Amy Coopes reported on TheMHS Conference held in Sydney from 29 August – 1 September, 2017, for the Croakey Conference News Service.

#TheMHS2017

Croakey is a social journalism project for public health based in Australia. http://croakey.org
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#TheMHS2017 conference: previewing the voices of lived experience

Amy Coopes writes:

Mad studies, lived experience and the diverse voices of those walking within and alongside the mental health space will be the focus of a major forum in Sydney later this month.

TheMHS Learning Network annual conference – *Embracing Change Through Innovation and Lived Experience* – will bring together hundreds of workers, consumer-survivors and advocates from the mental health sector to discuss the latest reforms, realities and roadblocks to care.

From humble beginnings as an offshoot of the RANZCP annual conference in 1991, when a handful of clinicians paid for satchels and program materials out of their own pocket, the annual TheMHS summit now attracts up to 1,000 delegates from across the mental health spectrum.

Proudly multidisciplinary, with an emphasis on consumers and collaboration, the TheMHS conference program features a mammoth 12 concurrent streams over three packed days, on topics ranging from human sexuality, workplace mental health and trauma through to substance use, inpatient services and the NDIS.

Lived experience is a central tenet of the TheMHS framework and features prominently in the 2017 program as one of the year’s themes.

Viv Miller, director and founding member of the conference, said consumer voices had been essential from the event’s very first year and were now a defining element of the mental health space in Australia, both at a policy level and within the workforce.

“It’s all very good for those of us who are clinicians to say, ‘oh yes this is a really good program’, but if it’s not perceived by the person who’s receiving it as helping them, then why bother,” said Miller.
“Employing consumers and carers helps change the atmosphere in a service because you can’t talk about us and them, you can only talk about us; you can’t put a patient over there and say they are the ones with a mental illness, it’s all of us really.”

Open dialogue

Flick Grey, a childhood trauma survivor, social sciences academic and practitioner of a ground-breaking crisis care model known as open dialogue will deliver one of the keynotes, speaking about her personal experiences within the system.

A scholar of the discipline known as ‘mad studies’, Grey advocates looking beyond the ‘psy professionals’ in understanding mental health as a politicised space.

“The DSM was created in a particular historical and sociopolitical context. It’s not a universal truth, and yet it is presented as if it is universal truth, and covers up or shuts out a lot of other voices,” said Grey.

Mad studies privileges lived experience without reifying it as having “this kind of truth value that is the end of the story”.

Instead, it invites an interrogation of what lived experience means, to whom, and whose voices it amplifies or suppresses.

“There’s always people in the room who say, ‘I’m not sure that I should be here, that I belong, because my abuse wasn’t that bad; or my family was ok, we had money; I got a diagnosis but I was never involuntarily in hospital; I was involuntary but it was only for 6 months not for 10 years’,” she said.

“It’s this continual sense of who belongs and whose experiences are legitimate.”

Grey understands her own journey through open dialogue, and has come to be a practitioner of this care model pioneered in Finland more than two decades ago.

Ecological approaches

Rather than encountering someone in distress as an individual, open dialogue understands crisis as a network event involving multiple people and requiring immediate, flexible and mobile solutions such as group meetings in home environments.

Much more than partnership, Grey said open dialogue was about a complete reconfiguration of power and knowledge in the therapeutic encounter.

“It’s really about bringing together whoever is in this crisis, whoever is involved, to really come together and find a common language,” she said. “It’s about adding more voices and understanding that you will get a much more nuanced understanding of what is going on.”

Medication is used sparingly, if at all, and global experience had shown that people whose crises were managed with open dialogue were less likely to become chronic patients, she added.
Grey’s work is heavily influenced by queer theory, social justice and Indigenous perspectives, where one person’s distress is seen as a suffering of the whole community and “the worst thing you could do is isolate that individual”.

She’s also drawn to ecological ways of interrogating how systems change and respond to their environments, rather than looking for one-size monolithic solutions.

“To take a metaphor, we need an ecosystem that’s flourishing. We don’t need lots and lots of pine trees all laid out in a row – that actually kills ecosystems. How do we have a thriving diversity, I think that’s how I approach these questions.”

**Gayaa Dhuwi**

Kamilaroi/Gomeroi man Tom Brideson, coordinator of the NSW Aboriginal Mental Health Workforce Program and chair of the TheMHS management committee, said the conference had been instrumental in advancing the Indigenous mental health agenda.

Two years ago, Professor Pat Dudgeon and the National Mental Health Commission launched the *Gayaa Dhuwi (Proud Spirit)* Declaration on Aboriginal and Torres Strait Islander mental health and suicide prevention at the TheMHS conference.

This landmark document paved the way for and has been embedded within a chapter dedicated solely to Aboriginal and Torres Strait Islander mental health in the fifth *National Mental Health Plan* – the first time the issue has ever had national policy focus, Brideson said.

Mental health, incarceration and suicide prevention had been glaring omissions from the Closing the Gap targets, he added.

“There is a gap – there’s high rates of distress in Aboriginal communities, there’s higher rates of hospitalisations for mental health disorders, and there’s certainly higher levels of suicide,” he said.

“There’s also lower levels of workforce that are actually able to deal with that, it’s something that’s really needed in a serious way.”

(For more on this – Pat Dudgeon recently edited a special edition of *Australian Psychologist* on Indigenous psychology with some excellent resources, including an overview of Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health).

Until Indigenous-led, sustainable, place-based mental health workforce solutions were found, Brideson said “we’re potentially barking up the wrong tree”.

Inclusion of Aboriginal and Torres Strait Islander peoples in all facets and at all levels of policy and program development, and ongoing evaluation of services was absolutely critical, he added.

“Only a few of the programs across the country that have been funded over many years have actually been evaluated in a serious way, and that to me is just a real disturbing fact,” he said.

“What it says in some ways is that it doesn’t matter what happens to Aboriginal people and it doesn’t matter what programs happen because we’re not going to look at what’s good out of them, what works and what works well.
"There’s funding but there’s no checks and balances, and that’s a real shame.”

**Tackle racism at all levels**

As illustrated by the [Yarra Council Australia Day furore](#), Brideson said racism was an enduring mental health issue, reflecting unfinished business with Australia’s First Nations peoples.

This went from the uppermost echelons of government right down to individual service provision level.

“The relationships between the state and Aboriginal people have just not been resolved to a way that’s satisfactory to all parties,” he said.

“It’s very awkward when you have to become an expert on everything from boomerangs to land rights and everything else in between, and defend or not defend decisions – and that goes for every Aboriginal person.”

Rather than have this discussion, or address issues such as incarceration and child removal, Brideson said the conversation remained simplistic, and paternalistic at best.

“Surely the health of Aboriginal people isn’t just about going to school, having a job and eating fruit. It’s got to be much more in-depth than that.”

**Embracing change for the better**

Meantime, Aboriginal communities, and particularly those in the mental health space, faced a “serious overload of expectation” and rapid reforms and funding shifts that made the system impenetrable and difficult to navigate.

“While I’m about change and embracing change, we want to actually try and make change happen in a better way,” Brideson said of the conference theme.

Federal governments of both political persuasions had been keen to put their stamp on mental health and promote themselves as champions of the sector in the past decade that, while commendable, had seen a succession of short-term programs with little connection to existing services.

On the ground, funding arrangements meant providers had to compete rather than collaborate or complement one another, and Miller said this had resulted in a squeezing of the public sector.

In these circumstances, Miller said coming together for meetings like the TheMHS conference was more important than ever.

“It’s a learning experience for attendees, but it’s also about connections and forming networks,” she said.

“It all adds to an impetus towards reform and better outcomes for consumers and families.”

Listen to a preview on ABC Radio National: **Peer workers a powerful way to support those with mental illness**.
You can track Croakey’s coverage of the conference here.

#TheMHS2017 conference to centre the voices of lived experience

Twitter previews

TheMHS @themhs.org • Aug 16

#THEMHS2017

Melissa Petrakis @MelPetrakis

It will be great to have @Fay_Jackson_MH present at @themhs.org conference on Thursday re co-leadership work of @FlourishAus #MentalHealth

TheMHS @themhs.org • Aug 16

#themhs Checkout the featured symposium on mentally healthy workplaces Fri 1Sep at TheMHS conference. Register themhs.org

beyondblue @beyondblue

Mentally healthy workplaces rarely just ‘happen’. Creating a mental health strategy is crucial: headsup.org.au /healthy-workpl... #HeadsUpAU

TheMHS @themhs.org • Aug 16

#THEMHS2017... ParraGirls: Past, Present. Registrations still open bit.ly/29IRpKf #mental #health #conference

FEATURING AT #THEMHS2017

Virtual Reality
ParraGirls: Past, Present.
3D immersive experience presenting the Parramatta Girls’ Home through the vision of the girls who were incarcerated in the home as teenagers.

TheMHS Retweeted

Murray PHN @MurrayPHN • Aug 8

Murray PHN and @blackdoginst will be presenting the StepCare program at @themhs.org conference in Sydney on 30 August themhs.eventsair.com /TMHEventInfoSi...
Profiling a “paradigm shift” in mental health

Amy Coopes writes:

A recovery-oriented movement in mental health that centres lived experience and social inclusion as primary prevention is disrupting a no-longer-defensible biomedical status quo.

This was the message from the University of Nottingham’s Professor Mike Slade, in his opening keynote to the annual conference of TheMHS Learning Network in Sydney.

Slade, Professor of Mental Health Recovery and Social Inclusion, said there was a paradigm shift underway in mental health, spearheaded by consumers, peer workers, carers and families.

As previewed at Croakey, the conference – Embracing Change Through Innovation and Lived Experience – is bringing together hundreds of workers, consumer-survivors and advocates from the mental health sector. It trended nationally on Twitter yesterday.

Slade said the lived experience and recovery-oriented movement was reframing mental health as a social responsibility – everyone’s business rather than the system’s alone – where “success” was measured not as resolution or cure but the ability of everyone to live lives of their own choosing, and diversity was celebrated.

This movement recognised that there were structural drivers of exclusion and discrimination and that inclusive societies were primary prevention; that problems were not of “them” but “us”, and that recovery took place in the community.
In this context, lived experience was the “natural evidence base of what recovery looks like” in all its diverse forms, said Slade.

“It’s not rocket science,” he said of those in contact with the mental health sector. “They – as do we all – need something to do, somewhere to live, someone to love and something to hope for.”

Individuals were understood not just as a collection of symptoms but as people, and the question became not “what is wrong with you” but “what happened to you?”, he added.

Treatment was acknowledged as a choice, not a fait accompli, and pointing fingers was traded for “learning elbow to elbow”.

While diagnosis was a lifesaver for some, others considered it a death sentence, and experiences with medication – though helpful in the short-term – could shorten life expectancy by 15-20 years, something he described as a looming scandal in the sector.

Slade said recovery model and approaches should be as familiar as medication for mental health workers, with peer support at the top of this list in terms of proven efficacy and a robust evidence base.

A Cochrane review of peer support workers, taking in 11 randomised controlled trials (RCTs), had shown outcomes to be no better or worse than those seen with professional treatment, and Slade said traditional metrics just couldn’t account for some dimensions: “How do you run an RCT for hope?”

Peer delivery and design (for example, through recovery colleges) was a feature of the new paradigm, as were the principles of no force and housing first, trialogues and shared decision-making.

Viewing lived experience as an asset was the litmus test of whether we had truly grasped the potential of the recovery movement, said Slade, noting that there was still a way to go.

Real progress would see the barriers to discussing experiences of mental health broken down for everyone – professional and peer workers – rather than viewing it as a commodity to be imported into an organisation.
Movements like **Mad Pride** were “game-changers” in this push, creating a space to acknowledge that “we are all in this together”, he added.

He invited delegates to imagine a time when recovery was seen as a transitional discourse and the emphasis was on a kind of “gross wellbeing product” living as well as possible.

This was distinct from “wellness” practices like mindfulness and positive thinking which Slade questioned as “responsibilisation” seeking to pacify those with lived experience and stifle collective dissent.

He described socio-political activism as the core job of health workers, pointing to an editorial from Lancet editor Richard Horton calling for health professionals to be “agent(s) of resistance for justice, rights and equity”.

Casting into the future, Slade envisaged the system itself becoming an anachronism as the us/them silos were dismantled, and power – including money, leadership and service structures – was redistributed.

Peer leadership, a human rights focus, political consciousness and engagement would define this new order.
Profiling a “paradigm shift” in mental health
#TheMHS2017
Minister Tanya Davies

"We need a better balance between Clinical and Community Care." @TanyaDaviesMP #THEMHS2017

Few reviews into #mentalhealth underway - submissions still open for this one, says @TanyaDaviesMP northernstar.com.au/news/parlament… #THEMHS2017

Parliamentary inquiry into Lismore Base Hospital d… A PARLIAMENTARY inquiry into the ‘horrible’ death of a woman at Lismore Base Hospital’s mental health ward in 2014 was welcomed by heath district CEO. northernstar.com.au

Terms of reference released for NSW mental health Terms of reference and expert review panel named. Including NSW Deputy Mental Health Commissioner, Dr Robyn Shields. nswmentalhealthcommission.com.au

You can track Croakey's coverage of the conference here.
You can track Croakey's coverage of the conference here.

Profiling a “paradigm shift” in mental health

#TheMHS2017

Minister Greg Hunt

Amy Coope - @coopesdetat - 13h
Focus on rural services - telehealth - & eating disorders other priorities says @GregHuntMP. Stigma still major issue in latter #THEMHS2017

Rose Celadon @RoseCeladon - 13h
Greg Hunt: The NDIS should never been used as an excuse to role back on existing com based  psychosocial services. #THEMHS2017

Amy Coope - @coopesdetat - 13h
We lose 3000 people a year to suicide, more than 60,000 attempt every year. That says to me we have to do more says @greghuntmp #THEMHS2017

MHCSA @MHCCoalitionSA - 13h
@GregHuntMCP committed to not rolling back psycho-social support w/ NDIS rollout. #THEMHS2017
You can track Croakey's coverage of the conference here.

Profiling a “paradigm shift” in mental health

Awards

What a privilege to have Dame Prof Marie Bashir to give the mental health service awards @themhsorg #THEMHS2017
You can track Croakey's coverage of the conference here.

Profiling a “paradigm shift” in mental health

#TheMHS2017
You can track Croakey's coverage of the conference [here](#). 

Profiling a "paradigm shift" in mental health

Read more about this award [here](#).

Congrats the fabulous @Fay_Jackson_MH on the award at #TheMHS2017 - I enjoyed the quick hug and catch up.
You can track Croakey’s coverage of the conference here.

Selfies

SMART Mental Health @theSMARTwebsite · Aug 28
The SMART team will be at the #MHS2017 conference in Sydney until Friday - come & talk to us about the project!

The Vmiac @VMIAC · Aug 29
#MHS2017 Having a good time. #MaggieTok #DebCerlon
Watch Professor Mike Slade

Professor Mike Slade at #THEMHS2017 in Sydney
Relationships, stories and healing: Indigenous knowledges for mental health and wellbeing

“Two-eyed seeing”, a framework for integrating Indigenous and Western knowledges, was profiled at the conference.

The conference also heard about the importance of relationships and storytelling for healing.

Amy Coopes writes:

Culture is medicine and healing, and stories are its salve, with Indigenous knowledge more vital than ever to the planet and to health, a major mental health conference was told on Thursday.

Dr Lewis Mehl-Madrona, a researcher at the intersection of Indigenous healing and the biomedical model, delivered a keynote address at the TheMHS annual forum in Sydney on etuaptmumk, a word from the M’ikmaw Nation in Canada meaning ‘two-eyed seeing’.

Two-eyed seeing is a framework embracing Indigenous ways of understanding the world and integrating these with Western bodies of knowledge, in an endeavour of collaboration and respect, where a tribal consciousness was cultivated, taking the best from both worlds.
Mehl-Madrona, who is of Lakota and Cherokee heritage and started his address with a traditional song of welcome, shared his personal journey with culture, from Stanford to Saskatchewan, working as a “roadie” for Lakota medicine man Melvin Grey Fox in an era where ceremony was illegal.

During this time he witnessed powerful experiences of healing, revealing a profound, millennia-old body of Indigenous knowledge about the mind and mental health that centred relationships and stories.

“Stories are knowledge systems in and of themselves,” said Mehl-Madrona. “Through stories we learn to be who we are... we are co-constructed by story and community.”
A swarm of stories

In Lakota culture, the closest thing they had to an understanding of the ‘self’ was a concept known as nagi – the “swarm of stories that make us who we are”, each story containing a spark of the being who told it.

Mental health was seen as a product of these stories, whether good or bad, and diagnoses or labels were understood not as a noun but a process – for example depression was “performed”, not innate.

Stories were regarded as “all we have to fight off illness and death” he said, noting that data supported this for Indigenous people.

In British Columbia, for example, communities that had lost their language had 50 times more suicide attempts than the general population; where language was intact or fluent, these attempts were 55 times lower than population averages.

Stories had the power to change the body, said Mehl-Madrona, relating research showing that people with elevated blood pressure who were told stories about blood pressure being reduced actually went on to realise this physiological effect.

“If you want to change the world start talking and keep talking, tell your story,” he said. Stories had more power than statistics because, instead of simply revealing an effect, they allowed an interrogation of the ‘how’.

Many truths

Whether in North America or Australia’s Aboriginal and Torres Strait Islander communities, Indigenous knowledge-making had some striking similarities, said Mehl-Madrona.

It was derived from systematic observation of the way things work, and was consensus driven, arrived at through collaboration and deliberation in groups.

Mehl-Madrona said Indigenous epistemology was, by necessity, pluralistic and the opposite of positivism and reductionism.
“In Australia there are 500 creation stories, they are all true and they are all different,” he said. Each was true for the place of its origin, and for the people who told it.

“We choose explanations based on their usefulness, and we often need more than one. Explanations exist at multiple levels.”

This was especially relevant in mental health, he said, where love or depression couldn’t be explained through neurochemicals alone, or the parts of the brain activated and affected.

Indigenous cultures captured the collective dimension of health in a way that was lost in individualistic biomedical approaches, even understanding the mind as a plural enterprise where there were conflicts and coalitions.

Where there was one world and one people, everybody was responsible for one person being sick, with the social environment shown to change the brain much more dramatically than drugs in studies.

Research on mirror neurons and work around the social brain had validated how important this was, he added.

In this context, Mehl-Madrona said Indigenous cultures understood that people “get unwell on our behalf” and should be honoured, because if it hadn’t been them, it could have been you.

Two-eyed seeing conceptualised mental health for Indigenous people as the product of intergenerational and direct trauma, of bad spirits and stories (maladaptive narratives), impossible situations and relationships, seeing severe mental illness as the “canary in the societal mineshaft”.

It also had much to offer in terms of healing, he said.

While it was unknown whether conventional approaches to mental health actually worked, Mehl-Madrona said the “invisible system” of Aboriginal mental health did.

“We need Indigenous knowledge now more than ever, ecologically and humanistically, to leave the world better for generations after,” he said.

“Culture is medicine. Culture is healing, or it can be.”

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Indigenous ways of healing. Every song, every thought is a prayer. The body, nature, animals, plants. Stories, intention

#THEMHS2017

Where science intersects with Indigenous knowledge #THEMHS2017

- Speaker-Listener Neurocoupling (Intercerebral"
- Audience Effect
- Power of Community
- Social Brain Hypothesis
- Epigenetics
- Power of Listening to Story

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#TheMHS2017

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Croakey “Conference News Service”
Proud spirit

The MHS chair Tom Brideson – a Kamilaroi and Gomeroi man – said it was time to start advancing the two-eyed seeing framework in Australia, placing Indigenous stories and healing alongside the biomedical model.

Imprisonment and juvenile detention, mental health, suicide and self-harm and substance use had not improved for Aboriginal and Torres Strait Islander people, and Brideson said “we need to do better than ‘jobs, schools and fruit’.”

On mental health, in particular, he said the complexity of policy and funding arrangements was “absolutely out of control”.

He pointed to the Gayaa Dhuwi (Proud Spirit) declaration on Aboriginal and Torres Strait Islander mental health, and said community would be crucial to advancing this agenda.
You can track Croakey’s coverage of the conference here.

Relationships, stories and healing: Indigenous knowledges for mental health and wellbeing

Amy Coopes @coopesdetat · 13h
Whether we are looking at #MarriageEquality, constitutional recognition, we have a leadership role says Brideson #THEMHS2017

Amy Coopes @coopesdetat · 13h
Complexity around Aboriginal mental health ‘absolutely out of control’ says Brideson #THEMHS2017

Dave Peters @Dpeters20177 · Following
We’re too busy being busy- Tom Brideson #themhs2017

Future needs of our youth
- A less messy policy space
- A better organised system
- A comprehensive approach
- A better future
- Our job is to ensure we leave this in a better place
More tweet reports

Amy Coopes @cooperdatat
Starting his keynote w a traditional song of welcome, acknowledging Australia’s Indigenous peoples & meeting on Gadigal country #THEMHS2017

Dave Peters @dpeters1977 · 13h
The importance of connecting with your cultural identity... @mehimadrona #themhs2017

Christopher LaLonde:
Aboriginal communities in British Columbia whose language is intact (most people are fluent) have 55 times less suicide attempts than the general population of B.C.

Aboriginal communities who have lost their language have 50 times more suicide attempts than the general population.
You can track Croakey’s coverage of the conference here.

Song invites the ancestors to come, says I exist, I am standing here in aliveness. Welcome to your ancestors & friends #THEMHS2017

For Canada’s Indigenous peoples, mental health has many drivers - @mehlimadrona #THEMHS2017

Severe Mental Illness

• Inherited Trauma (Intergenerational)
• Direct Trauma
• Hungry Ghosts
• Canary in the Societal Mine-shaft
• Deficient stories for life (low skills)
• Being caught in an impossible situation
• Fought/forced spiritual awakening
• Impossible relationships (double bind).

Lots of work using two-eyed approaches in Canada - Toronto, Winnipeg, Ontario. Traditional healing alongside Western medicine #THEMHS2017

Bottom-up approaches succeed where top-down fails - @mehlimadrona #THEMHS2017

48 year old Lakota woman with 90+ hospitalizations and 75 suicide attempts.

Top-down: Therapists telling her what to do and physicians prescribing every possible combination of medications.

Bottom-up: I don’t know + plus storytelling
(Intention, faith, deep listening)
Eventually art and ceremony
You can track Croakey's coverage of the conference here.

**Summary:**

- Indigenous people have been concerned with mental health for thousands of years.
- Today's dominant paradigm (biomedical psychiatry) dismisses indigenous wisdom as non-scientific and not evidence-based.
- Two-Eyed Seeing allows us to take what works from multiple perspectives with respect for all.

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**Listen to Dr Lewis Mehl-Madrona**

Follow on Twitter: @mehlimadrona
Standing ovation for powerful calls to democratise mental health services

Flick Grey: calling for a truth and reconciliation process in mental health

Amy Coopes writes:

Disrupting power and democratising clinical environments through the centring of lived experience in mental health was the focus of a rousing conference keynote in Sydney on Friday by consumer-survivor and self-described “wandering, mad academic” Flick Grey.

Grey, a survivor of childhood abuse and mad studies scholar, received a standing ovation for her talk on violence, hegemony and othering in mental health environments.

Listing her credentials as a “PhD in madness and shame from the university of life – and I am so over learning” – Grey said she came “as a truth-teller, and I hope you will join me in saying, when we need to, that the emperor has no clothes.”

She called for a truth and reconciliation process in mental health to speak about the “bad things” – the products of objective and structural violence, as conceptualised by philosopher Slavoj Zizek.
Objective violence – the imposition of a specific biomedical, diagnosis-driven universe of meaning – and the structural violence of ‘business as usual’ in this paradigm, had the effect of silencing and marginalising the lived truth of those in contact with the mental health system, said Grey.

“I don’t think of myself as a person with a mental illness or personality disorders,” she said, joking that she was now in double diagnostic digits and expected, once she reached 20, to receive a letter from the Queen.

“I think of myself as human, as an animal, as star dust.”

**Benevolent othering**

Grey spoke of her experiences with mental health and encounters with the system, describing her distress as “very present tense – it is very present and sometimes very tense.”

“I have a deep and profound relationship with suicide and earlier this year we became really, really close,” said Grey.

It wasn’t an attempt or suicidal ideation – “cruel” language that she said “eviscerates the experience from experience” but she ended up admitted to (and then running away from) hospital.

While the staff were kind – “they gave me three new diagnoses” – Grey said they pointed to her personality as the problem, when what she so desperately needed was human connection, “non-othering companionship”.

Grey’s PhD explores a concept she describes as ‘benevolent othering’ – where the ‘other’ is still understood as ‘bad’ but this is couched in falsely positive terms. For example, saying you don’t have a problem with gay people but wish they “wouldn’t flaunt their lifestyle”, she said.

Benevolent othering was a common experience of many marginalised groups, including in mental health, and functioned as a campaign of self-affirmation which upheld objective and structural violence, she said.

In its place, she called for a space to have difficult conversations, where consumer-survivors and peers took the lead and madness, distress, suicidal thoughts were valued, listened to and honoured as part of the human condition.

Instead of co-opting spaces belonging to those in contact with the mental health system, she called for clinicians and allies to open doors and walk alongside, listening rather than imposing meaning.

“Part of what we offer is more words into our ecosystem to challenge psychiatry’s insistence on a dominant monoculture,” said Grey.

“I share in the knowledge that by doing so I open up enough space for us all to tell the truth.”
Polyphony and healing

In closing remarks to the conference, Grey emphasised the value of a dialectical approach incorporating “both/and”, where those both within and outside of the system would achieve change and “we are all subjects, there are no objects”.

Professor Mike Slade, who delivered the opening keynote, said the question of “revolution versus evolution” in mental health had been a dominant theme over the three days of the event.

Slade said tokenism and nominal involvement continued to abound in mental health and the system continued doing the same old “toxic” things that had been shown not to work – inpatient units, hospital admissions, medications.

Disrupting this status quo would require dialogical rather than monological, monolithic spaces – a “polyphony” of voices where those with lived experience were truly heard, said Slade.

Rather than worrying about whether peer work should be a profession, political or a social justice movement, or whether change ought to come from within or without, Slade urged those with lived experience of mental health to continue showing up.

“Every time you turn up, you make a difference,” he said. “Every time you open your mouth, you make a difference. You create discomfort, and that’s what’s needed for people to change and grow.”

Dr Lewis Mehl-Madrona, a keynote presenter on day two, echoed frustrations about the limitations of “business as usual”, describing psychiatry as the only profession where “the consumer is always wrong” instead of the true experts in recovery.

Instead of asking people in treatment “are you happy, or happier?”, Mehl-Madrona said the imperative was “homo economicus” – the psychiatric pharmaceuticals market – where millions were spent on drugs that just didn’t work.

This was supported by Slade – chair of the European Network for Mental Health Service Evaluation – who said the overwhelming majority of psychiatric drug trials were paid for by pharmaceutical companies and evidence for their effect in practice was unconvincing.

Mehl-Madrona said it was important to ask whether the system, on average and all things considered – was working for the people it was meant to serve.

“Is there hope for the mental health system or do we just need to create an alternative?” he asked, emphasising the need for approaches that were dialogical, peer-driven and inclusive.

Returning to the themes of his keynote on “two-eyed seeing”, a framework incorporating Western and Indigenous worldviews, Mehl-Madrona urged everyone present to go home and create a “healing circle” where truths could be spoken and reconnection take place.

“You need a place that doesn’t cost anything where you can go for healing,” he said. “Everyone can be healing for someone.”
Tweet reports

Dave Peters @Dpeters1977 · Aug 31
Can't wait to hear the incredible @FlickGrey as keynote speaker at the start of Day 3. Go Flick! 😊 #themhs2017

Standing ovation for powerful calls to democratise mental health services

Grey shares Danica Lani's 'Acknowledgement', encourages others to sing along #THEMHS2017

Amy Coopes @coopesdatat · Aug 31
Worl'd be on this stage or in this world without these women says Grey #THEMHS2017
Thank you @FlickGrey for telling it how it is!
#themhs2017

Standing ovation for powerful calls to democratise mental health services

#TheMHS2017

Alternatives to Suicide is a group that allows us to talk about our pain & feelings with others like us @FlickGrey #themhs2017

Alternatives to Suicide
– Western Mass RLC

- Alternatives to Suicide groups meet in community spaces.
- They are co-facilitated [only] by people who identify with their own struggles with thoughts of suicide.
- We talk about suicide but, more importantly, we talk about the pain, desperation, loss and loneliness we feel.
- We offer an another a culture of self-help, mutual respect, support and empathy.
- We cry. We laugh. We heal.

TheMHS you have pioneered allyship in the conference space. Thank you, says Grey #themhs2017
Standing ovation for powerful calls to democratise mental health services.

Further reading and resources: Our Consumer Place; Open Dialogue.
Watch this interview with Flick Grey

More tweet reporting

So pleased to have Mental Health Commissions here #THEMHS2017 in conversation about culture change for better mental health
Standing ovation for powerful calls to democratise mental health services

Embracing change at #THEMHS2017. Meeting amazing speakers, learning from lived experience, and generally having a great time.
Standing ovation for powerful calls to democratise mental health services

You can track Croakey’s coverage of the conference here.

The John & Jemima show with keynotes Mike, Lewis, Flick at #THEMHS2017 closing

Standing ovation for powerful calls to democratise mental health services

#TheMHS2017

Neami National @neaminational · Aug 31
Sydney council supporting diversity on CBD streets outside #themhs2017

Amy Coopes @coopesdatat · Aug 31
As a side note, so chuffed and heartened to see so many @AMEquality #MarriageEquality lapel pins on display at #THEMHS2017 #VoteYes

"Conference News Service"
Standing ovation for powerful calls to democratise mental health services

#TheMHS2017

Croakey

"Conference News Service"
An indepth examination of progress (or not) with the NDIS

Amy Coopes writes:

The National Disability Insurance Scheme represents a watershed opportunity for those living with a psychosocial disability but there is real potential for people to slip through the cracks, with the rollout already leaving some behind as the states pull services and funding.

This was the message shared by consumers, carers, families and researchers working in the mental health space at the annual TheMHS conference in Sydney last week.

The NDIS was one of the featured symposia at the three-day event, which brings together hundreds of clinicians and health care workers, consumer-survivors, advocates, carers and academics to discuss developments in mental health.

There were several NDIS-themed sessions at #TheMHS2017, as well as a performance of NDIS: The Musical – an irreverent take on the scheme written by consumers for consumers for the Victorian Mental Illness Awareness Council (VMAIC). (You can watch a 2016 performance of the musical here)
Health Minister Greg Hunt set the tone for discussions, drawing applause by telling delegates the NDIS “should never have been used as an excuse to wind back psychosocial services”. Over the following days this emerged as a common experience, with those at the front-lines feeling the pinch as the scheme rolled out.

Scoping the NDIS

Eddie Bartnik, from the Government’s National Disability Insurance Agency, said the NDIS – “the biggest social policy reform since Medicare” – presented a raft of opportunities but there were also major challenges around coordination and integration.

The 460,000-person target of the scheme included 64,000 with a psychosocial disability, and Bartnik said 6,000 had been enrolled so far.

Echoing the Health Minister’s sentiments, Bartnik said that the NDIS “was not intended to replace the supports or services being provided by mainstream services”, but help those eligible with social and economic participation though “ongoing functional support”.

Contrary to what had been assumed about the NDIS, he said organisations that were collaborating rather than competing were doing well (see more tweets from his and other presentations at the end of this story).

PHN perspectives

Translating this into practice required navigation of what Walter Kmet from Western Sydney PHN described as a “cobbled road” of service fragmentation.
While the NDIS had the power to be transformative, Kmet said it would require looking beyond “doing things better with what we have to taking the system to a better, more relevant place”.

Strengthening the links between primary care – the “gatekeepers” – and mental health services would be essential in this task, he said, as would measuring and rewarding outcomes rather than inputs, or what one delegate described as “funding busyness”.

“Rather than asking how the system would work better for its own continued existence, we should ask how it could work better for the people it is meant to serve,” said Kmet.

Kmet outlined PHN priorities for such commissioning:

**8 commissioning priorities**

1. Aboriginal and Torres Straits mental health and wellbeing
2. Low intensity services (NEW)
3. Psychological Services to hard to reach groups
4. Children and Youth
5. Severe Mental illness and care packages in Primary Care (NEW)
6. Suicide Prevention
7. Regional Plan
8. Stepped care (NEW)

**Funding questions**

Amanda Bresnan, executive director of Community Mental Health Australia, told the conference that federal funding for mental health programs was being transferred to the NDIS and a flexible funding pool for PHNs to commission services through a stepped care model.

Bresnan said the concern was that not all people currently covered by federal programs such as **Partners in Recovery, Personal Helpers and Mentors**, Day to Day Living (D2DL) and **Mental Health Carer Respite Support** would not be eligible for the NDIS, and there was a great deal of uncertainty about what would be left for them as the states pulled service funding.

“Money should not be pulled out or shifted until we see the full picture of the NDIS,” said Bresnan.

Bresnan said the community mental health sector saw the NDIS as an opportunity to have a conversation about the evidence for services, and about roles and functions within the space.

“We need to look at the evidence, look at what consumers says they need, and use that to drive investment,” she said.

“There’s an opportunity for the NDIS to be not just a health response but a whole of community response” encompassing housing, employment and other factors, added Bresnan.
Early interventions

Dr Lisa Brophy from the University of Melbourne and Mind Australia presented research showing that three early interventions “ticked all the boxes” for the NDIS: social skills training, supported employment and supported housing.

These interventions supported recovery, were evidence-based and reflected personal choices and goals for those living with a psychosocial disability, said Brophy, pointing to loneliness, dealing with physical health or getting back to work or study as common experiences.

Brophy said it was “time for us to stop tolerating mediocrity” in mental health service provision and to stop underestimating the potential for people with a psychosocial disability to participate, issues she said were driven by stigma and discrimination.

She said advocacy needed to be built into the NDIS, with “staggered” experiences of acceptance into and navigation of the scheme reflecting inconsistent access to and funding for appropriate supports.

“Brokerage models are very problematic,” said Brophy. “People don’t need a broker, they need someone to build a relationship with, to help them meet their needs.”

Slipping through the cracks

Consumers and carers shared mixed experiences with the NDIS, with some reporting that it had already been life changing and others with stories of loved ones who had slipped through the cracks, Bresnan said.

One carer related her daughter having state-based services withdrawn because “you’ll be eligible for the NDIS”, leaving her housebound with little supports for going on several months while she waited to be assessed. In the meantime, the family had gone into debt to keep the basics covered.

Carer advocates Patricia and Sarah Sutton shared the story of Peter and Ben – sons and brothers living with schizophrenia – and their struggles both before and after getting onto the NDIS, and finding appropriate services.

“Not since Medicare has there been such a landmark reform for those in mental health as the NDIS,” said Sarah. “But psychosocial disability is still very widely misunderstood.”

The Suttons said the NDIS application process lacked relevance and accuracy for psychosocial conditions, where impairment “can be much less apparent on the surface” and could be a barrier to participating in assessments.

The episodic nature of conditions and concept of recovery made access problematic, and it was important to note that not every person with a mental illness had a psychosocial disability (defined as permanent or likely to be permanent), they added.

While the NDIS represented a potential “light at the end of the tunnel for people with a psychosocial disability”, the Suttons said it needed to break down systemic and structural barriers, and take family and carer voices seriously.
Consumer concerns

Elena Sutcliffe, policy officer with Being, said consultations with consumers had revealed a lack of or conflicting information about applying for the NDIS with a psychosocial disability, and many reported being knocked back the first time before going on to be successful with the help of an advocate.

It was a stressful and exhausting process, the NDIS language was not consistent with recovery-oriented practice, and pricing had a Western cultural bias.

Service provision was overwhelmingly offered by religious groups, presenting an access barrier to LGBTQI+ clients.

Even when a ‘good’ package was obtained, there was a paucity of services to spend it on, and people feared that if they improved their package would be scaled back or withdrawn.

Consumers were also afraid of retribution in the form of service refusal for complaints or criticisms, Sutcliffe said.
Debbie Hamilton, a consumer, said the mental health system was struggling to come to terms with the NDIS, and often found itself at odds with its central tenet – individual choice and control.

Restructuring in the sector due to the rollout was having an impact on the frontlines, with support workers not showing up, and Hamilton said NDIS literacy was a major issue, echoing calls for advocate funding.

Other consumers reported finding it impossible to get the NDIS to return calls or clarify concerns, describing the scheme as trying to do too much too quickly; a “rollout and run”.

**Hearing from trial sites**

From a rollout perspective, there were presentations at two sessions from trial sites in Victoria and New South Wales – one dissecting a failure and the other a success.

Kim Lane from Hunter New England Mental Health shared the challenges and lessons from a successful NDIS transition, which had so far seen 37 people at a 91-bed long-stay inpatient facility able to be discharged into the community.

Some of the factors she nominated as being instrumental:

- Clear governance and structure
- Robust interface with the NDIA
- Appointment of NDIS ‘champions’ to field inquiries
- Hiring of specific staff positions to handle the rollout
- Clinical tools and resources including cheat sheets on where to find forms and language to use to apply to the NDIS, as well as service provider kits to help consumers navigate the sector
Some of the challenges had included explaining the benefits to both consumers and staff, and having the facts and resources available to distil who would be eligible and how and where to go to fill out applications, and for information and support.

Ongoing issues included rejection by some consumers of the NDIS, ‘real’ collaboration with CMOs, staff education, a ‘shifting sands’ environment and market failure, with services not able to meet needs.

Asked for her advice to others confronting the rollout, Lane highlighted collaboration, family-inclusive and consumer-led practice and taking time, as well as review to ensure mistakes weren’t repeated and lessons were learned.

Learning from failures

Priscilla Ennals and Glen Tobias from Neami National presented on the failure and their subsequent acquisition of Geelong provider Pathways following the NDIS trial, saying it had fallen victim to a combination of local issues, factors with the trial (including psychosocial disability being ‘tacked on’) and provider issues.

Though well intentioned, by trying to minimise the impact to consumers of a huge discrepancy between their pre and post-NDIS funding (from $104/hr to $42/hr), Pathways ultimately went under.

In its place, Tobias said Neami set up a streamlined, NDIS-ready organisation called Me Well, taking the lesson that “transformation rather than transition” was required.

Me Well used a mobile workforce with client database and case notes on tablets, bumping up billable hours to 90 percent.

Staff were recruited on a self-motivation and growth mindset as well as competence, and Tobias said in future an “Uber-style” rating technology could be on the cards.

He said the NDIS was very much a “retail offering”, a way of operating which established organisations were not familiar with. (Check this Twitter discussion on consumer rating systems.)
Lessons from an NDIS failure #THEMHS2017

Learnings
- Tolerance and patience – everyone is learning
- Acceptance of a changed funding model
- Need for close data monitoring – service delivery and financial
- Build strong local relationships with NDIS, LACs, & planners
- Active support & management of change, this change is huge and stressful for consumers, families, staff, providers and the NDIS
- Partnerships across the health & social system need renegotiating
- Find effective ways to communicate concerns to NDIS/NDIA
- Separate advocacy efforts from service delivery
- Shared effort to evaluate scheme impacts is needed

Slides and tweets
Eddie Bartnik
You can track Croakey's coverage of the conference here.

An indepth examination of progress (or not) with the NDIS

#TheMHS2017

"Conference News Service"
Mental health has a very different burden of disease profile, need for investment. Impact of changing social environment @WKmet

Capacity building in primary care gatekeeping in mental health so critical says @WKmet

An in-depth examination of progress (or not) with the NDIS #TheMHS2017
You can track Croakey’s coverage of the conference here.

You can track Croakey’s coverage of the conference here.

An in-depth examination of progress (or not) with the NDIS

Amanda Bresnan

**Potential for Early Intervention in the NDIS**

Mind Australia & University of Melbourne report 2016 examined the potential for early intervention in psychosocial disability to improve functional capacity & reduce costs, & identify the most effective interventions for the NDIS:

- Social skills training, supported employment & supported housing – evidence-based, personal choice & recovery outcomes.
- Illness self-management, cognitive remediation & CBT for psychosis – can assist mitigation of impairments, but might not be personal choice or goals.
- Supports for improving physical health – potentially a priority but contribution as an early intervention not substantive.
- Family psycho-education – evidence very strong but may be limited participants who see this as meeting individual need.
- Peer support – improves recovery aspects for all interventions.
- Assertive outreach – currently not directly funded by the NDIS could assist in engagement & coordination of supports for people reluctant to engage with services.

**Where Are the Reforms Having an Impact?**

- Partners in Recovery (PIR), Personal Helpers & Mentors (PHaMs), Day to Day Living (DZDL) and Mental Health Respite for Carers, transferring to the NDIS – PIR & PHaMs provide a flexible, low barrier to entry early response. Not all people now in these programs will be eligible for the NDIS.
- Proposed amendments to NDIS Act regarding the funding and interface with chronic illness.
- Funding a number of federal mental health programs transferring to the PHN flexible mental health funding pool to commission services through a stepped care model – PHNs had been directed not to commission psychosocial services.
- 2017-18 Federal Budget included $80 million for psychosocial services for people not eligible for the NDIS – states and territories to match funding.

**Emerging Gaps in What People Living with Psychosocial Disability Say They Need and What is Available**

At the end of June 2017 there were 6,069 NDIS participants nationally with primary psychosocial disability and approved plans (7% of all NDIS participants)

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#TheMHS2017
Lisa Brophy

A framework for understanding early intervention and psychosocial disability
@LisaMBrophy #THEMHS2017

An indepth examination of progress (or not) with the NDIS

#TheMHS2017
An in-depth examination of progress (or not) with the NDIS

#TheMHS2017

Support recovery

Personal choice and goals

Evidence-based

You can track Croakey's coverage of the conference here.

#TheMHS2017
Let’s talk about sex – and also find some sexual healing. Theme songs from #TheMHS2017

Amy Coopes writes:

It’s not known about, it’s not talked about, and it should be seen as more important in the mental health space.

That was the message of a candid forum on sex and intimacy at the annual TheMHS conference.

The session, which kicked off with a rousing all-in rendition of Salt-N-Pepa’s Let’s Talk About Sex led by chair John Downie, delved into the too often unspoken-of intersection of mental health and what the conference organisers dubbed “warm human contact”.

Image from Salt-N-Pepa clip: Let’s talk about sex. (Watch in full at end of article)
Downie, formerly a mental health nurse, said sex was a major taboo for both people working in and those in contact with the sector.

There was a long history of sex being linked to ‘perversion’ and mental illness and Downie said current clinical approaches were all about risk avoidance, rather than viewing physical intimacy as something positive and necessary.

“There’s a lot of very lonely people living very solitary lives,” he said.

According to data from one consumer survey, Downie said 76 percent reported having no one in their lives that they would consider a carer. Up to 52 percent of those in contact with the mental health system ever married, and 30 percent of those who did divorced.

Lack of intimacy was rated seventh in the top unmet needs for consumers, yet Downie said the research in this area was scarce and narrow in focus and clinicians simply didn’t have the conversations.

“Most of the literature regards sexuality and intimacy as something that you should worry about when you are well,” said Downie.

“It’s not talked about, it’s not known about,” he added. “It should be more important but it’s seen as ‘not my job’.”

Responsive research

Suzanne Leckie from SANE Australia presented research sparked by a comment on one of SANE’s chat boards asking whether anyone had talked to their treating team about their sex life. It unleashed a wellspring of responses.

Leckie, a psychologist, said she realised she had never asked a client about sex because “I didn’t think I had any answers”.

Professionals “partitioned off knowledge” and didn’t feel qualified to inquire about such matters because “I’m not a clinical sexologist so I better not ask”.

After the message board moment Leckie said she decided to launch an online survey to test the waters on this issue, thinking “if I get 50 responses that would be great.”

More than 2,000 people completed the survey.

Three-quarters of respondents said their mental health had affected their sexual and non-sexual intimacy, detailing experiences of stress, guilt, anxiety, avoidance, disconnection and withholding or withdrawing. Eighty percent said it had affected their relationship.

Contrary to the orthodoxy that adverse effects of psychiatric drugs were most often to blame, Leckie said this issue was well down the list of causes. Instead, 69 percent attributed it to their condition, 67 percent blamed poor self image and 42 percent nominated previous trauma. Medication side effects were a factor for just 35 percent of respondents.
Of those surveyed, 55 percent said they had raised the issue with their treating team and only 21 percent of these reported being happy with the outcome.

For those who didn’t raise the issue, some of the reasons offered were embarrassment, shame, lack of trust and that it wasn’t a priority, or a “luxury I can’t afford”.

“Staying well for many meant sacrificing this area of their life,” said Leckie.

Only a third of those surveyed said they wanted help with this issue, with a similar number reporting that they had found workarounds such as medication vacations and relaxation techniques.

Stigma in the clinical relationship came through as the strongest barrier for starting these discussions, said Leckie.
A personal journey

Ceris Lane shared her deeply personal journey with sex, intimacy and mental health – a road to diagnosis that started with a deep and abiding overnight obsession with British boy band One Direction.

An insatiable libido and feelings of intense connection with strangers – later given the clinical term hypersexuality – was a feature of this period and though Lane said she never acted on her feelings, “it was a narrow and dangerous escape at times”.

Things culminated in an involuntary admission to hospital, which Lane described as the “loneliest and saddest time of my life”.

Though the nurses would come in for 15-minute checks on her welfare, never once did someone offer her a simple act of human contact.

To be touched on the shoulder or to have had her hand held while she was alone and afraid would have meant so much, she said. Craving it left her feeling shame, embarrassment and humiliation.

The two years since her diagnosis had been a rollercoaster, but Lane said there were two things that she had very distinctly not experienced: an offer of human touch as comfort by mental health providers or her sexual needs asked about or addressed.
Because hypersexuality had been part of her mania, Lane said sexuality was now seen as a symptom to be stamped out, when what she needed was the opportunity to be human, to access physical comfort and to have honest and direct conversations about her sexual health.

Speaking from the floor, delegates shared stories of kneejerk reactions from clinicians to raising these issues typically being ‘oh we will adjust your medication’, without any space to discuss the possibility that this wasn’t a solution.

Others asked where the medications were with fewer adverse effects on sexual health and why those with such a profile weren’t listed on the PBS.

Closing the session, Downie said there were lessons to be taken from the disability and youth work sectors on how to better have these conversations and navigate this terrain. There was no excuse for not doing this better.

The final words went to Marvin Gaye, with Downie leading a chorus of Sexual Healing.

For your viewing pleasure

- Amy Coopes (@coopesdetat) on Twitter:
  Chair John Downie seranades us with Salt N Pepa. The whole room joins in. This is going to be saucy #THEMHS2017

- Marvin Gaye - Sexual Healing

- Salt 'N' Pepa - Let's Talk About Sex
Lived experience and peer workers: transforming mental health services

Amy Coopes writes:

Employing peer workers in mental health is about much more than ensuring their voices are heard – it is a political act that re-frames the balance of power and is part of a movement towards greater equity, rights and justice.

This was a standout message from the 27th annual TheMHS conference in Sydney, where the importance of lived experience in mental health service provision was a prominent theme.

Peer support workers, educators and those sharing their lived experience in service provision were at the centre of what keynote speaker Professor Mike Slade described as a paradigm shift in mental health, and several sessions profiled projects and perspectives from practice.

Kate Higgins, from Wellways, said a 133-strong peer workforce was at the centre of their mission – a right to belonging, connection, recognition and upholding of human rights – as well as being a powerful change agent with the potential to transform the lives of individuals, families, policy and practice and society at large.

Higgins described peer work as part of a broader movement to equality and rights, challenging the dominant paradigm and reclaiming power for those at the centre of the system.
Beyond the comfort zone

If organisations did not acknowledge that power differences existed in mental health, Higgins said it was easy for them to fall into the trap of co-opting recovery, and she called for a fundamental interrogation of the dominant model of care.

Wellways colleague Ben Matthews, who heads up the peer workforce program, said peer workers were “there to drive culture and reform”.

“We don’t learn in our comfortable spaces, we learn when we go out of our comfort zone,” he said.

The potential for peer work to challenge the often-problematic status quo was emphasised by Louisa Dent Pearce, who said power was the critical issue in successful integration into service provision – “how much is taken, given, and how this is managed.”

She mapped the rising prominence of peer work against broader shifts in the mental health space:
Seize the power

Dent Pearce, something of a peer work veteran, shared a journey from ‘invisibility’ to being essential in her workplace, something she said had required overcoming insecurity and self-doubt to actually seize the power offered to her and recognise the importance of her voice.

Letting go of the indoctrination to blindly respect hierarchy, as well as the anger and resentment that came with feeling powerless, had been important elements in her growth as a peer worker.

“If I expect a flattened hierarchy where my voice is equal, I have to feed that back to my colleagues,” said Dent Pearce, emphasising the need for diplomacy, kindness, patience, and the sense of working “with, not against”.
She said it was also vital to challenge perceptions that peer work was not something worthy of remuneration, or was something that people were happy to do for free, as well as the notion held by some clinicians that sharing lived experience was damaging.

For those planning to implement a peer work program, she urged thorough planning and preparation, and a transparent and robust structure and training for staff – both peer and professional.

Elsie Cairns, a peer worker from the Margaret Tobin Centre in SA, echoed these thoughts on the importance of peer workers in an organisation and the unique qualities they could bring:
Storytelling matters

Several organisations presented their peer work programs, including Alison Bell from One Door Mental Health, where 20 consumers and 10 carers were employed as peer educators and trained to tell their stories.

“I really believe storytelling and being heard is such a vital part of recovery,” said Bell.

“Listening to people’s stories is a different way of learning, and it does ultimately improve service outcomes and delivery.”

Peer programs were part of what she called “practice-based evidence rather than evidence-based practice” in mental health.

The many benefits of storytelling

#THEMHS2017 Alison Bell @OneDoorMH
Focus on discharge

Three hospital discharge initiatives using a peer workforce were profiled, demonstrating positive responses.

One was a Hospital to Home pilot across three PHNs in NSW involving 10 peer workers, with support including re-connection of utilities and re-stocking of groceries after a long inpatient stay, help navigating Centrelink and ongoing social and emotional mentoring.

Peer workers would come onto the wards about two weeks before discharge to be involved in planning, and project coordinator Lesley Morrison from One Door said responses had been positive:
For the peer workers, some of the challenges identified had included maintaining their boundaries, knowing what to share and when, and using personal experiences constructively.

They were also sometimes required to return to places where they themselves had been inpatients, and to work with clinicians who had previously been their treating doctor.

**Participatory approaches**

Aimee Sinclair from Consumers of Mental Health WA (CoMHWA) presented a similar program, Peer2Peer, which offered post-discharge support for up to weeks, delivered and evaluated by a lived experience workforce.

Peer2Peer was peer-driven and based on a participatory framework:
Sinclair said the findings so far had demonstrated a profound need for this kind of work, with structural issues evident to peers that were invisible through a biomedical lens.

She also cautioned against “ghettoization” of the peer workforce, saying that proper remuneration, training and upskilling were a must.

The conference was also told of an extended post-discharge support program in Melbourne using 25 peer workers – two-thirds consumers and one-third carers in acknowledgement that family conflict was a major risk factor in readmission.

Michelle Swann from Melbourne’s NorthWestern Mental Health said early results of the program included a decrease in re-admissions and reduced aggression in the inpatient setting, as well as increased clinician understanding of the role of peer work.
Sam Stott, from the South Eastern Sydney Recovery College, detailed the four “wheelie bins” of doing a lived experience workforce wrong.

In no particular order, she said these were:

• The Wheelie Bin of Tokenism
• The Wheelie Bin of Inspiration Porn
• The Wheelie Bin of Purposeless Storytelling
• The Wheelie Bin of Intrusive Questions.

**Intentional peer support**

Lisa Archibald, from New Zealand’s Te Ara Korowai peer support program, spoke powerfully about intentional peer support – a framework she said was more than just training or a resource, but about social change and meaningful dialogue.

“Instead of illness and containment, intentional peer support is about rights, consciousness-raising and emphasising experience, not symptoms,” said Archibald.

“It doesn’t see people through a mental illness lens but asks people what they know.”

The principles of intentional peer support were moving from helping to learning, and doing ‘with’ instead of doing ‘to’; restoring reciprocity and rejecting the idea that one person had to change by replacing an encounter of individuals with a relationship; and allowing hope and possibility to take the place of fear.

Fear had been the basis of the traditional biomedical model of mental health and rested on what she said were the 4 Ps: predicting, prescriptive, prying and power imbalances.

Archibald outlined the four tasks of intentional peer support:

• Connection – being present, authentic, attentive
• Worldview – asking how do I know what I know
• Mutuality – both giving and receiving
• Moving towards – not getting stuck in the problem and moving ahead.

Intentional peer support understood and valued that there were two stories in mental health – the diagnostic story and the lived, Archibald said.

**Collective narratives**

Using a shared language was so important on the road to recovery, with an incompatibility sometimes seen between the personal and the academic, said Helena Roennfeldt from Griffith University and Marianne Wyder from A Place To Belong.

The pair presented a collective narrative project called Our Sunshine Place, a first person account of experiences in the mental health system drawn from the stories of more than a dozen women.
It’s powerful and personal, and worth reading in full, speaking to fear and alienation, a loss of identity and isolation from the world.

It ends thus:

I don’t talk about weird nightmares I’ve been having and how the world still feels weird and terrifying. If I would tell him that he may keep me here longer.

I just want to go home where I can start my healing.

Wrapping up

This is the final Croakey Conference News Report from #TheMHS2017, which brought together hundreds of consumers, carers, clinicians and others in contact with or working in the mental health system. Stay tuned though for an e-publication compiling all of our coverage – the stories, photos and tweets.
Warm thanks to all who helped to share the news through Twitter and other social media.

The Symplur analytics show there were more than 32 million Twitter impressions and 693 Twitter participants using the conference hashtag.

You can track Croakey’s coverage of the conference here.

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You can read the full Twitter transcript here.

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For help or more information

For people who may be experiencing sadness or trauma, please visit these links to services and support:

- If you are depressed or contemplating suicide, help is available at Lifeline on 131 114 or online. Alternatively you can call the Suicide Call Back Service on 1300 659 467.
  - For young people 5-25 years, call kids help line 1800 55 1800
  - For resources on social and emotional wellbeing and mental health services in Aboriginal Australia, see here.

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Croakey Conference News Service

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