into community living leads to continuity of care
23. Proper follow up care for clients after staying in a mental health facility. Clients should be provided with details of support. Clinics should be informed when a client leaves hospital. This would help to avoid re-hospitalisation.
24. Preventative care rather than waiting till the police have to be called out to take a client to Graylands.
25. Mental Health Professionals. Treating people as human beings rather than a clinical problem to be placed on a list of statistics
26. Provide a mentor for mental health clients to assist with living skills e.g. Cooking, doctor's appointments, bankers
27. Educate the general public so that the stigma of mental illness is decreased.
28. Provide mental health services for youth who are aged 18+ so that young people are not lumped in with older clients
    Service Example: Headspace for 12-25 is operating in the Pilbara, a federally funded project. The premises are upstairs from Maccas (McDonalds), the stairway leads to an internet café on one side, and Headspace on the other, so it is not apparent to everyone which premises a person is entering, offering privacy and encouraging more youth to attend. Headspace is funkily decoration, has age appropriate attractions such as Xboxes etc for clients. Services then come to Headspace, e.g. Divisions of GP attend t afternoons per week. Headspace does not pay for these doctors – they provide their services in a private capacity through Medicare billing. Clients want to attend the premises, and the services are brought to them.
29. Department of Mental Health should provide speakers to go in to schools. These could be trained mental health clients and people from the department. Clients are not always comfortable with being in the spotlight.
30. Train school teachers so that mental health can be discussed as part of health education
    Recommendation: Teachers could undertake MH First Aid Training
    Discussion: Schools will say that MH First Aid Training is a matter for the school counsellor or social worker. However it was pointed out that an episode can occur anywhere and it is important that a person suffering an episode has appropriate care at the time
31. Provide more free counselling for young people
32. Conduct tests e.g. Blood tests. Sometimes there is a physical reason for mental health e.g. low functioning thyroid can be a cause of depression
33. Take a holistic approach to mental health. Mind, body, spirit
34. Streamline bureaucracy. Ensure agencies are aware of what is on offer and can refer appropriately.
35. Conduct a survey to see where and which services are needed
    Discussion: Surveys are sometimes conducted in individual facilities, but there has been no comprehensive, statewide survey undertaken
36. Explain why patients have to fill in the Kessler 10. What is it used for?
    Explanation: This is a self-assessment instrument, a voluntary test which can be conducted every three months to determine how a client's mood is over time. Used properly in partnership between client and service provider, it can enable the patient

to have input into their own care. It is comparative over time to plot any possible long term improvements. It is a NOCC – National Outcome Case Mix Collection tool.
Recommendation: clinicians need to explain more clearly what tests they are undertaking and why

37. Instead of building flashy new treatment centres keep the old houses and renovate them as living skills centres. These older places feel more homely and less clinical.
38. Ask consumers what they want (See point 35 above)
39. Provide more psychiatrists
40. Provide more psychologists
41. Build a community centre which includes mental health facilities for facilities side by side. No separation of mental health patients from other patients. 1 in 4 who go to a GP have mental health problems
42. Stop the spin. The smoking ban at Graylands is not working so stop lying to the West Australian newspapers (see points 10 and 16 above)
43. Encourage sporting groups to include mental health clients
44. What provisions are being made for the growing number of seniors in relation to mental health care?
45. Stop excessive working hours e.g. 8-6 required by an employment agency. Overwork can lead to exhaustion and eventually to mental health problems.
46. Make counselling available to the whole family, not just the person who receives treatment for a mental health problem

The issue of Care Plans was raised at the end in some detail, with a discussion between carer IM and DR.
Recommendation: When a patient is moved into the community they need a caseworker who continues to liaise with the family not just about medication but also about recreational opportunities. This reduces the risk of the patient becoming alienated from family members who need to nag/ prompt the patient to ensure they are complying with their health and life commitments.
DR commented on the commitment to provide a WHOLE care plan process
Concerns about how the no smoking policy implemented on the ground were discussed in some detail.

Session Code: **2J**

Session Title: **Elderly Mental Health Issues – 'The Tsunami'**

Initiator: **Gary Budrikis**

Recorder: **Graham Brown**

Participants (initials): **SH, SB2, GD, KS, RS, PB, TF**

- Lack of priority for elderly issue.
- Ageing population of people with intellectual disability (also physical disability amongst intellectual disability) diagnosis of mental illness is problematic.
- Diagnosis of dementia is problematic.
- Being diagnosed with dementia is problematic.
- Being diagnosed with dementia causes adverse consequences to accommodation of persons who were previously DSL clients.
- Need to examine criteria for entry to psychological services.
- Inadequate facilities for persons with dementia and behavioural disturbance
- Lack facilities for holistic as opposed to purely custodial care of elderly.
- Need to normalise environment & activities (let resources smarter, drink alcohol, and use the TAB).
- Inappropriate level of emphasis on behavioural issues in ACAT assessment.
- Perverse incentives in Commonwealth nursing home payments
- Poor wages of carers in nursing homes – poor quality of staff, staff don't speak English etc.
- Inappropriate staffing models for inpatient psycho-geriatric facilities.
- Huge exit block. Acute bed numbers possibly would be adequate if CAP patients could be discharged.
- Lack of appropriate facilities for persons with dementia and behaviour disturbance in regional areas (there are zero!).
- Skills to assess & treat delirium in regional areas lacking.
- High care units to have support from MHS.
- Lack of knowledge of elderly MH issues.
- A single health system (not a unanimous view) possibly.
- HACC services to be planned on need rather than historical factors.
- Quality of care facilities is very poor.
- Population growth rates are huge and do not appear to be getting taken into account in planning processes.
- Nursing home care staff are ageing or, if young, do not speak English.

Session Code: **2K**

Session Title: **Preventative / Early Intervention**

Initiator: **Kevin Mullican**

Recorder: **Kevin Mullican**

Participants (initials): **IJ, BP, POK, JN**

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1. Develop minds of all our young to have the necessary skills, abilities to cope.
2. All of us (Mental Health Professionals, Parents, Teachers, Work Colleagues, Friends etc) – Need to pool knowledge; skills; compassion.
3. Alternative Programs developed for all those afflicted with mental health problems.
4. Look behind the issues of 'those' who have and are currently abusing / using drugs.
5. Stop the "Brick Wall" mentality faced by all those who are reaching out for real help.
6. Early intervention needs "Community Support" most of all -> education on drug issues especially and most mental health problems.
7. Changes of all mental health resources / systems will only happen if the government of the day actually mandates these changes.
8. Rehabilitation needs to be a 'free resource' for those who need it. Transport, fees etc.
9. Money has risen above compassion in the system
10. Leaders do not reflect "the compassion" instead aspire to the capitalist ideology.
11. Education system denies they have a responsibility to educate children on mental health issues; teach coping skills -> left to parents and others

Session Code:	**2L**
Session Title:	**Provision of In-House, Supervised, Longer Term Living Skills Homes**
Initiator:	**Ian Coulser**
Recorder:	**EM**
Participants (initials):	**IC, EM**

Eden Hills living skills home was sold in 1992. It provided a significant respite and rehabilitation service in the community for people with OCD and schizophrenia.

Can this be condensed in the larger state plan for rehabilitation and recovery services? There is a need for longer term rehabilitation (9 months in Ian's case) to be able to live in at the same time as learning living skills which then enables you to go and get a job, rent a house look after yourself for best quality of life.

Session Code:	**2M**
Session Title:	**Annual General Elections to Promote and Maintain a more Robust Democracy**
Initiator:	**David Tehr**
Recorder:	**David Tehr**
Participants (initials):	**DT2, CB2, BN, ED, SH2**

Annual general elections would cost approximately $10 per voter per year and be a very cost effective way to promote "best practice" from governments of all persuasions, whilst encouraging better accountability, transparency, stability, long-term planning and overall widespread dialog about what is important within our communities.

By holding full and free elections EVERY year it would also help embed the democratic principles of fairness & responsibility into our culture – just as all traditional & secular annual festivals help to inculcate and celebrate their own particular "world view".

Facilitator David Tehr is holding a meeting in the **NEDLANDS area** for those interested in hearing more about this important political reform (or who want to move this reform forward) at

2pm on Sunday April 13.

Phone David on **0417 182 834** or email **dt@cygnus.uwa.edu.au** if you wish to attend.

Session Code: 2O

Session Title: Accommodation/Respite for Chronically Ill

Initiator: Maureen Burke

Recorder:

Participants (initials): SD, KM, DC, PB, KS, LW, CH

- Amphetamines on the increase therefore psychosis increasing with the use of drugs.
- Various agencies but not co-ordinated.
- Rehab – teach people how to survive in the outside world – lot more needed.
- Attracting staff to work in services. Staff that are encouraging & assist people to be independent.
- Difficulty accessing services outside your catchment areas
- People being referred to ACAT that are not elderly – need for permanent accredited, safe accommodation. Need for a similar assessment & accommodation for people with chronic mental illness.
- Try not to institutionalise people in the first place.
- Caring for children with MI can cause family breakdown.
- Hospitals under pressure because of new standards. Hostels are private businesses, some are good.
- Where do people go if they have a history of violence?
- Are hostels doing the right thing with their clients?
- More options for housing!!
    - Living standards
    - Healthy meals
    - Recreational facilities
- Health services under pressure
- Some agencies are compassionate & aware whilst others feel every client can be rehabilitated.
- Respite funding various providers establishing services currently. No out of home respite.
- Houses within community, staffed by mentors & recreational staff & chef/cook available for long term care and respite for those with chronic mental illness.
- These must not be regionalised, i.e. if Busselton suits a client for a week then allow to happen.
- Houses currently not available for those with chronic illness.
- My daughter was given respite over a weekend in a geriatric respite facility – she is 33!
- Staff need to be aware of individual client when becoming delusional by suggesting a walk or trip to the beach or movie.
- Medication needs to be given to those with chronic illness as dementia and forgetfulness is part of the illness.
- Companionship and social support helps self image.

- Staff don't need to be clinicians.
- It's about their ability to connect and support.
- There are many agencies but no one to co-ordinate.
- Discrimination against those with mental illness when trying to rent.
- Growing issue of "ghosts on the wards" – people who have chronic mental illness who won't be taken by hostels because there is a reference on their file to violence; also people diagnosed as autistic, locked into mental health wards and made involuntary because there is nowhere else for them to go.
- Problem of Disability Services versus Mental Health Departments – someone (1 person) to deal with both issues at same time.
- No respite for carers looking after chronically mentally ill in their own home.
- Problem of ageing parents who are carers.
- Problem of providing activities for chronically mentally ill – need a lot more day time activities to keep them occupied.

Session Code: **2P**

Session Title: **Gender Issues in Mental Health with Special Reference to Men**

Initiator: **Allan Huggins**

Recorder:

Participants (initials): **BN, EW, BG**

- Mental health promotion needs to take into account gender issues for both men & women that contribute to mental health conditions.
- Social & cultural determinants of mental health often drive mental health conditions e.g. High suicide rate for men, high attempted suicide rate for women.
- Men & boys feel that they cannot express their problems because the culture has determined that to do so makes men & boys appear weak.
- If suicides are 80% men we need to target boys & men more in a gender specific way: in schools, media, and parents.
- Drug & alcohol abuse, violence, self harm, anger is mostly about men. Narrow definitions of masculinity that are encouraged by the culture often stop men seeking help especially things like depression.
- Funding for booklet for a men's referred base. There is one for women but not for men. Including MH services & accommodation.
- Why is it that Kalgoorlie which is a male dominated town has more services for women than men??
- We need a gender specific approach to men's mental health issues.

Session Code:	**2Q**
Session Title:	**How to Reduce Stigma for People with Mental Illness who Offend?**
Initiator:	**Viki Pascu**
Recorder:	**Viki Pascu**
Participants (initials):	**AH4, DC, PW2, AP4, EM, MP3, PM4, SH2, SW2, VP2, MT, PB**

1. The lengthy process of reviewing the CLMIA Act (since 2003) which impacts and further stigmatizes this group of people / patients.
2. Criminalising mental illness => further stigma.
3. Limited resources available for community support accommodation for all mentally ill; less for mentally ill offenders. Who has the responsibility to advise the community about the history of these patients? Short term benefit VS long term benefits of broader education of the community to break down barriers of communication; improve general knowledge of the community.
4. Engaging the media in providing services (??) education about the impact of mental illness; help the media balance their dual role (alerting, sensationalizing news and education of community).
5. Education within the general mental health system.
6. Creating a profile for the forensic mental health services.
7. A more proactive approach to dealing with mentally ill offenders.
8. Educating the courts, justice systems about the need to look at diverting people with mental illness to general mental health services -> diverting from Department of Corrective Services.

Session Code:	**2S**
Session Title:	**Honesty, Accountability, Individual Justice by the Government & Mental Health Services**
Initiator:	**Peter Thomsett**
Recorder:	**Deborah Tedeschi**
Participants (initials):	**JB3, DT1, PT2, DT3**

When a mentally ill person dies there should be a forum for all parties involved (families, agencies, medical persons etc) to come together & look at what went wrong, how things could be done better in the future.

- A way of doing this without lawyers & fear of retribution or consequences.
- A forum for families to come to terms with what happened

Families look for answers when a loved one dies at their own hand. The circumstances are usually complex & highly emotionally charged.

A catastrophe is the result of a series of small errors that combine together for a disaster.

When an injustice occurs the process should provide for an outcome that leads to justice being served.

Session Code:	**2T**
Session Title:	**Suicide Prevention for People not Using Mental Health Services**
Initiator:	**Louise Howe**
Recorder:	**Louise Howe**
Participants (initials):	**PF, AP, LH, PC2, JL1, MC, CR, HW, JF4, ST, KS2, MC2, PW**

People don't know where to go to get help.

GP's don't know where to refer people.

More advertising on TV regarding suicide help.

More crisis lines with trained suicide listeners, not just counsellors.

Cheaper (free) counselling.

Decrease stigma attached to suicide, including more advertising and awareness (like breast cancer and prostate cancer, aids etc).

More community messages to make people aware of suicide symptoms (self awareness) and seek help.

Mental health first aid is a GOOD THING!

Depression is the leading cause of suicide.

It was noted that more people commit suicide that haven't shown a previous history of mental health problems through the medical system.

Market suicide awareness like a product, through a professional marketing agency.

Skilling the community to be more resilient and have access to more resources (like how we all know about eating more fruit and vegies, exercise more etc for physical health). What do we need to know to keep ourselves mentally healthy?

Prevention is better than cure.

Need to reach out to different cultural groups and market prevention strategies to them (e.g. gay and lesbian communities).

Notable people (celebrities) who have had mental health problems but are still working, functioning to publicly say that.

NZ 'like minds' project is a very good example of de-stigmatizing mental health illness in the community and should be used as an example for WA.

Combination of medication **and** counselling/ psychotherapy/self help is the best way to recovery, not just medication alone.

Collaborative community approach to mental health appears to be the best way combat incidents of suicide.

Session Code: **2U**

Session Title: **Living with Bipolar Disorder**

Initiator: **Jamie Beggs**

Recorder: **EM**

Participants (initials): **JB2, EM, ST**

Family members need support to continue to live with persons with bipolar disorder.

Stuart (from CLAN) specifically interested in financial support/advice during their relatives' manic spending.

? Legislation for extended cooling off period if people have a diagnosis of hypomania (e.g. NSW legislation re housing).

Writing expenses in a book is helpful & Jamie has written a book called 'Inner Journey – learning to live with Bipolar Disorder'. It may help with other people.

Session Code: **2V**

Session Title: **Holistic Mental Health**

Initiator:

Recorder:

Participants (initials): **HS, BC1, KH, JD, JP1, IM, EC, BW, RE**

Over simplification of outcome measures.

- Who to ask:
  - Clinical
  - NGOs
  - GPs
  - Family carers
- Current methodology doesn't evaluate the right questions.
- Need quantitative and qualitative outcome measures.
- Indicators isolated, not integrated for an individual.
- How are outcome measures defined and who influences the selection of outcome measures.
- Client feels valued if asked for feedback.
- NGOs & private already utilising external qualitative evaluation.
- Is mental health evaluated well anywhere & how is this done?
- Asking the hard questions – feedback at individual clinician level and at service level
- "Secret stoppers"
- Evaluate whole of community mental health.
- Wellness index – family carers have lowest level.

Recommendations:

1. Resourcing qualitative evaluation
   - External skilled evaluators
   - Outcome measures developed in collaboration with stakeholders e.g. clinicians, clients, NGOs, GPs, e.g. carer distress.
2. Consider utilization of "secret stoppers" e.g. ring up and see how long to set an appointment.
3. Encourage research about evaluation of services.
4. Invest in researching appropriate evaluation tools – a combination of qualitative and quantitative measures.
5. Build capacity of service providers to evaluate and link this to service development.
6. Recommend a service to promote (develop appropriate outcome measures – combine with research into best practice evaluation).
7. Avoid over-burdening clinicians and NGOs with administrative tasks and outcome measurements.
8. Include measures that reflect
   - Quality of discharge planning
   - Continuity of care
   - Respect for person load

Session Code: **2SPE 1**

Session Title: **Communication Barrier Impedes Support for Mental Health Problems**

Initiator: **Anne Jeavons**

Recorder:

Participants (initials):

- Migrants do not speak the English language and find communication very difficult
- Interpreters do not have the skills to relay the information to the professional. The information relayed maybe incorrect or not accurate.
- Interpreters and professionals need to have training on how to work together
- Issues of Gender-discrimination against different orientations
- Interpreters in mental health are very difficult-the interpreters interpretation of the information relayed is different
- Isolation in a mental health hospital unable to communicate and this causes a lot of frustration. The health professional sometimes are not patient enough to communicate with the individual
- Teach communication techniques - a sub-specialty that is required in WA.
- People with mental health problems are not able to verbalize their needs. This causes frustration, which ends up with behavioural acting out.
- No support with taking medication
- People with mental health are found jobs and then the organization drops their support. The family has to intervene.
- Difficulty with providing equipment in the home. The difficulties lie with some community organizations - no knowledge of the availability supports
- To create a directory of services

Session Code: **2SPE 2**

Session Title: **I would like to talk to you about no Support for MH nurses Injured at the Workplace**

Initiator: **Marlene Parker**

Recorder: **Monica Taylor**

Participants (initials): **SW, MP, MT, JF**

- Lack of systematic management of critical incidents
- Agency nurses injured - levels of support
- Where does responsibility lay
- Workers compensation for nurses requires streamlining
- Mental Health trauma for nurses and easy access to employee assistance schemes - limited support from within organization
- We are not looking after our workers

Key message:

- Formal processes for critical incident response.
- Managers coordinate and trained in critical incidents response.
- Clinical supervision real access for mental health staff. Ongoing training for clinical supervision. System is not supporting mental health staff to do clinical supervision

Session Code:	**3A**
Session Title:	**Vision: to reach a point where mental health services are no longer needed.** **Provocation: do some aspects of the 'mental health industry' create an incentive for treatment instead of prevention?**
Initiator:	**Jonathan Smith**
Recorder:	**Jonathan Smith**
Participants (initials):	**CS2, AW2, JS1, RS2, TB, LE, KU, JM2, JF2, GL, ST, AP**

Key recommendations:
Current funding model focuses all incentives and attention on crisis end of mental health spectrum.

To move towards population level prevention requires:

- a major investment of funding and attention on 'mental wellness', instead of mental illness;
- a long term (20yr+) investment on outcomes that will not come within the traditional 3-4yr electoral cycle;
- Specific focus on 0-6 years, through creative delivery of parental education and training, with support continuing through 6-12 and adolescent years.

What is the problem?

- Mental health is a spectrum from 'healthy' to 'chronically ill'. All the resources are focused at the chronic end of the spectrum.
- We currently don't do rehabilitation or relapse prevention very well.
- Some of the underlying root causes of mental illness are poorly understood.
- There is an understanding of certain minimum conditions that must be met to support mental health, but these conditions are not evenly distributed across socio/geographic areas.
- Parents receive little or no training about how to encourage healthy mental development of their children.
- Children receive little or no training in basic life skills and resilience they could use to handle stressful or difficult situations in later life (e.g.: relationships, work, money, etc).

Why does this problem exist?
There was absolute agreement that the current system provides incentives for more treatment, more diagnosis and more prescription of drugs, rather than prevention of root causes for the reasons stated below.

- There are essentially two 'camps' in the mental health system: one concerned with treatment of classifiable mental illness, and one concerned with proactively developing mental health.
- The medical treatment model only addresses symptoms.

- The current system is essentially a 'sickness' model, not a 'wellness' model.
- Potential customers only present themselves for treatment at a late stage, or not at all. This is partly caused by the social stigma attached to mental health. There is also a lack of awareness of the range of services on offer.
- There are also issues around personal freedom and social control.
- Pharmaceutical companies and doctors are only paid for the work they do, not the work they have prevented, so they have a vested interest in treatment and in 'growing' their own business, which leads to more diagnosis and possible over-prescription.
- The funding model creates a 'peak' or 'hump' around crisis intervention, with very little funding available for early intervention or post-crisis rehab.
- Demand for beds in crisis care causes some patients to be released too early.
- There is little or no funding available for long-term psychiatric care.
- Countries that closed many of their crisis care facilities (USA, UK, and Italy) are now reopening/rebuilding those facilities – is this because they did not replace those units with sufficient investment in community infrastructure?
- Parenting and life-skills classes do exist, but the people who need them most often do not attend.
- Interagency collaboration is very poor.

What would we like to see happen?

- Creative focus on training for parents to provide healthy environments for children 0-6.
    - UK TV show 'Driving Mum and Dad Mad'
    - 'Supernanny'.
    - 'Nurses' on ABC TV.
    - One-off seminars.
    - Thailand-style social advertising?
    - Peer support training for extended family/social groups.
- Continued support and education for kids 6-12 and adolescents.
- More investment in communities to provide support mechanisms for mental wellness.
- Multi-tiered intervention for people before and after crisis care.
- More research into underlying root cause of mental illness.
- Greater education about the services available.
- More support for advocacy groups (WAAMH, ARAFMI, MIFWA, and MHPAL).
- More leadership and high profile advocates to break down the stigma associated with mental illness.
- Emphasis on mental wellness.
- Join the dots between various government agencies to combine social welfare and housing efforts with health.
- Provide incentives for keeping people well.
- Serious commitment over a 20yr+ period to solving these problems.

Session Code:	**3B**
Session Title:	**An Informed, Integrated & Coordinated Mental Health Consumer Participation Movement**
Initiator:	**Barrie Pack**
Recorder:	**Various**
Participants (initials):	**AB5, AM, BP, HM2, KM2, LR, LS4, PM3, IM, CS**

- Consumer participation plan is not a draft and has been signed off on.
- Consumers need support, education & training to meaningfully and equally participate.
- Lack of support and respect for the consumer movement and consumer projects.
    - Consumers are in fact, willing and able and we should build on the existing movement with consumers.
- Suggest a steering committee for consumers
- 2 years on where is SAETIS (State-wide Advocacy Education Training and Information Service)?
- Get rid of the stigma that people with a mental illness were nothing before and will be nothing after their illness. We are all individuals with skills and qualities.
- SAETIS would help consumers to provide a collective 'voice'.
- Need an open space forum for consumers not at a health institution forum
- Need to strengthen existing consumer position in HD – resources & budget – strengthen CAGs – regional & statistical issues.
- Need an external consumer/advocate peak body group funded equivalent level such as WAAMH, Carers WA, and ARAFMI.
    - To really give consumers a collective voice (very easy to ignore individual reps), e.g. CANDO org. in NSW a sample.
    - Driven by consumers with executive officer selected on merit.
- Not fair to seek individual consumers on committees without support structures organisation to auspice the consumer 'peak qs'.
- Could WAMIAC with this additional funding + support take on this broader peak role?
    - Training of consumer reps.
    - Look at models in Eastern States.
    - Anything else is token.
- Or within NGO sector an agency to auspices the development
- WAAMH as a transition phase – development of independent org.
- Not appropriate for the consumer program to go to the HC Council of WA – wrong model – taking it out of the MH sector – dilute the voice.
- Mental health is different from physical illness, developmental disability, intellectual disability. It is best to build capacity for the mental health consumer to have a stronger voice rather than dilute it within a broader consumer health network.
- Need to attract new consumer voices.

- This is to achieve real cultural change within WA. Without a strong voice/consumer involvement the change will only go so far…
- Alternative is to lobby politicians individually.
- We need to have a consumer driven & real consumer group & organisation.
- Need to employ consumers to lessen the strain on nurses & other resources.

Topic Code:	**3C**
Topic Title:	**Intellectual Disability (ID) and Mental Illness (MI)**
Initiator:	**Samantha Barnes**
Recorder:	**Samantha Barnes**
Participants (initials):	**DL, WS, AG, PG, KM, PW1, LL, BP, MB, SL, EL, ?C, CN**

Issues:

- Access to psychiatric services
- Diagnosis and Assessment Difficulties
- Not enough communication between support agencies
- Importance of opportunities for community participation
- Difficulty getting both mental health services and disability services involved > tendency for one service to no get involved if another service involved
- Having an intellectual disability > means can be socially isolated (need research for this) hence risk factor for depression
- Difficulty of person with intellectual disability expressing self (e.g.: misdiagnosing symptoms can occur)
- Importance of having meaningful things to do
- Mental health workers need skills to work with people with ID and mental illness
- G.P skills – e.g.: how to communicate with people with ID
- Adults with ID can have a lack of sense of control over obsessive behaviours
- Possibility of having people who can interpret for people with ID at appointments > particularly someone who knows the person
- Difficulty accessing support from clinics
- Problem of symptoms being attributed to ID and overlooking possibility of symptoms being a reflection of mental health issue
- What are the options for people with mental illness when they are discharged from hospital e.g.: recreational activities
- Historically mental health and ID have been kept as separate groups
- Who is responsible for providing support > need to consider persons needs
- Structure of organization can be restrictive > i.e. in terms of what it can find – an option could be having flexible funding within an agency for people with multiple needs
- Research needed into numbers of people with ID and MI issues and into how mental health issues are identified in people with ID
- Protocols between MH services and disability services / care coordination
- Disconnection between policy and operation of mental health > policy should inform operation
- Service provider may not know what to do with someone with a mental illness and ID – this needs to be reflected in knowledge and training of service providers
- Need to provide follow-up support post discharge from hospital – transition planning important

- Lack of resources to implement plans
- Importance of listening to care-givers feedback on how someone is presenting > behaviours can be overlooked as standard for the person although care-givers may recognize changes > need to pay attention to this

PLANNING FOR LONG TERM:

- Issue of parents of people with ID aging > difficulties in planning for these situations important > transition planning can be difficult > how do we engage people to consider these issues > e.g. Elderly parents
- Dementia can also be present
- Promotion of those agencies and services that are available for people
- Planning needs to include how to meet intellectual disability related needs but also how to meet mental health issues

Session Code:	**3D**
Session Title:	**Recovery**
Initiator:	**Judith Durnin**
Recorder:	**Carron Hall**
Participants (initials):	**IW, DT2, NH, JP, CR, JF3, JD, KH, CV, JF2, WS, SD, PS1, LC, BC1, SC, PM, SM, AC, AP**

What is recovery?

An Individual, person centred, holistic approach with the client, family, treating team, NGOs and any other stakeholders that the client identifies as significant in their journey to recovery.

Important suggestions, ideas etc for the road to recovery- the return of life for people living with mental illness:-

Understanding of the recovery process across all of the stakeholders involved with the client e.g. family, clinicians, community support workers etc so all are working together toward recovery rather than simply maintaining the client. More funding for training specifically in the recovery process to achieve this aim – Ron Coleman Recovery Workshops are excellent – Richmond Fellowship ran these.

That people with mental illness direct their own crisis plan and recovery themselves with the appropriate support mechanisms. That they make their own choices about how to manage when they become unwell not that other individuals or agencies make decisions for them.

Appropriate training for mental health workers and remuneration that acknowledges the skills they bring to their patients/client.

Valuing the worth of people living with mental illness, their families and the workers who work alongside them.

Better transition from hospital with appropriate follow up and communication between agencies, family etc to assist people to live interdependently in the community.

Education about mental illness and mental health resources for the community at all levels including schools, colleges, community forums, justice system, police service, GP's etc.

Accommodation vital for recovery – stable environment.

Linking clients into social and community networks including self help groups, sports and recreation, arts/crafts etc at their request.

Passing on of info to client/families about supports available.

Prevention, intervention, working with the whole family – education, skills development etc.

More information about alternatives not just hospital.

More community education & consultation.

Session Code: 3E

Session Title: Creating a Healthy Mental Environment

Initiator: Anne Jeavons

Recorder:

Participants (initials):

- Need for resiliency -> prevent/reduce adolescent problems etc
    - Need more programs towards resiliency
    - Can significantly help child in later life
    - Schools/parents have crucial role in this
- How can we achieve this in dysfunctional homes? Perhaps school? Also need in community.
- Need support and continuity between home, school and community networks
- Younger children may be more able to develop such resiliency and benefit from these programs
  EDUCATION IN HOME – HOW TO ACHIEVE THIS?
- ARAFMI – 'share and care' groups – get together to discuss common problems and can pass on ideas/experience to help other parents/carers.
- A key issue is having common goals and continuity between different organizations/individuals, that impact upon children/carers and parents – need more collaboration and integration between organizations and stakeholders – parents, schools – uncoordinated and conflicting/confusion in practice
- If someone needs help e.g. as a parent/carer then how and where do they find help – do we need a directory of services?
    - People need to know about services available
- For parents who have children with MH problems, once the child is discharged from hospital they may not have a clue of what services are available to them and this information is not forthcoming
- Parents need this to be made clear to them by a case manager or clinician – need to be made aware of services like WAAMH.
- Point raised again that there is no kind of directory or 'map' of services
    - No one agency can provide you with this kind of information
    - Need an up to date list/map/directory of services that people can easily access and are aware of
    - Need to know what these agencies are and what they offer
    - Even NGO's agencies don't know themselves who other agencies are
    - Federal vs State – who is driving MH reform?
    - Who will fund this kind of directory?
    - Agencies etc need a directory so they can refer someone to a more befitting, local agency if they themselves can't – at the moment they can't do this.

- UWA are currently working on such a directory – should be available in near future – with hopefully a public launch
    - Idea that each agency would have their own login so that they can update their details etc and the database will be kept up to date
    - Others expressed (in group) that such a directory being kept up to date is the key
    - Could try to keep directory up to date by having a monitored email address to which people can send comments/feedback e.g. that number for a service is no longer correct etc.

Session Code:	**3F**
Session Title:	**Psychological Treatments for SMI within Integrated Service**
Initiator:	**John Penman**
Recorder:	**John Penman**
Participants (initials):	**JP1, PC2, PB, BC1, DT, PT, AB3, CH2, KS, LG**

- Insufficient psychological treatment in mainstream mental health services for people with severe mental illness (schizophrenia and bipolar disorder) – therapies of all types – e.g. CBT, Group, Individual
- Aim to enhance peoples sense of themselves, self esteem or overall sense of cohesion, which can be damaged by experiencing psychotic episode
- Narrative therapies appear to be of particular benefit
- Not to replace biological treatments but to enhance overall care
- Comment that all treatments should be integrated through a holistic approach (including physical, nutritional, and dental care) – Problem with confusion about who is responsible.
- Psychological treatment can engender sense of hope that recovery is possible.
- For serious mental illness therapies that improve the sense of self esteem important
- Again problem of lack or deficits in availability of suitable services was raised
- Perception that psychological services within hospitals is limited
- Stories were given that illustrate distress of families bereaved by suicide – and perceptions of lack of services and inadequate treatments.
- Other countries e.g. Denmark give a model for a different approach to integrating psychological services into hospital care.
- ? Need for greater attention to psychological issues from very beginning of care.
- Suggestion that it is important to educate people that psychological treatments are important both for consumers and families
- Need for psychological services for families bereaved by suicide
- Recommendation:
    - money
    - Good mental health leaders
    - Psychological services at early stages of illness
    - Education
    - Systems approach to all mental health consumers, families and communities.
    - There are problems related to discontinuity between inpatient and outpatients care within public sector (and discontinuity of care in private sector) therefore recommend to reduce this discontinuity.
    - Involvement of families of carers in treatments
    - Early identification of people who would benefit from psychological treatment and therefore improve early intervention.

Session Code:	**3G**
Session Title:	**Effective and Appropriate Inclusion of Families/Carers Throughout all Levels of Service**
Initiator:	**Tara Ludlow**
Recorder:	**Tara Ludlow**
Participants (initials):	**GH1, EW, PC1, LW1, CB2, DB1, FM, MT, KT, OP, JL, LW2, MH2, AH4, KS1, AG, HM2, ST, AB5, CN, Merrill**

Overarching principle:
Carers need to be acknowledged as early as possible, involved at all levels (from individual, to care partner, to systemic) and included in the care and treatment plans as much as is possible in order to provide the best care and support for all of the family / community.

Confidentiality Guides: (Carers WA/MHD/OCP) have people been using them? Have they been useful? Feedback has been that the guides have been of great benefit to carers with being informed of rights, responsibilities and parameters, but there are still frustrations that MH clinics etc and staff often don't acknowledge the guides, don't know about them or just don't want to talk to families – 'hide behind confidentiality'.

"Only 1 doctor in 10 years has asked us to come in and talk with us about our son – we were totally excluded until then. Being able to meet with clinicians, find out as much as we possibly can, share our story and the background leading up to our son's troubles, what we live through, is very important. Families are the ones that have to pick up the pieces when he is discharged. This meeting has been of great benefit and relief to us – we are angry that it hadn't happened sooner.

To be involved in discharge planning and any changes that take place with medications – we often aren't told. What is the rationale, what are the side effects and what services are out there for us as family and for them in the community?

Problem with services being completely decided on by consumer as adult – we may need the service to come in and help, but if consumer says 'no', they listen to him, not to us. We need that time out, but he is the one that decides – even if he is unwell. Carers need to be consulted within the service provision, under the Carers Recognition Act WA 2004.

Upon diagnosis, we need to be informed about:

- Diagnosis – what it means
- Behaviour that we may need to look out for
- What services are available for them and for us
- What are the med's and their side effects, what are they for?
- What to do if they start to exhibit signs

- What are the early warning signs so that we can get help before they need hospitalization
- Who do we contact in your service if we have concerns or questions?
- What therapeutic interventions are taking place and what can we do to support consistency at home?

Have consistency of carer information packs in both public and private hospitals and clinics.

Have a 3-way information flow, between family/friends, consumer and clinicians so that the full story is told, rather than just the one side. As family, we have so much important information – history, other family issues, knowledge of behaviour, side effects of medications, other drug use etc, and yet, we are rarely if ever contacted. It is like we are of no real benefit, and yet we have vital information and must be respectfully involved.

Be able to gain 'carer' status on consent forms as soon as possible – and whilst consumer is well!!!

All need to be able to self-advocate and be our own lobbyists. Would be good to be taught how to do this. Would be good to be heard and for clinicians to listen to what works in our family system.

Would be good for the psychiatrist etc to ask 'what was your son's condition in previous years?' Get a family history, maybe a family session every 3 months or whatever.

Best thing has been the carer support group – helping to share and gain knowledge has been of great benefit.

When consumer moves from one jurisdiction to another, their records and preferably their support people should move with them. Has caused lots of problems with him moving from South metro to North. Need consistency amongst the disruption of the move.

Consumer getting the support that they need to live as independently as possible is paramount to us being supported as their carers.

The system seems to be so fragmented – no-one else knows what the others are doing. Would be good for there to be a list of available services and what they offered, to whom, and what the pre-requisites were.

Being listened to when my husband says that there is nothing wrong with him. I keep a diary of the issues and behaviours at home, and yet no-one wants to hear it. To be able to be listened to and acknowledged that I have very important information that may help with his treatment. This would lessen the burden for me at home. *Credibility as a key player in the care team.*

Have a case manager involved when there is a complex case or more than one person being cared for at home. This would help all to cope.

Being involved in the care plan, discharge plan and treatment plan and being able to provide key and meaningful input as a part of the care team. Carers have just as much knowledge and expertise when the person is in the community and it would be of benefit to all to be involved.

Build capacity for services to be available when we need them!

Family need to be supported to be able to let go of the consumer in a healthy way.

Housing has become a massive concern for carers. Housing for young families - what happens when the person goes into hospital for an extended period of time, and their children may become homeless?

Family needs to know that there will be meaningful support for the consumer when they are no longer able to provide support or pass away. Future planning like in DSC.

Who represents us as carers in the government and other high level? Need to have a voice at all levels that supports us and can 'go in to bat' not just in times of need, but at all times – resources need to be provided for effective carer representation (Carers WA provides this)

The clinical team needs to include and keep families informed. Give written instructions to families when new med's are introduced.

Children as carers need to be seen as a very important aspect of the care situation. They can be highly marginalised – the whole care situation needs to become more holistic in its focus. Is far too focused on consumer only.

- Family carers need to be involved in all levels of care, from the outset, with meaningful interaction, not just tokenistic inclusion when the service requires.
- *Carers need to become an embedded and intrinsic part of the care team, sharing and receiving information regularly in a professional way.*
- *Carers and consumers need to be seen as equal partners with services. This can only help to improve social and community support, making it more sustainable.*

If carers are supported to care, they can do so for longer, more effectively and capably.

Session Code: **3H**

Session Title: **Chronic Hyperventilation: The Scourge of Western Health**

Initiator: **Peter Kolb**

Recorder:

Participants (initials): **PK1**

Cancelled due to lack of interest.

Session Code: 3K

Session Title: Human Rights Approach to Mental Health

Initiator: Pui San Whittaker

Recorder: Pui San Whittaker

Participants (initials): AH, MC, AL, AF, JF, PW, PSW, KV, MN, AH, HS, KM, PF

Human rights and responsibilities

Basic human rights are housing, employment, education, health care, transport, reproductive rights, respect and dignity, financial control. Personal freedoms need to be balanced with responsibility. Rights of the family, consumer and community need to be protected. This is an issue in areas such as involuntary treatment orders.

Labels and stigma

Labels given to people with a mental illness by psychiatrists and doctors needs to be less damaging. E.g. "temporary depression" rather than "manic depression". Is it the label that is damaging or the societal/community attitudes that results in stigma? Labels are used to describe the whole person rather than part of the person. The media perpetuates stigma by using sensational language, particularly when reporting violence. Stigmawatch is helpful in monitoring the portrayal of mental illness in the media. There is a need for services to promote positive mental health stories.

Conventions, legislation and policies

UN Convention on the Rights of Persons with Disabilities was ratified by Australia in 2007. There is a need for human rights legislation on a federal and state level. Politicians need to use the language of rights. Victoria Office of Disability has developed human rights indicators for people with disabilities which state government departments must report on. Would this add another layer of bureaucracy? Australia should be accountable as signatories to UN Conventions, including Conventions on the Rights of Indigenous Peoples. It is important that policy translates to practice on a grass roots level.

Social inclusion

A Social Inclusion Policy Unit would be beneficial to promote rights, overcome discrimination and promote equity for people with a mental illness in areas such as employment.

Community education

There is a need for community education on human rights, mental illness and stigma. This should include schools, training for educators, health professionals and government staff that deal with the public such as police and Transperth staff. This could be provided through Mental Health First Aid, which was done at the Department of Housing and Works. Training needs to be "real", with real life stories such as Gary MacDonald's experiences, include consumer stories, demystify stigma, be interactive and provide resources on services that you can refer to. Suicide rates are now close to

road accident death rates. There should be increased funding and advertising campaigns to promote mental health awareness.

Advocacy, support and resources

Human rights abuses need to be reported and followed up. Linking people to strong advocacy services needs to be enhanced. What can we as individuals do to promote human rights in day to day life and help people to access advocacy support? There is a need to educate consumers to be empowered, aware of their rights and advocate for themselves. Support groups exist but people need to find what suits them. Healthright produced a card on what issues you should raise with your doctor. Could mental health consumers have a book similar to what is used in child health, where doctors fill in progress reports, medication etc so that consumers have a copy of this. There should be a database of all mental health issues and services that is accessible online through the State Library.

Care coordination

Care coordination would help people to access services and activities. Consumers need input into their care plans for when they get sick. Look at other successful models of outreach in other countries.

Workforce

There is a need to increase staff levels such as psychiatrists, psychologists and mental health nurses. Staff should be surveyed with a prize to increase the response rate. Conditions that could be improved are flexibility, shorter hours, longer holidays, improved working environment. The culture of organizations can make it a difficult place to work and result in high turnovers. Need to look at competitors in other industries and talk to staff about what keeps them in the workplace. Older staff could mentor younger staff. There could be more graduate places that allow people to gain further qualifications and experience.

Session Code:	**3L**
Session Title:	**Use of Medication with Young Adolescents** • Level of supervision/monitoring • Informed consent • Crisis management
Initiator:	**Deborah Tedeschi**
Recorder:	**Deborah Tedeschi**
Participants (initials):	**KS2, SR3, BN**

- All medication for children and adolescents should be prescribed with a checklist indicating what the medication is to be used for, how to use it, what to do if person goes off meds suddenly, contraindications & side effects, what to do in the event of side effects. The parents should be given a copy.
- Chemists should be obliged to ALWAYS provide a consumer medication leaflet
- A crisis management plan should be developed with the parents.
- In the event of a suicide while on medication or non compliance with medication a psychological autopsy/post mortem is carried out. The premise for this is:
    - Any catastrophe is usually made up of a string of small errors or system errors. We need to examine these errors without fear of retribution.
    - The effect would be to
        - Provide the family with all the information they need to make sense of a horrible tragedy – give them a certain peace. Keep everyone out of the courts – give them a forum to express their disappointment & despair – give them a chance to help make sure this doesn't happen to other families.
        - Provide the service providers with information on the weaknesses in their services

Session Code: **3M**

Session Title: **Shifting Current Resources into a Direct Rehabilitation Approach**

Initiator: **Kevin Mullican**

Recorder: **Penny Thomas**

Participants (initials): **KM3, MP2, PT, JF2, CB3, ZZ**

- Important for more people with mental health knowledge and skills to work in rehabilitation
- Go out and find the work, don't wait for it to come to you.
- Holistic approach – people in partnerships
- Important that the people who are capable are able to move out of mental health services and not come back!
- Helping each other; clinicians learning off each other
- Helping consumers to realize their potential
- It's not just about medication, medication used too much
- Medication = band aid
- Alternative therapies (e.g. meditation, healthy eating, detox) Introduce a specialist ED for mentally ill people (e.g. shut-down, quiet room)
- Important to de-stigmatise / de-medicalise problems that are normal human problems.
- Important that terminology is plain English
- Support people to recognize their own triggers
- Normalising human emotions
- Looking after mental health of young people
- Positive supports VS negative supports
- Positive reinforcement to self
- Services should be available to all for free (e.g. there should be free public transport for people with a mental illness to get to groups)
- Case managers should be actively involved in the rehabilitation plan
- Important that there is a consistent person in the clients life who follows them through all programs
- Client needs to be the centre of the treatment team rather than vice versa.
- Empowerment / self worth
- Introduction of "wellness" centres and rehab services prior to hospital. Rehab and recovery / wellness services should be available FIRST
- Should be no waiting times
- Improvement in crisis help lines is necessary
- Some institutions are too much like a holiday camp and make the institution inviting to return to.
- Important to ensure people remain independent
- Institutionalization
- Important that there are activities available for the people to do.

- On the wards, "the squeaky wheel gets the oil" i.e. people acting out get attention.
- Might be helpful to separate people with different issues (e.g. separate aggressive people out)
- Early intervention – help school kids to identify emotions
- Teaching / rewarding kids for supporting each other
- Possible skills shortage among clinicians results in inability to do rehab in generic positions
- Learning to look after our colleagues
- Workforce issues = if we up-skill clinicians it will be more realistic that rehabilitation can be done.
- E.g. training in skill development, CBT
- It seems that clinicians are doing rehabilitation or whatever is their interest and this isn't a good way to work. Not according to what is an identified need.

Session Code: **3N**

Session Title: **Self-Healing is the Only Time Healing**

Initiator: **Josephine Wright**

Recorder:

Participants (initials): **TW, DP3, DD, SH2, LS2**

For every unkind remark like "you are so stupid" an energy imprint remains. It is said to take 10 encouraging events to erase it. Unless it is erased it will remain, broadcasting its message. Imagine how it would be in a world of no judgement where everybody was treated as gifted.

Duc:
I talked about 100th monkey & mental telepathy easing vibrational harmonies. How can self healing happen? Working with the mind.

DP:
Talked about her interest – the art of living.

T:
Was a social worker from MH corrective services who worked with very sad cases of self-sabotage & destruction largely Aboriginal.

SH:
Talked of his observation of destruction of the planet from a depressed point of view while saying he is bipolar and caring about saving the planet

DP:
Interested

Told my story that 'life is expansion'. See the future for old people (I'm 75½) expanding conscious awareness and their phenomenal lives to be a resource and raise community energy, awareness and wisdom.

Session Code: 3O

Session Title: Advocate & Co-ordination of Mental Health Services

Initiator: Maureen Burke

Recorder:

Participants (initials): RS, PH, AF, PW, KD

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1. No central contact to co-ordinate agencies.
2. No knowledge for carers & consumers as to who they may contact.
3. Has funding limited to business hours when those with chronic illness need more "hours" to assist them to live in the community, i.e.:
    - Social
    - Mental
    - Domestic
    - Budget
    - Shopping
    - Bank & etc
    - Medications
    - Doctor appointment
4. Rehabilitated consumers on committees don't understand difficulties of those caring for chronically ill consumers
5. Central office -> refer to: particular person (position), co-ordinate services for individual clients living in community, i.e.:
    - Agency funded to assist client in all areas.
    - Contact number for client
    - 2 days social support recreation
    - 2 days per week domestic help, washing, cook meal, house cleaning, medication assist.
6. Awareness of various agencies needs to be given to carers, i.e. DOHA, Dept of Health & Aging workshops. Workpower. "No clearing house in whole of Australia".

Session Code: **3P**

Session Title: **How do we Know it Works? Research & Outcomes**

Initiator: **Duane Pennebaker**

Recorder: **David Buchanan**

Participants (initials): **DP2, MC4, LH, CR1, and various others**

Duane:
- A barometer of interest?
- Efficacy – effectiveness – difference
- Are we making a difference?
- We don't do enough evaluation
- We go around in circles ??? the 'Concur Race', but we do not have enough evidence to suggest what we are doing is either effective or efficacious.

Margaret Cook:
- Parents & children gaps in research – no research – no funding.
- Children & parents who have MI
- Scenario based research, lived experience of MI, abuse & patterns of trauma (inter-generational).
- Complete causes beyond diagnoses
- Homelessness
- Co-morbidities – E&OH & substance abuse, esp. Methamphetamines

David:
- E.g. Barwon (Geelong, Vic) & TCM
- Jigsaw program
- Seamlessness of service
- Clinical models of service
- Research inform better service
- Treatment Head = 89% of $

Danita:
- Global Mental Health RC so every service can tap into it.
- Research needs to be co-ordinated for every service to local – ?? perspectives

Louise Howe:
- Trieste Community Recovery
- Community recovery approval
- 100% success rate & recruitment
- Micro community

Ian C
- Residential intensive care e.g. Eden Hill

- Extended support
- Invaluable
- Community support & authentication

Callum Ross
- All research has to reflect the subjective realities of the clients/consumers

Danita:
- Needs to be a co-operation between industry & universities to inform & evaluate practice.

Louise:
- Grow – national & international award winning research (qual) which integrates with the subjective experience – vital for evaluation.

David D:
- Outcome measures – Kassler 10 dis.

Margaret:
- Stereotyped, distanced antipathetic

Bob:
- Research was once seen as irrelevant & now is highly pragmatic & deeply involved.

HoNOS:
- Consumers do not know about HoNOS

Duane:
- Strategic data over investigation driven data

Phillipa:
- Likes research

Group recommendation:
- Central research centre to be a resource to all MHS

Session Code: **3Q**

Session Title: **Sharing Community Education**

Initiator: **Stuart Tomlinson**

Recorder:

Participants (initials):

Wouldn't it be good if short courses for the community were truly accessible to the community?

There is an opportunity for service providers to promote their courses together alongside each other in a shared space, i.e. a website.

Members of the community to go to one place to see all the courses on offer in their geographical area and area of interest.

To make this work, service providers could use this system to book people onto courses others are running.

Idea will be progressed

Session Code: **3R**

Session Title: **Counseling, Mental Health & Training**

Initiator: **Marin Philphott**

Recorder:

Participants (initials): **AH2, RF, MP3, CB3, AJ1, AB1, SW1**

- Counselling not available to mentally ill population
- Everyone should have access to counselling
- Less medication might be needed
- Psychiatrists are not therapists?
- Not enough mental health nurses available
- Physical conditions and mental illness needs to be taught
- Self harm assessments need to be taught
- Co-morbidity – alcohol & other drugs & 20% & mental illness
- Specialisation with self harm
- Borderline personality disorder – a hated diagnosis
- A need for specific mental health training for counsellors
- Long wait lists in emergency departments
- Stigma extends to professionals?
- Emergency department for mental health only?
- No facility for deaf and linguistically challenged persons
- More training of deaf

Session Code:	**3S**
Session Title:	**Mental Health Issues for Humanitarian Entrants (Refugees)**
Initiator:	**Elise Orange**
Recorder:	**Elise Orange**
Participants (initials):	**AS, OP, KU, NS, CJ, RH1, SH3, LS1**

Refugee's arriving in Australia currently have experienced significant complicated issues and are experiencing on going difficult complicated issues which contribute to their mental health or mental health difficulties.

Interpreter services

Within the public and NGO services there is a need to access specialist interpreter services.
Currently there are no guidelines for training interpreters.
The TAFE course for training interpreters does not allow for specialist training and a degree course for interpreter training would be much more appropriate.

Recommendation: Universities undertake interpreting as a degree level course

Within the public service there may be policy that interpreters are to be engaged but no procedure for front line staff on how to go about this.
Recommendation: Each sector of the public service review their policy document to ensure there are procedure that back up their policies.

When bicultural workers or interpreters are engaged by services there can be difficulties where the interpreter come from within the cultural community and so there are issues of confidentiality. Within some cultures people feel a cultural obligation to share information within their cultural group.
Interpreting for MH is a subspecialty, which lacks people with appropriate expertise. MH workers need to work with interpreters to create appropriate language and descriptions where there is no language or description within a language group. For example in many languages there is no concept or words for 'dual diagnosis'.

Stigma

Mental Health issues have huge stigma within certain cultures and this can result in people failing to access services or not share information (either through inappropriate interpreter or not).
In order to over come this there is a need to *make networks* within particular cultural groups and know who the important community people are HOWEVER this is not core business and often this sort of community development activity is not supported by management structures within the public service.
Knowing community networks allows

- a holistic approach
- engaging with traditional healers and healing methods
- engaging with important community people.

Recommendation: Health Dept support staff in engaging in community development activities that support them in developing networks within CaLD communities.

People who arrive from refugee camps don't recognise their illness and symptoms because either everyone else in the camp is experiencing the same symptoms or because they are stigmatised and marginalised within the camp if they discuss their symptoms.

Suggestion: Could the Mental Health First Aid resource currently available through the Commonwealth (MHFA.com.au) be implemented into a refugee context and distributed to key stake holders

Early Intervention & Screening tools

How do we educate people that exposure to trauma is an inherent risk factor for developing mental health issues. By doing this we are able to access and implement early intervention programs and prevention programs which are evidenced to by more effective and supportive.

Can a screening tool be developed or implemented for new arrivals which will assist in identifying issues and intervening early.
There is a need to have tools and education programs that are simple and useable to assist in the identification and early intervention of mental health issues.
There is a need for education programs that assist key people
-DIMIA staff
-English language educators and schools
-Police
-GP's
That will enable to them to identify and support refugee's experiencing mental health difficulties and direct them to appropriate services.

Recommendation: A screening tool be developed or implemented for every new arrival to assist in identify people experiencing mental health difficulties.

The majority of people who arrive in Australia through a refugee experience have experienced some level of trauma. There needs to be skilled people to support these people in this and to differentiate between those who have experienced trauma and have demonstrated resilience and those who are exhibiting PTSD symptoms. When we have this information we will then be able to identify factors that support people to be resilient and be able to intervene for those who are experience PTSD.

<u>Engaging people with appropriate skills</u>

Currently there are people entering the country with qualifications and skills who are not having these recognised and used. Many of these skilled people work in low skilled jobs or in jobs that are not appropriate to their skills.
How do we use the wealth of knowledge and expertise that is currently available within some cultural communities but is not being used?

Illegal Entrants

There are currently people arriving illegally who are only accessing services once they have contact with the police because they are illegal entrants. Often these people are very unwell and are employed in illicit or illegal industries such as prostitution.

Mental Health Carer Respite

There are not appropriate carer and carer respite services which is another stressor for families' already experiencing stress.

Funding

Commonwealth funding is currently distributed across agencies that compete for funding. This result is small piecemeal programs that are not coordinated and who do not refer to each other. These services are not funded enough for their admin time so the Public Service/Sector finds it difficult to access them because they are so under the pump providing services they do not have the resources to deal with the bureaucracy inherent in the Public Sector. Similarly they are not able create appropriate policy and evidence based practice.

<u>Culture within the public service</u>
Currently there is a culture within some aspects of the public service which refuses to embrace the need for flexibility or appropriate cultural responses to particular community issues.
The response to this needs to be both top down with policy responses and bottom up with coal face workers having contact with people from various cultures. There is a dearth in appropriate training for coal face workers although there is significant training available in the Eastern States.
Recommendation: Appropriate training be made available to public service workers from service providers in the Eastern State

<u>Things that are working in refugee experiences or in the MH sector.</u>

- The Queensland's Government response to domestic violence in CaLD communities identified those CaLD communities most at risk and then undertook focus groups which
    - Identified key messages which were not reaching the community
    - Identified cultural practices which were beneficial but were not recognised within mainstream culture
    - Identified mainstream practices and language which wasn't working
        - Language that was inappropriate or being inappropriately interpreted
        - People who should be involved in processes

    - How to position the therapist in a way that is culturally appropriate.
- In Western Australia Osborne Park Hospital has been running a program with women pre and perinatally which is very successful (Dr Branden Jansen)
- Curtin University in conjunction with others is running a perinatal support group for Iraqi women which as been successful.
- Danni Rock – Case Management in pre and post natal care settings.

Session Code: **3T**

Session Title: **Accommodation for Youth with Mental Health Problems - Homelessness**

Initiator: **Denise Follett**

Recorder: **Denise Follett**

Participants (initials): **DF2, JL1, MJ1, AW3, TF, LL2, DW, KD**

- Current planning and roll out of accommodation options under mental health structures not addressed (proportionate to need), specific dedicated youth accommodation options – Recommendation % of all supported accommodation places be dedicated to youth proportionate to population.
- Current SAAP funding models not sufficiently staffed / resourced to meet the more complex behaviour management of young people with mental health problems – need for different / specialist programs.
- Poor communication believe accommodation providers are mental health services – particularly after discharge from hospital
- Poor advice to accommodation providers re managing mental health and behavioural problems from MHERL and CERT
- Recommend a project links and Fremantle Youth Homelessness project to be developed, funded and implemented in North Metro including clinical resources to support residential programs.
- Poor knowledge of mental health referral pathways in youth accommodation providers.
- Supported accommodation options need to? By residential treatment and residential rehabilitation programs that are youth specific.
- Consumer involvement in planning
- All accommodation planning needs equity proportionate to population to support youth. NB current ILP programs offers only 3 beds / 10 places of psychosocial support to youth.
- Privacy and anonymity, confidentiality for young people – separate from any services that their parents are accessing.
- Cultural security and sensitivity and access to cultural consultants in accommodation facilities – ATSI practitioners included in multi-disciplinary teams
- Vulnerable young people under 18 – Not necessarily make minors who need supported care not independent living and acute DCP management.
- Transition for young people leaving out of home care – lack of accommodation.
- Jail and hospitals become the default position for young people.
- Full comprehensive continuum of care through inpatient – step downs / day programs. Supported accommodation – transition to independent accommodation including residential rehab treatment programs for young people with affect regulation problems
- Specific needs for young parents with mental health problems.

Session Code: **3U**

Session Title: **Community Mental Health Education**

Initiator: **Ken Stafford**

Recorder:

Participants (initials): **MS5, RD2, DT1, KR, AP1, TC, LC2**

- Shortage of Mental Health Workers
- Country service – pick right person to train
- Inter-agency collaboration required
- Opportunities to educate youth workers and support agencies
- Boundaries of 'mental health' are blurred
- The challenge how to equip people in the sector/relating to people in mental health issues.
- Membership of professional associations how can this be monitored and evaluated regarding qualifications. Their suitability to address the community mental wellbeing issues.
- Quality assurance for the sector
- Educating people on what services are available is also an issue.
- Education programs need to incorporate the mental/physical relationship.
- Counselling has a practical orientation.
- Community education programs are an important Capacity building strategy to increase positive response to community issues of mental health.
- Start from task and look at what skills are needed.
- Change mindset
- Turn upside down process of training
- health professionals aren't necessarily well enough trained in recognizing mental illness or appropriate intervention
- Culture requiring discipline specifics
- Needs to be recognition from government to employ people with appropriate skills rather than specific qualifications
- Education benchmarks rather than specific professional registrations
- Peer support workers
- Well consumers, trying to get better, hope, choices, information, support for choices
- Difficult to pin point ratio of whole of life care needs/psychotherapy/medical support
- Opportunities for staff development and training
- Are professional able/trained to develop/implement care plans.

Session Code:	**4A**
Session Title:	**Mental Health Services for Infants and Families**
Initiator:	**Patrick Marwick**
Recorder:	**Christine Hatch**
Participants (initials):	**PM2, JM2, RK, PM1, CH2, AF2, AW3, RR, BP, MN2, MJ1, GH1, DF2, KD, MH**

- Very few infant specialist services
- Lots of research in area but little money spent
- KEMH Mother – baby unit -> community based
- We need language to describe 0-3 yrs mental health
- Is it acquired or inherent?
- Early interventions must look at parent – baby interaction
- There are barriers (e.g. geographical) to accessing services.
- International experience tells us that money spent on infant mental health is money saved later.
- Organisations like Education Department, DCD would have more clout if they collaborated on this.
- Beyond Blue has recognized the WA progress on issue.
- What condition would warrant 12 sessions a year for under 3 year olds?
- Not all consumers in this age group are brought for help so need to look at going out into the community.
- Best Beginnings is an outreach program which already exists and could screen for risk factors in mental health area.
- Continuity of care across agencies is important.
- Direct service model is currently how funding applies.
- Sharing care demands more of both / each agency however outcomes are potentially much better.
- Feasibility and desirability of home access visits was discussed.
- Some populations are highly disadvantaged (within Perth and within WA)
- Strategies for promoting infant mental health
    - the media
    - another forum
    - CaLD
    - ATSI
- New maternity / hospital discharge follow up any concerns.
- Post natal depression funding doesn't always recognize mother and baby as a unit
- Infant mental health is everybody's business
- Screening for mental health problems would be good for the whole community
- Partnership with consumers was a strong recommendation.

Session Code:	**4B**
Session Title:	**Education and Awareness Training for Mental Issues in Community**
Initiator:	**Anne Jeavons**
Recorder:	**Stuart Tomlinson**
Participants (initials):	**ST, AJ, SW, EN, TW, SW, AB, SR3, AP1, CH**

Some courses are not accessible to key target group because of cost. Mental health first aid is good and other related courses, especially when marketed to the community as a whole.

Good branding can break through stigma.

How about minority groups? SANE do pamphlets in different languages.

When individuals present, education is provided to family members.

In many families more than one individual has a mental illness.

Difficulties of accessibility due to distance / geography.

Some families function without external support.

We recognize the value of peak bodies and their role in mapping, sharing what is available.

Directories are very, very costly.

Can we have a similar session in 6 months to maintain momentum?

Session Code: **4C**

Session Title: **Checks & Balances – Managing Mental Health Complaints**

Initiator: **Pip Brennan**

Recorder: **Pip Brennan**

Participants (initials): **PB, JL, HM2, LS2 LS4, IM, LR, DT1, PT, CT, AM**

What complaints bodies are there?

- Service level (e.g. patient liaison officer, complaints officer)
- Council of Official Visitors
- Office of the Chief Psychiatrist
- Mental Health Review Board
- Mental Health Law Centre
- HD – Mental Health Division
- Office of Health Review
- Health Consumers' Council

Issue: There is not the same level of support in mental health services for the management of complaints as there are in hospitals, where there are often 3-4 people (patient liaison officers, patient advocates etc) who deal specifically with complaints. Therefore complaints drift from agency to agency, before arriving back at the provider via a Ministerial – the worst possible scenario. The end result for the complaint is that someone who has not necessarily been involved in the care provides a written response via the Minister's Office which does not always address the complaint

Issue: Patients are not always listened to. There complaints can too readily be dismissed as vexatious, or nuisance.

Issue: People can be intimidated by complaining, especially as they need to access the service they are complaining about on an ongoing basis

Issue: A culture of blame means that instead of looking at complaints in an open manner; in the current climate the only complaints that get heard are those that are not able to be covered up.

Issue: The culture of blame does not allow for patients and family members to obtain "closure" after an incident.

Issue: With all the different bodies to complain to, how do people know how best to proceed with a complaint?

Issue: complaints processes differ from health service to health service, campus to campus

Issue: concern that none of the agencies is truly independent – MHRB answers to SAT, some members are on both, HCC, OHR funded by Health Dept, OCP in Health Dept etc
Recommendation: have a body directly report to parliament (as in FOI, Office of Public Sector Standards etc)

What do you think is the best way forward for complaints? What do people want?

- The issues need to be dealt with at **service provider level** wherever possible. There needs to be support and resources (staff) at service provider level to deal with the complaints
- Need a **simple process** to make complaints
- Patients and family want an **explanation** – a review of psychiatric care, a review of the systems and processes in place at the time of an event (e.g. discharge of patient who subsequently completes suicide)
- Patients and family need an opportunity to be **heard**
- Patients and family need an **acknowledgement** that things have not occurred as they should have
- Patients and family need an opportunity for a **face to face meeting with actual providers** in order to feel that the matter has been resolved
- Patients and family need to feel that providers are made **accountable** for their actions
- **Providers** need to have an opportunity to **discuss the event** from their perspective
- **Providers** need **protection from compensation** claims to allow an open discussions on what went wrong

RECOMMENDATION

- At the local level, i.e. at the service level, ensure there is a local service quality service team which **reviews complaints** which has input from both the **provider** via the patient liaison officer and from either a **consumer** or a consumer representative group such as Council of Official Visitors in a **timely** manner

Topic Code: **4D**

Topic Title: **Mental Health Week Planning**

Initiator: **Anthea Low (Communications Officer, WAAMH)**

Recorder: **Karen Sheriff (ILC WA)**

Participants (initials): **AH, IW, DW, CB, AN, KS, KM, AP, AL, KS, PF, LW, LH**

International Theme – Mental Health a global priority, up-skill resources by citizen advocacy and action.

Mental Health Australia – This is about social inclusion and participation in 2008. "Participants 08"

WA Theme – suggestion Improve Mental Health – 'Speakout'

Suggestions: 'Vote out'
'Shout out'

We all have 'mental health' there needs to be more acceptance.

'Mental Health – everyone has it – How's Yours?'
'Mental Health – everybody business – including yours!'
or
'Mental Wellbeing – think about it – talk about it.'

'Mental Health – Think about it, talk about it.'

Materials/Resources: Bumper Stickers, stress balls, balloons, post-it-notes, magnets, pens, shopping list pads, caps.

Lifeline No:
Crisis Care No:
WAAMH Website

Week of 10th Oct

Other suggestions: TV, Radio, Press, Papers, Corporate opportunities

Choir: Choir of Hard Knocks – event 14 Oct – Perth Concert Hall

Connect Choir and Mental Health week – radio adverts, CD, radio

Access 31 – TV Advertising

Community Radio
Ethnic radio

Facebook

Try to connect service providers to jointly organize events 'congratulations and celebrations' mental health week – good news stories

Raise profile of inclusion in the workplace/community street theatre

Awareness talks – mental health in the workplace

Mental health First Aid training

Training DVD

Ensure people are linked up to Mental Health Week – network emails

Calendars (think about it everyday, use all year)

Session Code:	**4E**
Session Title:	**What Should our Public Mental Health Services be Providing to our Communities Across Western Australia**
Initiator:	**Warwick Smith**
Recorder:	**Warwick Smith**
Participants (initials):	**AB3, AB5, AH1, BC1, BW, CB3, EW, KS2, LE, LR, LS1, MP1, MT, PC2, PF1, PT, PW2, SH2, SM4, TF, WS2, WV, ZZ, PB2, BC3, HT2, SR4, RE2, GW2, JC2**

- 20% population
- Public mental health services should be serving 3% to 5% of the population.
- Range of services required for clients & families
    - Hospital
    - Intermediate care
    - Community services
- Focus has been on psychosis services, severe & enduring mental illness.
    - Far greater number of individuals could benefit from public mental health services.
- Comprehensive service unavailable in prison.
- Focus on role in public mental health services & get good at that first!! In CAMHS, Adult & Older Adult
- Refer for assessment/treatment or consultation/liaison or group programs.
    - This is a start?!
- Service to meet the community's needs, e.g. Rx meeting needs of GPs.
- Has it been evaluated whether utilisation of GPs is effective – everything we do should be evaluated!
- Quality of services is important.
    - Clearer about who should be provided services
- Particularly focus on special needs, e.g.:
    - Dual diagnosis
    - Personality disorder
- Consistency is a critical factor across Western Australia.
- Offering the community the connections with other agencies – currently inconsistent.
- Community services not part of the acute service – link to the community. Continuum of care, prevention & promotion, acute responses & rehabilitation. Working with GPs.
- Primary & secondary levels of care in the community.
- % formula to drive service provision.
- Identify communities at risk & target services to this.
- Where are the outcomes of the clinical mapping???
    - What kind of service is delivered
    - How many staff are providing level
    - Starting at a treatment level (is this the wrong way)

- No defined role for community mental health services?! Is it time to review with the change in NGO sector for mental health care?
- Services are driven by personalities of staff rather than clear direction – somewhat more so in rural.
- Education sessions & training & provide informed services.
- Better outcomes policy is not sound as some providers (of psychology) have insufficient training in counselling & therapy.
- Ongoing training is essential for skills & competency.
- Public mental health can provide guidance to GPs on appropriate, e.g. psychology.
- Different models of training for staff across Australia.
- Clear education on roles of drug & alcohol services, Dept of Child Protection etc.
- Support for people with mental illness to access other resources
    - Connectivity to other agencies e.g. GPs
    - Utilising peer supports e.g. NGOs
- Co-location model – care coordination.
- Prioritisation of clients that require services – not necessarily diagnostic.
- It should not be crisis driven approach.
- Quality driven approach, smaller teams (MST) seeding these services & letting them grow specialist point of view needs to include those that fall through the gaps.
- ? sufficient services to provide services into the prisons. Understaffed/underserviced. Neglected area, negligible service in jail & this is where people end up.

<u>GAPS</u>

- Focus not just on diagnostic categories.
- Quality of service & role for specialist needs.
- Conservation liaison services.
- No consistency of service over WA
- Aboriginal health.
- Focus on continuum of care.
- What do public mental health services do – who are our priorities?
- Clinical mapping - what are the results of Neil Preston's mapping exam.
- Rx levels.
- Services are personality driven rather than clear definitions.
- Is separating services creating the divisions?
- Co-location model.
- Integrated approach to service delivery (smoother & coordination)
- Disjointed services.
- Quality of data to share (PSOLIS) – gap of information:
    - Outcome measure
    - Hold accountability

Recommendations:

- Research part of all service delivery.
- Research & accessible information.
- Consistent method of delivery of services.
- Standards that establish a baseline of service.
- Consistent consultation/liaison service.

- Delivery of culturally specific services.
- Care coordination model.
- Development of education & training packages for staff – commitment to competent practitioners.
- Professional education in NGO sector.
- Supporting families & carers for patient to live their lives in the community.
- Role of service articulated into documents – communicate that to the public.
- Articulation of vision for big picture – 10-20 years time.
- Define how community mental health services articulate into the community.
- Introduction of support people (mental health support workers).
- Active CMH services members in their community.
- Encourage service initiatives.
- Local networks establishments.
- What is the role of the Division? No one knows! They should be a coordinated body.

Session Code:	**4F**
Session Title:	**Developing and Framing Social Inclusion Opportunities for People with Mental Illness at all Stages of Recovery**
Initiator:	**Fran Tilley & Leonie Walker**
Recorder:	**Fran Tilley**
Participants (initials):	**JP, RF, DT2, BP, TR, CS, PM3, NSM, PT, LW, PC1, KM, MB**

Range of Services Available

- Dada – Disability XXX in the Arts – program described organic nature, individual focus supports participants. Importance of art, relationships, places to go to support people with mental illness.
- Rainbow Project
    - Community lunches and befriender 1:1 support.
    - Open, flexible and supportive.

Discussion Points from Group

- Group supported importance of activities and relationship to aid recovery.
- Flexibility and acceptance important.
- Employment as a transition focus.
- Leading By Example – Sainsbury's MH service in UK – ideas for developing voluntary/part time back to work options.
- Funding for Dada – Aus Council of the Arts – Rio Tinto, Lotterywest, Mental Health Division, Arts WA, DSC, HACC.
- Ideas for rehabilitation, revegetation programs run by larger organizations, opportunities for involvement.
- Carer MH funding – but not all individuals with MH have carers.
- Issues around self-supporting consumers.
- Importance of employers recognising needs of individuals with mental illness returning to work as well as people with physical problems.
- Examples of discrimination & stigma surrounding participation in community activities. Need to change activities & stereotypes.
- Community Sheds given as an example.
- Need for services to be provided at no cost for consumers.
- Health club memberships provided in UK for people with mental illness.
- Prescriptions, dog green prescriptions – health trusts in UK
- Symposium in June 23rd – what is required for recovery in WA
- Examples to support consumers
    - Swimming club memberships
    - Book club memberships
    - Mah-jong club memberships
- These options enable reconnection & social activities.
- Importance of social inclusion and steps between hospital & work.
- Value, relationships.

- Grow
  - Mental health can't be taught, has to be learnt together
  - Friendship is the key to mental health, provides social opportunities & connections.
- Funded by Mental Health Department (international)
- Internationally developed consumer-led organisations
  - Trieste model – business run by consumers – 13 co-ops.
  - Options for NGOs to auspice enterprises for consumers, e.g. Cornucopia a café in Melbourne.
- Need for different entry and exit points, flexibility e.g.
  - Hobart Clubhouse – consumer run, US franchise
  - Lorikeet (no longer a clubhouse)
- Need for government support to enable groups to operate in community to provide this support.
- Raise profile of mental health practitioners, staff stigmatised as well as consumers.
- Need for 'a village' approach to supporting people with mental illness.
- Need for central focus on consumer.
- Barriers to the workplace, poor education, poor social skills, mental health issues, difficult to break into 'world of work'. Need to enable people to participate in workforce with support, to enable people to develop their skills & potential. Regulations make it difficult for people to rejoin workforce.
- Examples of employers & insurers not supporting employees with mental health problems, need to reform system so that insurance issues don't prevent employment. Identify minimum supports needed to enable people with mental illness to return, e.g. difficulties with working in morning, drugs that create afternoon drowsiness.
- Myth in the community that people with mental illness are dangerous.
- Importance of providing opportunities for people in the community to engage in dialogue with people with mental health.
- Health promotions to reduce fear, e.g. see the person not the disability, I can quit promotion, positive messages, seeing the person not the problem.
- Human library idea – human books, borrow for 15 minutes over a cup of tea.
- Inaccurate perception that if you have a mental health problem that your brain doesn't work.
- Build creative relationships within mental health and across the community.
- People connected to wires not to each other.
- Lack of friends is a common issue not just for people with mental illness.
- Environment that you live in & acceptance is so important in preventing stigma. Mental illness is a progression not an on/off mechanism.
- Issues around people on medication must inform DPI regarding their medication.
- Mental health professionals can often be the biggest propagators of information that supports stigma.
- Importance of recognising and taking responsibility for self and professional views.

Session Code: **4G**

Session Title: **Developing Employability Skills**

Initiator: **Pam Gardner**

Recorder: **Pam Gardner**

Participants (initials): **LJ, SM, HD1, DL, BC1, JL1, WS, FM, JC**

- Linking people to employment agencies – problem because of poor transport skills
- Need to support people to get into employment process
- Mental health periods have episodes – but will return
- Employment agencies – who are funded to place clients with barriers to employment – reluctant to take on employees because they will not get sufficient funding for people with MI
- Need more publicity for group workers e.g. position shared by several MH consumers
- In NSW in Glendesville – Cornucopia "Create" project which employs more than 1 worker for a position. Then a pool can be called upon for a job. This became self-supporting through their industry (also one in Nundah in Brisbane). Original funding came from TAFE.
- These projects provided people with training & employees gained accreditation & were paid.
- Need to have TAFE on side to develop courses that are more user friendly.
- Climate today more ready to create a model like this here in WA.
- Recreation & work skills courses e.g. computer courses – people do not learn skills unless they can be applied & are relevant.
- Similar project was closed in 2007 (Chris William & Pauline Miles) associated with DADA.
- Money being wasted because groups are competing for funding without there being a cohesive plan. All projects etc need auditing to make sure who is being serviced.
- Accessing employment for people with a mental illness need a more flexible approach – need a safe environment in which to learn & develop employability & specific work skills.
- Has to be environment which reduces stress.
- Same applies to kids in school – need stress to be reduced.
- What can be done to skill people in the residential environment?
- Abseiling etc give people confidence but the skills don't transfer into the workplace.
- Programs that offer a supported work environment (JPET worker who commented that this is need for 'at risk youth' & MH consumers).
- Workplaces need to know who to turn to when a worker becomes psychotic.
- People with MH problems don't disclose to employers that they have a mental illness.
- Unless carers in supported/live employment at risk of losing employment if have to look after MH consumer.

- Domino effect – carer loses job because of stress of looking
- Encouraging people to apply for jobs – develop employability/specific on the job.
- In Australia lose health card when you get work – if lose job etc due to mental illness recurring then takes too long to get health card etc back.
- Employment preparation – don't want sheltered workshops – want to be full valued in the open employment only good for short term – sheltered workshops become too safe.
- Welfare to work strategy – not enough steps for people in gaining skills & confidence
- "Change makers" could be used with groups of MH consumers – a structured approach to developing employability skills while developing a project as volunteers – e.g. how to then build a BBQ. Gain accreditation. "Change makers" has work books etc already developed – see Anglicare
- Incentive to employers – greenhouse/carbon credit points for employing a person with a mental illness.
- Difficulty for people in the workforce to increase skills/improve qualifications – study constraints.
- Demand that the public service employ a base % in their workforce who have a mental illness.
- Stigma – restricting people participating in the workplace & community activities.

Session Code: **4H**

Session Title: **Personal Responsibility**

Initiator: **Catriona Were-Spice**

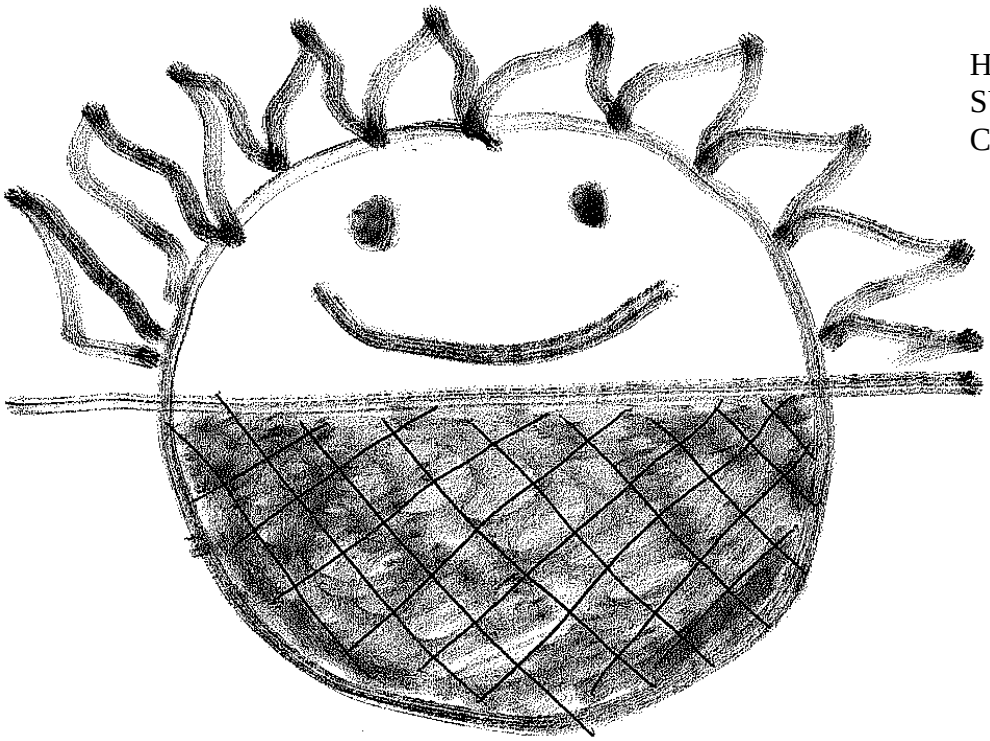
Recorder: **Catriona Were-Spice**

Participants (initials):

Start with the self!

Every interaction with others is affected by one's own attitudes.

If you carry + cherish positivity then that will flow to every person that crosses your



HELP IS THE SUNNY SIDE OF CONTROL!

path.

WHO RESCUES THE RESCUER?

Let go
Observe + respond accordingly
Value your independence
Establish your credibility

Let yourself be + that allows others to be themselves.

WONDER LOTS!
Catriona Were-Spice

Session Code: **4V**

Session Title: **State or Federal – Whose Responsibility?**

Initiator: **Alli Fillery**

Recorder: **Jasmina Brankovich**

Participants (initials): **HM, RA, JB4, EM, GW, AP**

- Confusion about what responsibilities & accountabilities of different governments
- Aged mental health crisis - is it aged care or mental health?
- Are more resources from the Commonwealth improving outcomes?
- Legal barriers have through AHMAC – they are not about money!
- Crisis versus preventative approaches/early intervention
- At the moment we have 'silos' so there's little cost co-ordination
- What will happen under the new Federal Government?

Closing Remarks

The Forum attendees who remained at the conclusion of the day were offered the opportunity to make a statement, insight, discovery or comment around how the day had been for them:

One person had felt other's passion for mental health and commented that it was as strong as hers. She had felt heard at every group she went to, and thought the day was fantastic.

Another person chose to reflect on some of the positive developments in mental health, and feels that clinicians and support workers for example are not acknowledged for what they do enough. This same person also asked what was going to happen from here…

One person shared that she had learnt how to look at, and deal with a personal situation differently.

Yet another person reflected that they had heard and seen consensus during the day. This was qualified by the comment that although people may have had different ideas; that the collective were generally heading in the same direction, which was encouraging.

The Department of Health was congratulated on the day. This person commented that if nothing more came of the day that it still would have been a success due to the connections that have been made. These connections were described as useful and powerful. The same person relayed that a health professional had commented that they hadn't heard anything new during the course of the day, which begged the question as to why the ideas haven't been captured previously. Mindful of systemic issues that had to be overcome, this person wished the Mental Health Division well in their journey of informing policy with the ideas that had been shared.

From the consumer perspective the day was considered encouraging as consumers walk as a collective alongside bureaucrats. The same consumer asked of Dr Steve Patchett – are you for real? He also challenged Dr Patchett to avoid consumers feeling disappointment through inaction, or misleading initiatives.

Brendan McKeague as Facilitator and the "wonderful" process of Open Space was congratulated. The request was made that the event be held at least annually.

Another consumer expressed that the day had renewed her passion as a consumer representative, but asked for action based final outcomes – NO GLOSSY DOCUMENTS!

A health professional participant appealed to fellow practitioners to look inside themselves and reach out. He asked colleagues to look beyond the medical model or the directions of the government of the day and use their knowledge, skills and experience to change their practice for the better. This person's last statement was ACTIONS SPEAK LOUDER THAN WORDS.

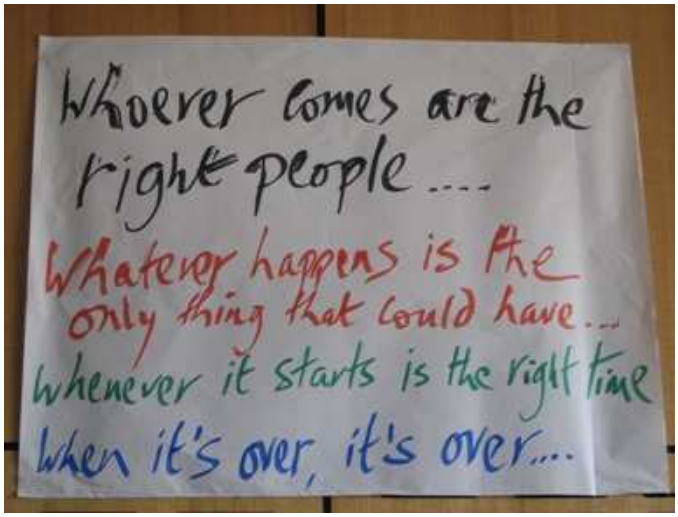
Another consumer reflected on their own healing process and advocated for the delivery of living skills in supported accommodation settings.

Remember…HELP IS THE SUNNY SIDE OF CONTROL.

The impact of the resources boom in the North of Western Australia was reflected on. That is, with the unprecedented population growth the reality is that social services are not keeping up with the increased demand, and unfortunately government funding will never meet the need. This participant posed the question of corporate sector responsibility…

Marie Taylor's Welcome to Country address was acknowledged and appreciated.

Dr Steve Patchett concluded the Open Space session with some closing remarks. Dr Patchett extended a genuine thank you to all participants for their honesty, passion and commitment to the day's proceedings. He stressed that this inaugural Open Space was only the beginning of a process – not the end, and made a commitment to host at least another three Open Space sessions in 2008-2009, with two of these being in rural areas. Participants were also thanked for both their kind words and challenges. Dr Patchett promised to use the information and ideas gained through the Open Space process to assist in planning a new and meaningful approach to mental health, which is broader than just new services.



List of Attendees

Title	First Name	Surname	Initials
Mr	Steve	Addis	SA
Ms	Pam	Anderson	PA
Mr	Max	Bach	MB
Ms	Stephanie	Bachmann	SB1
Ms	Pauline	Bagolonauicius	PB1
Ms	Judith	Balfe	JB
Ms	Samantha	Barnes	SB2
Ms	Karina	Bateman	KB1
Mrs	Ann	Bates	AB3
Mr	Jamie	Beggs	JB2
Ms	Jacquie	Belerby	JB3
Ms	Anne	Bellamy	AB4
Ms	Monique	Berkhout	MB1
Ms	Anne	Borley	AB1
Mr	Tony	Boschman	TB1
Mr	Anthony	Bourne	AB5
Ms	Carmel	Bower	CB1
Mr	Colin	Boxsell	CB2
Dr	Jasmina	Brankovich	JB4
Ms	Pip	Brennan	PB2
Dr	Adam	Brett	AB2
Ms	Cath	Brindley	CB3
Mr	Graham	Brown	GB
Mrs	Dianae	Brown	TB2
Mr	David	Buchanan	DB2
Dr	Garry	Budrikis	GB
Ms	Maureen	Burke	MB2
Mr	Pete	Burvill	PB
Ms	Barbara	Calcraft	BC1
Mr	Joe	Calleja	JC2
Ms	Anne	Cameron	AC1
Dr	Murray	Chapman	MC2
Ms	Sharleen	Chilvers	SC2
Mrs	Julie	Clampett	JC3
Mr	Barry	Clements	BC
Mr	Paul	Coates	PC1
Dr	Pauline	Cole	PC2
Ms	Debra	Coluin	DC1
Ms	June	Congdon	JC1
Ms	Margaret	Cook	MC4
Ms	Lorraine Joyce	Cooney	JC5
Mr	Sergio	Cooper	LG
Dr	Trudie	Cooper	TC
Mr	Ian	Coulson	IC
Ms	Diedre	Crayton	DC
Ms	Susan	Dartnell	SD
Dr	Rowan	Davidson	RD1
Ms	Kay	De'Brett	KD
Ms	Charmaine	Derschow	CD1
Ms	Caitlin	Donaldson	CD2
Mr	Rob	Douglas	RD2
Mr	Mark	Doyle	MD
	Mel	Croke	MC5
Ms	Hellen	Dunwoodie	HD
Ms	Judith	Durnin	JD
Mr	Robert	Edey	RE2
Ms	Lynne	Evans	LE
Ms	Joanne	Farkas	JF2
Ms	Phillipa	Farrell	PF1
Ms	Rachelle	Fentiman	RF
Ms	Alison	Fillery	AF1
Ms	Joanne	Fleming	JF3
Ms	Denise	Follett	DF2
Ms	Jane	Forward	JF4
Prof	Anthony	Fotios	AF2
Mr	Tony	Fowke	TF
Mrs	Pam	Gardner	PG
Mrs	Yvonne	Gillett	YG
Ms	Louise	Giolitto	LG1
Ms	Lyn	Gleeson	LG
Mr	Allan	Golledge	AG
Mr	Bob	Goodie	BG
Ms	Dena	Gower	DG
Ms	Naomi	Green	NG
Ms	Carron	Hall	CH1
Ms	Susan	Hardy	SH1
Mr	Sean	Harold	SH2
Ms	Geraldine	Harris	GH1
Ms	Rebecca	Harvey	RH1
Mrs	Jeanette	Hasleby	JH
Ms	Christine	Hatch	CH2
Mr	Chris	Hepworth	CH
Ms	Brianna	Higgins	BH
Dr	Ann	Hodge	AH1
Ms	Mindy	Horseman	MH2
Mr	David	Hounsome	DH1
Mrs	Louise	Howe	LH
Ms	Annika	Howells	AH3
Ms	Debbie	Hsu	DH2
Prof	Alan	Huggins	AH2
Mr	Donald	Hughes	DH3
Ms	Agneta	Hyland	AH4

List of Attendees continued...

Title	First Name	Surname	Initials
Ms	Anne	Jeavons	AJ1
Ms	Lee	Jones	AJ2
Ms	Adrianne	Jones	LJ
Ms	Margaret	Jones	MJ1
Ms	Carol	Joseph	CJ
Mr	Francis	Keegan	FK
Ms	Bronwen	Kelly	BK1
Ms	Stephanie	Kiesel	SK2
Miss	Renae	Kinsma	RK
Mr	Peter	Kolb	PK1
Mr	Peter	Kramer	PK2
Mr	Graeme	Lamont	GL
Ms	Juliet	Lange	JL2
Ms	Jenny	Langford	JL3
Ms	Lisa	Laschor	LL1
Ms	Angela	Lemon	AL2
Mr	David	Lewis	DL1
Ms	Linda	Locke	LL
Ms	Lorrae	Loud	LL2
Mrs	Anthea	Lowe	AL3
Ms	Tara	Ludlow	TL
Ms	Lyn	Mahboub	LM1
Ms	Kate	Malkouic	KM
Ms	Mandy	Mansell	MM1
Ms	Jan	Marshall	JM
Mr	Patrick	Marwick	PM1
Ms	Cathie	Masters	CM1
Mr	Ian	Mathews	IM2
Ms	Sally	McCallum	SM4
Ms	Francine	McCarty	FM
Ms	Kristine	McConnell	KM2
Ms	Helen	McGowan	HM1
Ms	Alistair	McIntyre	AM
Ms	Pia	McKay	PM2
Mr	Roley	McRobert	RM1
Mr	Richard	Menasse	RM2
Ms	Sue	Meyer	SM2
Mr	Ryan	Mezger	RM3
Mr	Con	Michael	CM2
Ms	Pauline	Miles	PM3
Mrs	Jill	Mills	JM1
Ms	Philippa	Milne	PM4
Mr	Michael	Mitchell	MM
Mrs	Joanne	Mizen	JM2
Dr	Elizabeth	Moore	EM
Hon	Helen	Morton	HM2
Ms	Idoia	Mosterin	IM1
Mr	Kevin	Mullican	KM3
Ms	Carolyn	Ngan	CN
Mr	Edward	Nieman	EN
Ms	Mary	Nolan	MN1
Ms	Marlene	Norris	MN2
Prof	Barry	Nurcombe	BN
Mr	Peter	O'Hara	PO1
Mr	Phillip	O'Keeffe	PO2
Ms	Lyn	Olds	LO2
Ms	Lisa	Olsen	LO3
Ms	Elise	Orange	EO
Mr	Barrie	Pack	BP
Ms	Vilma	Palacios	VP1
Mrs	Marlene	Parker	MP2
Ms	Audrey	Parnell	AP1
Mrs	Olga	Pasalich	OP
Dr	Viki	Pascu	VP2
Mr	Robert	Paterson	RP
Dr	John	Penman	JP1
Dr	Duane	Pennebaker	DP2
Ms	Amanda	Perlinski	AP2
Dr	Mark	Pestell	MP1
Ms	Judy	Peters	JP2
Mr	Frank	Petropoulos	FP
Mr	Alan	Philp	AP3
Prof	Martin	Philphott	MP3
Ms	Jan	Price	JP3
Mr	Alan	Prouse	AP4
Mrs	June	Prouse	JP4
Ms	Kate	Radosevich	KR
Ms	Sandra	Randall	SR3
Ms	Lee	Roberts	LR
Ms	Philomena	Robinson	PR
Dr	Rosie	Rooney	RR
Mr	Calum	Ross	CR1
Prof	Jim	Runaldson	JR2
Mr	Craig	Russell	CR2
Ms	Carol	Scherret	CS
Ms	Lavinia	Scott-Sellars	LS2
Ms	Natalie	Seigel	NS
Mr	Robert	Service	RS1
Ms	Karena	Sherriff	KS1
	Lee	Shew-Lee	LS3
Mr	Mark	Slattery	MS2
Mr	Warren	Smailes	WS1

List of Attendees continued…

Title	First Name	Surname	Initials
Mr	Jonathan	Smith	JS1
Mr	Warwick	Smith	WS2
Mr	Mark	Solich	MS3
Mrs	Linda	South	LS4
Mr	Paul	Staer	PS1
Mrs	Ken	Stafford	KS2
Mr	Ken	Steele	KS3
Mr	Rory	Stemp	RS2
Dr	Prue	Stone	PS2
Mr	Markham	Strange	MS4
Mr	Creswell	Surrao	CS1
Ms	Leanne	Suttan	LS1
Ms	Monica	Taylor	MT
Ms	Deborah	Tedeschi	DT1
Mr	David	Tehr	DT2
Ms	Jenny	Terry	JT1
Ms	Penny	Thomas	PT
Mrs		Thomsett	T1
Mr		Thomsett	T2
Mr	Ken	Thomson	KT
Ms	Fran	Tilley	FT
Mr	Stuart	Tomlinson	ST
Ms	Cathy	Toncich	CT
	Hieu	Trien	HT
Mrs	Kathy	Ussech	KU
Ms	Jennifer	Victoria	RE1
Ms	Sonia	Vinci	SV
Mr	Toby	Waddell	TW
Mr	Jonathan	Wagg	JW

Title	First Name	Surname	Initials
Mrs	Heather	Waite	HW
Mrs	Ellen	Walker	EW
Ms	Irene	Walker	IW
Ms	Leonie	Walker	LW1
Mr	Garry	Wallace	GW1
Ms	Danita	Walsh	DW1
Ms	Paula	Ward	PW1
Mr	Scott	Warner	SW1
Ms	Lynda	Waterman	LW2
Ms	Emma	Watson	EW1
Ms	Catriona	Were-spice	CW
Ms	Amanda	Wheeler	AW1
Ms	Anne	White	AW2
Hon	Martin	Whitely	MW2
Ms	Pui San	Whittaker	PSW
Ms	Bronwyn	Williams	BW
Ms	Adrienne	Wills	AW3
Dr	Deborah	Wilmoth	DW2
Ms	Kerry-Ann	Winmar	KAW
Ms	Glenda	Winnery	GW
Mr	Rosco	Woods	RW
Ms	Peta	Wootton	PW2
Mrs	Josephine	Wright	JW2
Ms	Shirley	Wyper	SW2
Mr	Zenith	Zeeman	ZZ

Guide to Acronyms

AOD	Alcohol and Other Drugs
ATSI	Aboriginal and Torres Strait Islander
CAG	Consumer Advisory Group
CBT	Cognitive Behaviour Therapy
CALD	Culturally and Linguistically Diverse
CAMHS	Child & Adolescent Mental Health Services
COPMI	Children of Parents with a Mental Illness
DCP	Department of Child Protection
DSC	Disability Services Commission
EPA	Enduring Power of Attorney
HoNOS	Health of the Nation Outcome Scales
ID	Intellectual Disability
KPI	Key Performance Index
MH	Mental Health
NGO	Non Government Organisation
OT	Occupational Therapy
PND	Post Natal Depression
PSOLIS	Mental Health Clinical Information System
SAETIS	State-wide Advocacy, Education, Training and Information Service
TOMS	Total Offender Management System