- Suicide prevention in country SA
- KidsMatter - for primary schools
- Aboriginal and Torres Strait Islander
  - Mental Health First Aid
- Feeling deadly not shame
- WHO Commission on Social Determinants of Health
The Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) is funded by the Australian Government Department of Health and Ageing.

Other than for editorial comment, views expressed in this newsletter are not necessarily those of Auseinet or those of our funders.

Contributions to Auseinetter are welcomed and are subject to editorial approval and editing for space and clarity.

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Cover image - Young women attending a fabric and dyeing workshop as part of the Wadninaka Self Esteem Resilience Program in the Northern and Far Western region of South Australia. For more information refer to the article 'Suicide prevention in country South Australia - towards a coherent approach' on page 6 of this issue.
Comments - Jennie Parham Project Manager

As we near the end of this phase of funding, it is timely to reflect on where we have come and where are we going in the future. It is an interesting time, one that is both challenging and exciting.

How far have we come?
Since its inception in 1997, Auseinet has grown and expanded, doubling its funding and staffing. The growth has led to an expanded scope and increased complexity. It is timely to reflect on progress and the outcomes of the recent external evaluation in planning future directions.

In 2001, Auseinet expanded its focus from early intervention with young people to addressing promotion, prevention and early intervention across the lifespan. Over the past 5 years Auseinet has consolidated its role as a leader in progressing the promotion and prevention agenda and in providing high quality information and resources. It has developed an exemplar model of communications, information management and dissemination infrastructure that is held in high regard both nationally and internationally.

Phase 2 of Auseinet focussed on building relationships with state and territory jurisdictions, mental health consumer and carer networks, Aboriginal and Torres Strait Islander sector and the Divisions of General Practice. It was characterised by consultations, scoping studies, audits of PPEI activity and provision of grants. It was an important phase in developing partnerships, understanding the scope of PPEI activity in different sectors and identifying the support needs of each sector with respect to implementation. During this phase, a key priority was to support state and territory jurisdictions to develop policy consistent with national policy. Five years later, most, if not all jurisdictions now have policy on mental health promotion and prevention in place. Auseinet has also been pivotal in providing a mechanism for state and territory governments to share learnings, experiences and models in a non-competitive environment.

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Implementation has also become a strong focus for Auseinet with translational research becoming an important area of expertise. Having conducted two successful consultations on national policy in promotion and prevention and suicide prevention, Auseinet has been able to provide a much clearer articulation of the issues associated with implementation. These include the need for ‘how to’ resources, fact sheets, practical tools, summaries of the evidence, case studies, promising practice examples and culturally appropriate and relevant resources. This is the case for both PPEI and suicide prevention. Another important component of our work in this area has been to provide a vehicle for building and sharing the body of knowledge on PPEI through the ongoing development of an online peer reviewed journal.

Phase 3 of Auseinet has continued to provide information and clearinghouse functions. We have also addressed the next level of capacity building which is workforce development. Although Australia now has a comprehensive policy platform to support PPEI and suicide prevention, policy alone doesn’t change practice. There needs to be effective strategies in place to support implementation. Auseinet has developed a range of print and online resources and tools to support implementation across a number of different sectors. These have included:

• Continuing the production and expansion of an online peer reviewed journal (AeJAMH – www.auseinet.com/journal) that supports building of the evidence base;
• Development of an online recovery toolkit to assist in the implementation of national policy on relapse prevention and recovery (includes case studies, protocols, tools);
• Fact sheets on promotion, prevention and early intervention for consumer, carer, the NGO and Aboriginal and Torres Strait Islander sectors;
• Four accredited Active Learning Modules for general practitioners on PPEI;
• Production of a storybook collating all the learnings from eleven funded projects;
• Supporting the Aboriginal adaptation of Mental Health First Aid for use in Aboriginal communities;
• Fact sheets on ABS statistics and self harm for use by those working in suicide prevention; and
• Providing practice examples of PPEI in the Aboriginal and Torres Strait Islander sector.

All of these resources/products have been developed in partnership with the relevant sectors. Some of these projects are featured in this issue of Auseinetter.

As well as being a leader in Australia on mental health promotion and prevention, Auseinet has also developed international linkages. These include the Clifford Beers Foundation, National Institute for Mental Health (England), the Scottish Executive and the Welsh Assembly.

1This report is available to download from the Parliament of Australia website at: www.aph.gov.au/senate/committee/mentalhealth_ctte/report/index.htm
Auseinet is supporting an international project coordinated by the International Union of Health Promotion and Health Education (IUHPE) on capacity mapping. At the time of this issue going to print I will be attending the World Mental Health Promotion Conference in Oslo, Norway where I will be presenting the Auseinet model along with other Australian initiatives.

Advocacy has been one of the key roles Auseinet has played through supporting local organisations and initiatives as well as through the reinforcement of key promotion and prevention messages at numerous conferences, forums and networks. Influencing policy makers and funders at various levels of government has also been an important role. The Australian Institute of Primary Care who undertook the external evaluation of Auseinet stated that there was: ‘more PPEI activity now than seven years ago and that Auseinet had made a significant contribution to that’.

Some of the key outcomes of the evaluation include:

- Auseinet’s strength is its communication, information management and resource development expertise and capability;
- Auseinet has moved from a project to an organisation and needs a governance and funding model reflective of this;
- The scope of Auseinet is too broad and needs to be reviewed; and
- The greatest penetration has been in the mental health/health sector, more limited in other sectors.

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Where to from here?
What now for Auseinet? What is the future for 2007 and beyond.
So what has Auseinet achieved and what can it take forward?

- A comprehensive communications, information management and dissemination infrastructure which can be further strengthened;
- Expertise and experience in translational research across a range of sectors;
- Capacity to develop and maintain strong partnerships and collaborations;
- Expertise in mental health promotion, prevention and early intervention and its application to a range of sectors and settings; and
- Expertise in developing high quality resources and publications that are culturally appropriate and relevant.

Auseinet has contributed to building capacity for greater implementation. In taking on board the outcomes of the evaluation, one of the first steps for Auseinet is to diversify its funding base and establish itself as an organisation. Discussions are currently being held with Flinders University to discuss how this can happen and with the Department of Health and Ageing with respect to future funding. Decisions regarding future funding from the Department of Health and Ageing have not yet been made.

One thing is for certain - Auseinet has come of age and the way forward for Auseinet in terms of funding, governance and operations will be very different.

In closing, I would like to thank all the team at Auseinet who have continued to remain committed through uncertain times, a testament to their professionalism and dedication. I would also like to thank all our partners and stakeholders for their continued support, commitment and perseverance in ensuring the promotion and prevention agenda is progressed.

Comments - Jennie Parham Project Manager
The LIFE: National Suicide Prevention website is managed by Auseinet and provides timely and comprehensive access to a broad range of up-to-date resources relevant to suicide prevention in a variety of settings. The website is aimed at those who undertake suicide prevention activities, as well as others interested in the area.

You will find on the website:
- Australian and state/territory government policies;
- Resources related to the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples;
- Australian statistics on suicide rates and trends;
- Bibliographic information about resources and research literature available via a comprehensive searchable database;
- Summary and fact sheet resources;
- Conference and event listings; and
- Links to other relevant websites in Australia and internationally.

**LIFE Website Email Alert Service**

A significant feature of information services provided by Auseinet includes a regular email alert service focused on suicide prevention. It provides up-to-date, summary information about events, research, resources and initiatives relevant to suicide prevention in Australia and internationally. To subscribe to this service, contact Auseinet on:

Tel: **08 8201 7670** or
Email: [AUSEINET@FLINDERS.EDU.AU](mailto:AUSEINET@FLINDERS.EDU.AU)
Suicide prevention in country South Australia – towards a coherent approach

Wadninaka Self Esteem and Resilience Program: Northern & Far Western region

Building on existing projects, this local initiative has engaged Aboriginal community members, including young people, in several communities (Leigh Creek, Copley, Nepabunna and Maree) in a range of cultural arts activities that occur within and beyond school hours, such as tie-dying and fashion design, dance and music workshops, wood carving, drumming, and painting murals for community display. This has provided opportunities for self-expression, belonging, strengthening relationships with trusted adults, and conversations about dealing with stress in effective ways. One location has also gone on a community camp to build connections between elders and young people and to reconnect young people with cultural knowledges.

Young Aboriginal Suicide Prevention Initiative: Riverland region

This initiative decided on a whole of community awareness raising program, combined with cultural arts and resilience building activities for young people. Local community workers undertook the ASIST or Applied Suicide Intervention Skills Training, train-the-trainer program, and then conducted a range of training programs across the community for Aboriginal and non-Aboriginal workers and community members. This program assisted people to know how to respond to a person at risk of suicide or self-harm, and to either create or access local support pathways to keep them safe. The activities for young people included song-writing workshops for Aboriginal and non-Aboriginal young people and an Aboriginal young people’s art project which has designed a youth resource card for the region.

Kathleen Stacey and Nicole Keller

The ‘Suicide Prevention for Country SA’ initiative has placed the need for community-based suicide prevention work to be both a priority and coordinated focus back on the South Australian Government’s agenda. Although South Australian government, non-government and community-based groups have been involved in suicide prevention activity in recent years, some of which has been funded by the Australian Government through the National Suicide Prevention Strategy Community Initiatives stream, it has been some time since the state played an active coordinating role in guiding and monitoring suicide prevention activity across the state.

This initiative has demonstrated the value of moving toward a coherent approach based on central coordination, support and the facilitation of cross-regional networking. This article outlines how the initiative commenced, the model of operation it developed, a brief summary of the locations and activities involved, and hopes for its future. There is much more to share in terms of practice wisdom, evaluation learnings and the role of community partnerships in supporting local suicide prevention work. Therefore, this article will become the first chapter of a forthcoming resource book on the initiative, which will be available via Auseinet within a few months.

Seeds of the initiative

The ‘Suicide Prevention for Country SA’ initiative is part of the South Australian Social Inclusion Initiative. Under the leadership of the Social Inclusion Board, the Social Inclusion Initiative aims to assist in the creation of a society where all people feel valued, their differences are respected and their basic needs – both physical and emotional – are met, so that as citizens they are empowered in their participation and contribution. The Social Inclusion Board endorsed the implementation of a suicide prevention initiative across regional South Australia, upon receiving advice from the Ministerial Advisory Council on the Prevention of Suicide and Deliberate Self-Harm.

This initiative has demonstrated the value of moving toward a coherent approach based on central coordination, support and the facilitation of cross-regional networking.

It was agreed that the implementation of the initiative would be led by the Mental Health Program, Country Health Division of the Department of Health and $680,000 over two years was made available for this purpose.

The aim of the initiative was to contribute to reductions in self-harm and suicidal behaviour amongst young people in regional areas. The local initiatives needed to:

- have a focus on local, young people - particularly young Aboriginal men
- be responses that were community owned and driven
- involve young people in the development and decision making processes
- demonstrate specific benefit for Aboriginal people
- contribute to ensuring that communities in regional, rural and remote areas of the state have access to suicide prevention and postvention services, as well as general mental health awareness programs.


2 The Department of Health has recently changed its structure, with the Office for Country Health and seven separate country regions becoming a single country region known as Country Health SA.
Early days

In truth, it was not a smooth start for the local initiatives. All seven of the (former) Country Health regions were invited to submit a proposal for the development and implementation of a local suicide prevention action plan.

Some regions were hesitant to become involved. There was concern that it was short-term funding with no promise of recurrent funding, but an expectation that initiatives would address sustainability. In some instances, regions suggested that suicide prevention was not their responsibility but were not clear on whose responsibility they believed it to be. During the early stages support for the regions from Country Health staff was directed at:

- clarifying regional roles and responsibilities within the initiative
- identifying their region-specific needs and priority focus
- using, strengthening or building their local links with relevant community services with particular attention to Indigenous services or groups
- providing regions with action planning resources and a template to determine and describe how they would address their needs and priority focus over the entire initiative period
- assisting regions in understanding the Department of Health’s accountability to the Social Inclusion Board, and the requirement to provide comprehensive quarterly progress reports.

It became clear to Country Health staff that the most beneficial level of support to provide to regions was not possible within their roles. This led them to a different strategy in order to address the need for capacity-strengthening in both suicide prevention and evaluation.

Point Pearce Leadership Action Group: Wakefield region

The Point Pearce Leadership Action Group (PPLAG) already existed in this region supported by a local youth worker from Families SA. The initiative linked to this existing group of Aboriginal young people who had already considered what they needed in their community to strengthen community spirit, connectedness and a positive identity. The local goals they chose for driving a range of activities that occurred were: enhancing young people’s connection to land and cultural identity; developing and promoting the ability of young people to act as leaders in a changing and challenging society; fostering relationships across generations; and to look at education, training and life-skills development opportunities and choices for youth. Some of the activities that have occurred to date include a cultural camp, surfing and netball clinics, cultural tours of traditional and sacred sites, event planning for the Youth Expo in Adelaide and dance, art, music and song-writing workshops and trips. The workers supporting the initiative have also undertaken suicide prevention and mental health first aid training.

No One Walks Alone: Hills Mallee Southern region

This region had been involved in a community-based suicide prevention strategy, funded by the Commonwealth under the NSPS, which was directed at both non-Aboriginal and Aboriginal community members. ‘No one walks alone’ specifically responded to the needs of the Aboriginal community with a focus on two areas: 1) direct support strategies for young people and families and 2) culturally relevant strategies and content in providing education on understanding and responding to people...

*We use the term ‘Aboriginal’ to include people of Aboriginal descent, people of Torres Strait Islander descent, and people of both Aboriginal and Torres Strait Islander descent.*
Trialling a new strategy: An external ‘implementation consultant’

In previous times the role of central office staff in government departments, particularly health, was different to how things operate now. These staff were in a position to play a stronger role in direct support, resourcing, planning and evaluation guidance for operational staff working in metropolitan, regional and rural areas. This has increasingly shifted over the last decade, with central office staff time predominantly focused on strategy, policy, planning, research and review activities, ministerial support, contract management for funded projects/programs, and developing and monitoring service agreements with the operational entities across a health portfolio. In South Australia’s case, these are called regions and have been set up as independent organisations with service agreements and reporting responsibilities to the Department of Health.

In the context of the ‘Suicide Prevention for Country SA’ initiative, there was limited time for the Country Health staff to be readily and frequently available to regions as the regions worked out how to undertake the complex task of community-based suicide prevention within their funds allocation while focusing on the areas, groups and activities of highest priority. Country Health decided to engage an external consultant, but with a different role – not as an external evaluator (a role they also engaged to evaluate the initiative from a statewide perspective), but as an external ‘implementation consultant.’ Kathleen Stacey was engaged to take the role of providing design, implementation, internal evaluation and coordination support to both Country Health and regional staff.

Country Health decided to engage an external consultant, but with a different role - not as an external evaluator, but as an external ‘implementation consultant.’

This type of role is a relatively new idea, and will be discussed and analysed in more detail in the forthcoming resource book. What did it involve? There were three main elements: facilitating cross-regional learning, networking and collaboration; capacity strengthening; and creating statewide coherence.
Creating opportunities for cross-regional learning, networking and collaboration

Given the broad scope of what regions could implement, it was acknowledged that there was strong potential for diverse and unrelated activities to develop at a regional level. While the issue of diversity was not a concern, the ability of the local initiatives to relate to each other and make a collective contribution to suicide prevention in Country SA was considered a priority.

The main strategy to facilitate cross-regional learning, networking and collaboration was to bring them together through a series of four workshops between August 2005 and October 2006. Regions were invited to bring 5-6 people to each of the first three workshops. These included relevant regional managers, the main contact person/worker for each regional initiative, and others from partner services or groups, in particular, Indigenous services or groups, who were supporting the initiative. The last workshop had a different focus and only 1 or 2 people attended from each region4.

Each workshop had a participatory process so that people’s knowledge, skills and experience were valued, and the practice wisdom emerging from local initiatives and the overall initiative was shared and strengthened. This also contributed to a stronger sense of being part of a collective and having some ownership over the initiative. Overall the workshops provided a solid foundation for planning, implementation and evaluation at local levels. Participants reflected on the learnings gained, priority issues and sustainability. Strong relationships developed across regions as a result of workshop participation. This resulted in collaboration on training and sharing tools, resources and strategies.

4 A second strategy of setting up an email listserv for all people involved in the project to facilitate greater communication and sharing had enthusiastic support, but when implemented there was limited active use, so this strategy was dropped.

Strong relationships developed across regions as a result of workshop participation. This resulted in collaboration on training and sharing tools, resources and strategies.

Building Bridges – Strengthening Hope: South-East region

This region has worked on community strengthening in two areas. First, it supported the work of the local suicide prevention network in developing a two-year plan for their activities and hosted ASIST train the trainer workshops to increase the number of people able to run ASIST workshops across the region. Workshops were focused on the more distant areas that have not been involved in previous suicide prevention work. Second, the regional health service has built its relationship with the local Aboriginal health and community service so that Aboriginal community members can be involved in awareness-raising and suicide prevention activities. This includes working with the Aboriginal Youth Worker to engage young people in identifying and creating programs that strengthen resilience and coping strategies. Most of the work is foundational, with access to ongoing support crucial in the partnerships being able to develop, access and run young people’s programs.
Local support for capacity strengthening

The implementation consultant set up visits to each region in November, with the focus and activities of each visit shaped by what each local initiative most wanted or needed, rather than a ‘one size fits all’ approach. This was a new role, so people involved in local initiatives were often unclear how to use the visit, as well as how this role differed from the external evaluators. This required the implementation consultant to be ready for anything, having prepared a range of processes and resources, and go with the flow upon arrival. In two regions it became obvious that further visits were needed in order to reach consensus, address the concerns of other local stakeholders about the intent and activities of the project, or to have time to progress things in a respectful manner.

As the external evaluation was not resourced to gather information about all relevant aspects of each local initiative, internal evaluation work was a priority for initiatives and this became a priority focus for the implementation consultant with each region. This also fitted well with regions, as this was the aspect in which they felt the least confident and resourced. In each region, the implementation consultant worked with local stakeholders to review action plans to ensure they fitted with what the region really needed and wanted to do, and that they could be evaluated. At times, significant changes were made but always occurred based on local agreements. It provided opportunity for clarity on the overall expectations, and support for initiatives to use language that had a better fit with their community, e.g. talking about ‘promoting positive identity and wellbeing’ rather than using the term suicide prevention.

Evaluation plans were co-developed so there was ownership, understanding of the internal evaluation tasks, and clarity about what support role the implementation consultant would play. These included creating evaluation tools or processes, assisting with analysis, and on occasions conducting review activities. Regions were also able to negotiate the activities they believed were best undertaken by the external evaluators rather than themselves.

In the period following the visits, and between workshops, the implementation consultant was available on an ‘as needs’ basis to regions to answer questions, troubleshoot issues, provide links to resources or just de brief and review progress - many regions took this option up. In addition, proactive contact was made every couple of months to check on how regions were travelling based on the commitments made for support in the evaluation plans or providing relevant information about resources, events or other project activities.
Creating statewide coherence
Regular communication and meetings occurred with the Country Health staff along with periodic meetings with Social Inclusion Unit staff. The implementation consultant provided bi-monthly reports that helped to track the progress of initiatives, e.g. in terms of local capacity, cultural competence and accountability, strength of planning and youth participation.

As part of the action and evaluation plan review and design process through local visits, it became possible to recognise the commonalities across regions, particularly in terms of the overall goals and objectives. Ideas from other regions were shared and common language adopted, where it fit for local initiatives, which meant that plans developed a ‘family resemblance’ while retaining their unique focus. The outcomes of the workshop reflection activities also brought sharper focus to the shared elements, and a coherent picture of the initiative started to form – finding a strategy for articulating it in a concise manner was needed.

There have been important learnings and confirmations about doing suicide prevention work, particularly in Aboriginal contexts, and significant achievements at a local and state level from the ‘Suicide Prevention for Country SA’ initiative.

Commitment to an ongoing coordinated approach
Articulating a coherent approach
In order for the initiative to gain ongoing central support, it needed to be described in a manner that fit within the language and culture of a government department. This occurred by creating a shared program logic in May 2006, which represented what the initiative had become at local and statewide levels. It was based on an analysis of each initiative action plans, combined with the outcomes of Workshop 2.

The program logic – refer diagram on previous page - demonstrates the coherence of the overall initiative in terms of the overarching goals, impacts and outcomes. It also reflects the degree of diversity in terms of processes or activities that local regions used in a manner that was geographically and culturally relevant. Further, it also indicated the range of inputs that was part of the statewide strategy in resourcing and supporting the initiative.

Signs of sustainability
There have been important learnings and confirmations about doing suicide prevention work, particularly in Indigenous contexts, and significant achievements at a local and state level from the ‘Suicide Prevention for Country SA’ initiative. These will be outlined in detail in the upcoming resource book.

Country Health SA is committed to continuing a coordinated and strategic approach based on the program logic. Importantly, at local levels there is willingness to build on the foundations they put in place over the previous 15-18 months so that suicide prevention remains a key focus area. They will be described in the forthcoming resource book, along with local plans for continuing the work. The availability of the resource book will be promoted via the Auseinet project and LIFE suicide prevention websites at: www.auseinet.com and www.livingisforeveryone.com.au

Acknowledgements
We want to acknowledge and thank the committed, passionate and thoughtful work that has occurred by the people working, supporting and participating in the local initiatives, as they are the force that has made the statewide initiative come alive and achieve what it has to date. As well we want to acknowledge, Country Health SA for their ongoing support and openness to trialling a new capacity-strengthening strategy, as well as their commitment to enable sustainability; and the support of the South Australian Social Inclusion Initiative in the implementation of this suicide prevention initiative.

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KidsMatter is the Australian national primary school mental health promotion, prevention and early intervention initiative that has been developed in collaboration with the Australian Government Department of Health and Ageing, beyondblue: the national depression initiative, the Australian Psychological Society, the Australian Principals Associations Professional Development Council and supported by the Australian Rotary Health Research Fund. It is a proactive response to the national concern regarding mental health and the need for coordinated and strategic action.

**KidsMatter recognises the fundamental importance of students’ mental health to their learning and wellbeing...**

KidsMatter recognises the fundamental importance of students’ mental health to their learning and wellbeing. Schools that address the mental health needs of students are more likely to achieve goals related to learning and academic success. KidsMatter builds on the work schools are already doing in relation to promoting the mental health of their students. It acknowledges the national, state, territory and sector based mental health initiatives and policies that are already in place. KidsMatter respects the uniqueness of each school and the efforts that may already be underway to address students’ mental health. KidsMatter encourages schools to move forward at a pace that is manageable, no matter how small the steps. KidsMatter has been carefully designed to ensure that all school staff will feel supported with the resources and skills to carry out the initiative, and will feel that their energies are being spent on things that work.

KidsMatter is not a set of curriculum materials, but a whole school approach that looks at the protective factors that can be strengthened through the school context, the family and the child. These protective factors are things that have been shown to strengthen children’s mental health and wellbeing and decrease their chances of developing mental health difficulties. Risk and protective factors can relate to a child’s individual abilities and needs, their family circumstances and relationships, or their school’s practices and environment.

**The KidsMatter initiative has three major aims:**

- Improve the mental health and wellbeing of primary school students
- Reduce mental health problems amongst students (e.g., anxiety, depression and behavioural problems)
- Achieve greater support for those students at risk of or experiencing mental health problems

KidsMatter focuses on some key areas that research shows can really make a difference to children’s mental health:

1. **A positive school climate**

Schools identify how they can enhance their school climate to support student mental health and wellbeing, giving particular emphasis to ensuring that students, staff, parents and families feel ‘connected’ to each other and the broader school community.

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>PROTECTIVE FACTORS</th>
<th>RISK FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s abilities and needs</td>
<td>Good social and emotional skills, positive coping style and optimism</td>
<td>Poor social and emotional skills, impulsivity and low self esteem</td>
</tr>
<tr>
<td>FAMILY</td>
<td>Supportive and caring parents, family harmony and stability</td>
<td>Family disharmony, neglect and instability; harsh or inconsistent discipline style</td>
</tr>
<tr>
<td>SCHOOL</td>
<td>Positive school climate where students feel a sense of belonging and connection</td>
<td>Negative school climate where students experience bullying, peer rejection and poor attachment to school</td>
</tr>
</tbody>
</table>
2. Parenting education and support
Parents and families receive opportunities to access information on child development and parenting as well as engage with other parents and families.

3. Teaching of social and emotional skills
Students receive social and emotional curriculum using evidenced based programs to improve their self awareness, social awareness, self management, relationship skills and their capacity for responsible decision making.

School staff and parents receive information on how they can support and assist children at risk or experiencing mental health problems.

4. Early intervention for students at risk or experiencing mental health problems
School staff and parents receive information on how they can support and assist children at risk or experiencing mental health problems. This includes information on detecting signs of mental health difficulties in children, information on local service providers and how to access evidenced based programs and interventions.

These four areas where schools can help strengthen student mental health make up the core content of KidsMatter. Dividing KidsMatter into the four components is a way of making the task of improving student mental health in schools more easily understood and manageable. It also ensures that the efforts that schools put into this initiative are being focused in the most effective areas.

National Roll Out of KidsMatter: A Two Stage Process

Stage 1: KidsMatter begins in late 2006 with a national two year trial involving 100 schools. Participating schools represent all states and territories, from government, catholic and independent school sectors and from metropolitan, rural and remote regions. Project officers have been employed in each state to assist schools to improve student mental health and wellbeing. This trial stage will be completely evaluated with parents, school staff and students asked to provide their views as to the success of the KidsMatter initiative and how it can be improved.

Stage 2: Following this initial trial, all primary schools in Australia will be offered the opportunity to access the resources and materials being developed under the KidsMatter initiative to assist their efforts to improve student mental health and wellbeing.

To find out more
The KidsMatter website (www.KidsMatter.edu.au) will be established late in 2006 to support those participating in the initial trial to provide project updates for those wishing to find out more about the initiative. In the meantime information can be obtained from the existing website at: http://www.apapdc.edu.au/kidsmatter/

Additional information can also be obtained by contacting the following:

Mignon Souter - National Coordinator, KidsMatter
Australian Principals Associations Professional Development Council
Tel: 08 8245 9809 or Email: mignon@apapdc.edu.au

Chris Champion - National Project Officer, KidsMatter
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Dr Brian Graetz - Senior Program Manager: Public Health
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Commission on Social Determinants of Health - World Health Organization

At the core of the Commission’s work is the belief that a society that has organised its social conditions so that its population has better health is a better society. (Sir Michael Marmot)

In both rich and poor countries, people’s health largely depends on the social conditions in which they live and work – the social determinants of health.

The link between people’s health and their surroundings can no longer be ignored. Health inequities continue to grow across social classes, occupations, and ethnic groups within countries, even where more resources are made available and in spite of applying ‘the best’ evidence based interventions. Faced with this challenge, health policy-makers are seeking ways to shift from disease-focused solutions to people focused solutions, taking into account the realities of people’s daily lives and the societies in which they live. Such an approach requires incorporating health equity into all policies.

The Commission on Social Determinants of Health (CSDH) recognises health is a social goal and a responsibility across the whole of society. There is increasing evidence that better coordination and leadership to address the social dimensions of health across all governmental policy-making is possible, and results in improved health and access to health care. By acting on the social causes of ill-health, governments are poised to meet their development goals, reduce health disparities, promote population health, and create and sustain economically-viable societies.

The goals of the Commission are:
• to support health policy change in countries by assembling and promoting effective, evidence-based models and practices that address the social determinants of health;
• to support countries in placing health equity as a shared goal to which many government departments and sectors of society contribute;
• to help build a sustainable global movement for action on health equity and social determinants, linking governments, international organisations, research institutions, civil society and communities.

Health is a measure of the degree to which the society delivers a good life to its citizens. (Sir Michael Marmot)

The Commission’s approach allows it to:
Re-dress major gaps in evidence
CSDH collects state-of-the-art information on major social determinants of health on a global scale which will improve the performance of health policy, its targeting and monitoring.

Promote learning by doing
Countries advancing action on social determinants are contributing their learning to the evidence-gathering work of the Commission, while learning from the experts and evidence assembled by the Commission.

Create new alliances
Action and knowledge agendas are being developed with the simultaneous involvement of leading scientists, practitioners, civil society organisations, government officials and global initiatives, creating new networks of advocates to tackle the social determinants of health.

Set the foundation for a new health agenda
The innovative global, regional and national networks being created by the CSDH enable it to create the foundations for a new and sustainable global agenda, which promotes a comprehensive approach to health and health equity. The CSDH hopes that after it has reported to WHO it will leave behind it a network of countries taking action on the social determinants of health and advocates for further policy uptake.

Reaching beyond national borders
Regional-based strategies to address the social determinants of health provide opportunities for exchange and collaboration among countries, both within the same region and across regions. In formulating its regional strategies, CSDH emphasises:
• The dissemination and use of existing knowledge in the region
• Advocacy through regional forums
• Strengthening institutions and regional networks
• Strengthening and promoting the participation of civil society organisations in regional work.

Knowledge for action
Countries are often aware of the social causes of ill health, but few are successful in sustaining the implementation of actions to reduce inequities in health. Knowledge of how to act is still fragmented and not always useful for different stakeholders.

In both rich and poor countries, people’s health largely depends on the social conditions in which they live and work – the social determinants of health.

Working through nine specific themes, the objectives include:
• Collecting best practices on a global scale: the focus is on ‘what works’ and providing policy-makers with interventions/actions that can be used to improve health and reduce inequities.
• Using an innovative process for knowledge collection: not only through research institutions but also from governments, communities, civil society organisations and international institutions.
• Providing an interface between knowledge collection, changing the way all types of knowledge are valued and used by key stakeholders to improve health and health equity.
The nine specific themes are:

- Early child development
- Social exclusion
- Globalisation
- Health systems
- Employment conditions
- Priority public health conditions
- Urban settings
- Measurement and evidence
- Women and gender equity

Social conditions don’t just impact child mortality. They have a powerful impact on adult mortality, so powerful that a poor person at the age of 30 in Lesotho has far fewer years in front of him/her than does a poor person of the same age in Sweden. (Sir Michael Marmot)

Commissioners – leading voices on health inequities

The Commissioners represent a wide range of experience in all of the areas that make up the social determinants of health. There are academics who have worked on the science base. There are doctors who have worked in various parts of the health field. There are people from government and from non-governmental organisations who have been actively involved in the development and implementation of policies. In bringing representatives from these groups the Commission benefits from their experience, their wisdom, and their leadership. Because they are people who have played prominent roles in various spheres, they will not only benefit the process of identifying effective means to address the social determinants of health, but they are also in positions to advocate for the uptake of these means by decision-makers.

Michael Marmot – Commission Chair is Director of the International Centre for Health and Society, and Professor of Epidemiology and Public Health, University College London, United Kingdom. Frances Baum is Head of Department and Professor of Public Health at Flinders University and Foundation Director of the South Australian Community Health Research Unit. Monique Bégin is a sociologist and the first woman from Québec elected to the House of Commons, Canada. Giovanni Berlinguer is a member of the European Parliament where he serves in two Commissions: ‘Environment and Health’ and ‘Culture, Education and Information’. Mirai Chatterjee is Coordinator of Social Security for India’s Self-Employed Women’s Association (SEWA) - a trade union of over 200 000 self-employed women. William H. Foege is Emeritus Presidential Distinguished Professor of International Health, Emory University (USA), and a Gates Fellow. Yan Guo is Professor of Public Health and Vice President of the Beijing University Health Science Centre, China. Kiyoshi Kurokawa is President of the Science Council of Japan and the Pacific Science Association. Ricardo Lagos Escobar is the former President of Chile. An economist and lawyer by qualification, he worked as an economist for the United Nations from 1976–1984. Stephen Lewis was Canadian Ambassador to the United Nations from 1984–1988. Alireza Marandi is Professor of Pediatrics at Shaheed Behesht University, Islamic Republic of Iran. Pascoal Mocumbi was Prime Minister of the Republic of Mozambique from 1994–2004. Ndoro Ndiaye is Deputy Director-General of the International Organization for Migration. Charity Kaluki Ngilu is the Minister of Health of Kenya. Hoda Rashad is Director and Research Professor of the Social Research Center of the American University in Cairo, Egypt. David Satcher is Interim President of Morehouse School of Medicine, National Centre for Primary Care, USA. Amartya Sen is Lamont University Professor and Professor of Economics and Philosophy at Harvard University, USA. Anna Tibaijuka is Executive Director of the United Nations Human Settlements Programme (UN-HABITAT). Denny Vågerö is Professor of Medical Sociology and Director of the Centre for Health Equity Studies, Sweden. Gail Wilensky is a Senior Fellow at Project Health Opportunities for People Everywhere, an international health education foundation.

For more information about the World Health Organization, Commission on Social Determinants of Health and the individual Commissioners, consult the website at: http://www.who.int/social_determinants/en/
Stellenbosch University, where I work, is historically an Afrikaans-medium institution, with a long pedigree of links to the old apartheid regime. The question of the future of Afrikaans in the university is a matter for painful and heated debate, and has consumed the letters page of the local Afrikaans-language daily newspaper. Afrikaans-speakers were very successful during the twentieth century in turning Afrikaans into the most widely-understood language in the country, and a language for transaction in all spheres, including the academic sphere. There are now great fears that as the university actively opens its doors to a more diverse student and staff population, Afrikaans will be dominated by English, as has happened with many other local languages world-wide. Many academics in the university, however, including the rector, believe that for Stellenbosch to be an internationally competitive institution which attracts the best talent locally and from abroad, there needs to be a greater emphasis on multilingualism, and an acceptance of the importance of English to academic life internationally.

An astonishing feature of this debate, parochial to a degree as it is, is the lack of serious engagement with what multilingualism really means, especially in the context of preparing professionals for the world of work in a diverse South Africa. For example, Xhosa is the indigenous language spoken most widely in the area of South Africa where Stellenbosch is situated, and one of the 11 official languages. The majority language in this province, the Western Cape, is Afrikaans (with most native speakers being 'coloured', or of diverse and mixed racial origin), but the number of Xhosa-speakers is increasing in the province, and, nationally, native speakers of Xhosa and its cognate language Zulu account for almost 40% of all South Africans.

Given the salience of these facts for a Department of Psychology training professionals to meet national mental health needs, we as a staff have been taking Xhosa lessons in order to improve our proficiency in that language. Some of us are beginners; some, like me, have been studying Xhosa for many years. One of my Xhosa-speaking colleagues has been telling me, though, of some of the feelings indigenous African people have when white and coloured South Africans embark on courses in local languages apart from Afrikaans. She tells me that people question the motives of those who engage in such courses. People say, apparently, that white people are learning Xhosa and similar languages so that they can get around employment equity criteria when they apply for jobs. Often, companies which want to employ indigenous Africans in order to diversify their staff profile and to meet legislated equity criteria, will not say directly that they want to employ indigenous Africans – they will say, instead, that they require ‘Xhosa-speaking’ staff. My colleague tells me that many people believe that white people are now learning Xhosa so that they can say that they too are ‘Xhosa-speaking’.

Regardless of the prevalence of this view, or even the accuracy of what my colleague tells me, her raising of this issue highlights one of the most difficult but also most important issues at stake when we try to work multiculturally.

We carry and embody traditions of power and exclusion, and goodwill alone is unlikely to be accepted simply for what it is. People who have been oppressed and abused for generations would be unwise, to say the least, simply to trust the good intentions of those more powerful who, apparently suddenly, embark on new ways of reaching out to others. It would be foolish to ignore the patent self-interest, in a new democratic dispensation, of white people learning indigenous languages.

There is another aspect to this issue, for which another story will serve. I have been speaking Xhosa (not very well) for over twenty years, and am constantly working on improving my skills in that language. One important aspect of the language that I have been taught repeatedly, is that it is polite to address all people of one’s age group as ‘sister’ or ‘brother’, and all older people as ‘father’ or ‘mother’. All the Xhosa teachers I have had have stressed this, and my experience of working with Xhosa-speaking people as colleagues and in mental health and community work, has borne out the view that this is a polite way to communicate. The other day, however, I was speaking to a Xhosa-speaking colleague whom I do not yet know well, and I called her ‘sis’ (‘sister’ in Xhosa). My colleague became extremely angry with me, and told me that she would use the term ‘sisi’ only for her biological sister, and not even for what in South African kinship terminology is known as a ‘cousin-sister’ (a first cousin who is regarded as almost the same as a sister in terms of kinship). She also commented that in her experience it is only white teachers of Xhosa who teach their white students to use these kinship terms. We were learning Xhosa and similar languages so that they can get around employment equity criteria when they apply for jobs.

People who have been oppressed and abused for generations would be unwise, to say the least, simply to trust the good intentions of those more powerful who, apparently suddenly, embark on new ways of reaching out to others.
There are at least three reasons for my colleague’s differing from what I have been taught and what I have seen over many years. Rules of politeness may be changing in a rapidly-changing society. There may be regional differences in cultural rules (my colleague comes from an area with which I am not familiar). Or my colleague may be making a boundary between me and her, asserting an insider knowledge and a world to which I cannot assume access.

Regardless of whether any or all of these interpretations is correct, the unsettling experience has been useful to me. The hopeful view of multiculturalism is that of a ‘rainbow nation’, a wonderful and exciting mixture of cultures in which we all take pleasure and pride. A bleaker view, though, emphasizes the performances of exclusion and power, the counterintuitive and seemingly unhelpful ways in which communication across divides is mistrusted, subverted, sabotaged. In contemporary South Africa, over the past few weeks, we have had both images writ large. On the one hand, in the context of the tenth anniversary of the Truth and Reconciliation Commission, we are made aware again of how much we have got right in a country which many agreed was headed for all-consuming catastrophe. On the other hand, we have witnessed the spectacle of the rape trial of our former Deputy State President, Mr Jacob Zuma. Mr Zuma was acquitted, and due process was followed by the court, but the implications of the trial for South Africa are far-reaching. We have seen, for example, how the notion of Zulu culture and Zulu masculinity (both Mr Zuma and the complainant are Zulu-speaking) can be used to reassert damaging sexist ideas about women ‘asking for it’ in the context of rape, and of men having ‘natural’ desires and needs which cannot be controlled.

What does this all have to do with multicultural mental health work internationally? Quite a lot, I think. The South African case is stark because there is so much at stake here, but any attempt at being ‘culturally sensitive’ in mental health work anywhere in the world cannot but be politically loaded. We cannot do good things about culture and mental health without at the same time breaking some rules. We cannot do the work without making mistakes. This is part of what makes the work frightening at times, but exhilarating. We all perform identities and cultures for a range of complex reasons, and this goes for both mental health clients and mental health service providers. Especially in the world context of fear and terrorism, which affects us all at present, we lose the edge of what we do if we are too afraid to consider how what we do is potentially transgressive, unwelcome and difficult. Though multiculturalism as an ideology commonly emphasises understanding and rapprochement, crossing boundaries is perilous. The trick is whether we can use the confusions, the unhappinesses, and the conflicts around cultural issues in a helpful way, rather than denying or smoothing over the problems. Of all groups of people, those of us interested in mental health should be able to face rather than to ignore the difficulties.

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Citation:
AeJAMH

Call for contributions
Contributions are invited from clinicians, practitioners, consumers, carers, researchers, academics and commentators across the broad range of disciplines that are involved in PPEI approaches to mental health.

We are interested in:
• reviews and theoretical articles;
• original applied research and empirical studies;
• analyses of population needs;
• evaluations of innovative or model programs;
• service reorientation studies offering solutions for administrators, policy makers and service providers;
• comments on policy, history, politics, economics and ethics.

We accept contributions on an ongoing basis.

For contributor information see:
www.auseinet.com/journal/contribute

Original contributions can be sent to ejournal@auseinet.flinders.edu.au

For further information please contact:
Anne O’Hanlon  Editor, AeJAMH
Tel: 08 8201 7670
Email: anne.ohanlon@flinders.edu.au

Australian e-Journal for the Advancement of Mental Health
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Special issue now online – Multicultural Mental Health
Volume 5, Issue 2, August 2006
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Editorial: On disadvantage
Graham Martin, Editor in Chief

Guest Editorial: ‘They first killed his heart (then) he took his own life’: Reaching out, connecting and responding as key enablers for mental health service provision to multicultural Australia
Nicholas G. Procter

Guest Editorial: Moving multicultural mental health into the mainstream: Building capacity and facilitating partnerships
Meg Griffiths

Guest Editorial: Useful conflicts: Dispatches from the culture wars
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A culturally sensitive consultation model
Jill Benson

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Unipolar depression across cultures: A Delphi analysis of the methodological and conceptual issues confronting the cross-cultural study of depression
Melinda Redmond, Rosanna Rooney and Brian Bishop

What CALD consumers say about mental illness prevention
Rita Prasad-Ildes and Elvia Ramirez

Issues faced by carers of people with a mental illness from culturally and linguistically diverse backgrounds: Carers’ and practitioners’ perceptions
Rosanna Rooney, Bernadette Wright and Krissa O’Neil

Serve, subvert or emancipate? Promoting mental health in immigration detention
Pauline J. McLoughlin

Sailing in a new direction: Multicultural mental health in New Zealand
Ruth DeSouza
General practice is recognised as an important setting for promotion, prevention and early intervention approaches to mental health. This is well documented in a number of key policy documents in Australia including the National Mental Health Plan 2003-2008 and the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2000). More than one in ten of all general practitioner consultations are for mental health related problems. In Australia, a number of recent initiatives have facilitated the upskilling of general practitioners to provide better mental health care. The Better Outcomes in Mental Health Care Initiative developed in 2001 and funded until 2009 by the Australian Government aims to improve patient care by addressing the obstacle of accessible, high quality mental health education and training for GPs.

Partners in Prevention Project
Auseinet and the Australian Divisions of General Practice (ADGP) continued their partnership in the second phase of the Partners in Prevention project, which focuses on developing evidence-based mental health resources and complementary education and training modules for general practitioners.

PPEI Learning Modules
The suite of four evidence based promotion, prevention and early intervention (PPEI) for mental health in general practice learning modules has been completed to content and piloting stage. The modules address PPEI across the lifespan targeting GPs’ skills to identify and respond to mental health issues associated with child behaviour, older adults, and children in families experiencing separation and divorce. The modules and the consultants who developed them are:

Introductory module: PPEI - What is it for GPs?
Dr Debra Rickwood, Rickwood Research and Consulting, Canberra.

Child Behaviour
Centre for Community Child Health, Royal Children’s Hospital, Melbourne.

Managing the Impact of Separation and Divorce on Children
Australian Psychological Society, Melbourne.

Older Adults
NSW Institute of Psychiatry, Sydney.

Module resources
The development of the modules has included preparation of literature reviews to explore the evidence for PPEI approaches, translation of the evidence into interactive training programs, and development of resources that GPs can use in their everyday practice.

The literature reviews identify levels of evidence, where possible, to inform the content of the module. These are currently undergoing revision following external review. On completion of this process each of the literature reviews will be considered for wider availability via the Auseinet website.

In addition to the literature reviews, the modules comprise skills-based training programs which are designed for a national audience with flexibility for local input. The training components are presented in a way that is lively, engaging and attractive to GPs. The consultants have utilised a variety of presentation formats consistent with adult learning principles as specified by the accreditation boards. The formats include PowerPoint presentation, case studies, small group and large group discussions, video, role plays and a self directed learning CD ROM. They have also produced an extensive range of resources for GPs to complement their training program including workbooks, a reference card, strategy booklet, tip sheet for parents, practical checklist, summary card, a mental health assessment tool, and localised referral lists.

Three of the four training programs have been piloted. These have been received favourably with only minor modifications recommended.

Accreditation
Auseinet has coordinated the accreditation of the modules, working closely with the consultants and the accreditation bodies to ensure that all accreditation criteria have been met. Accreditation has been obtained from the Royal Australian College of General Practitioners (RACGP), the General Practice Mental Health Standards Collaboration (GPMHSC) and the Australian College of Rural and Remote Medicine (ACRRM).

Dissemination
Auseinet and ADGP have been working on a dissemination strategy for the roll out of the modules which is being informed by the pilots and by the COAG Reform Agenda in relation to general practice. It is anticipated that we will have an agreed strategy by December 2006.

Next steps
Following finalising the dissemination strategy Auseinet and ADGP will seek funding to implement this strategy in 2007 and beyond.
Reframing Responses

Improving service provision to women survivors of child sexual abuse who experience mental health problems

Dr Louise O'Brien
Consultant Researcher to the Project, University of Western Sydney

Corinne Henderson
Policy Officer, Mental Health Coordinating Council

Background
The Mental Health Coordinating Council (MHCC) have completed a one-year project, ‘Reframing Responses: Improving service provision to women survivors of child sexual abuse who experience mental health problems’, funded by the Victims of Violent Crimes Grants Program. This project was coordinated by MHCC in consultation with Dr Louise O’Brien, University of Western Sydney. The project acknowledges the central contribution of the many participants involved in the research process – the providers and recipients of services for women survivors of childhood sexual abuse, and members of the steering committee who gave so generously of their time.

The aim of the project was to study capacity across and between non-government organisations to provide services to women survivors of childhood sexual abuse who experience mental health problems and have complex needs, by evaluating existing service delivery, developing an understanding of safety issues, models of care and by identifying gaps, inequalities and barriers to access.

What the research says
Over the past twenty-five years, researchers, human service providers and mental health practitioners have endeavoured to fully understand the impact of child sexual abuse on psychological health. Child sexual abuse rarely occurs in isolation but usually in the presence of other forms of abuse. An established body of knowledge clearly links childhood sexual abuse with higher rates in adults of depressive and anxiety symptoms, substance abuse disorders, eating disorders and post-traumatic stress disorders. ‘There is no doubt that the physical, emotional and psychological effects accompanying sexual abuse can last a lifetime’ (Kennedy, 2000).

According to NSW Health, in 1997-98 child victims accounted for 34% of all presentations of women requiring services from women’s and community health centres and mental health services. Adults who experienced recent sexual assault accounted for 42% of presentations and adult survivors comprised 24% of victims seen by sexual assault services in Australia. Comparative studies in the USA have shown similar rates of mental health service utilisation.

The ratio of women to men adult survivors presenting to sexual assault services in 1997-98 was approximately five to one (38% were aged between 16 - 24 years) compared to seven to one in 1993 - 94. In over 60% of cases the time between the assault and presentation was more than ten years.

Service usage
Survivors of child sexual abuse also appear to utilise high levels of health care (more physician visits and higher outpatient costs) than women who have been victims of other types of crime. Women with sexual assault and abuse histories also present with physical problems with greater frequency than those women who have not experienced sexual abuse.

Women with abuse histories access services from a wide diversity of government, non-government and private health sectors. This diversity may include: mental health; drug and alcohol; sexual assault; supported accommodation; employment; community and women’s health and counselling agencies; mental health services; GPs; private psychologists; psychotherapists and counsellors; private hospitals and survivor support organisations.

In the context of sexual assault services both government and community organisations report that an absence of adequate resources necessitates prioritising service delivery to victims of recent sexual assault. Survivors increasingly experience ongoing barriers to access and equity since they do not present in ‘immediate crisis.’

Services in metropolitan and particularly in rural, regional and remote areas lack both the time and resources to undertake outreach work. Marginalised groups, especially Indigenous women, women with disabilities and women from culturally and linguistically diverse communities, as well as those living in rural or remote areas, are often unaware of the services available. Without the possibility of outreach work, the ‘accessibility’ of services is severely compromised.

Research study design
The Reframing Responses research study design was qualitative, participatory and feminist. Participation was invited from both providers and recipients of services for women. Separate focus groups and
interviews were conducted with a total of 51 participants. Participants were asked to describe their experiences of services from their own perspective.

The research identified ‘evidence-based’ best practice as an approach to service delivery that offers a range of flexible ‘holistic’ services. NGO community based services play a crucial role in responding to the complex needs of this group of women who experience difficulties in accessing mainstream services.

**Study recommendations**

It is clear that increased access to support services for survivors of child sexual abuse in Australia is urgently needed, without decreasing access to recently abused and assaulted children and adults. The *Reframing Responses* literature review, combined with qualitative findings has provided a basis for recommendations to improve access and equity to this population in the community.

The study confirmed that implementation of national standards and guidelines embodied in government policy is crucial, setting a ‘bench-mark’ for outcomes, including evaluation and ongoing improvements to service delivery. Data collection for longitudinal studies for research and outcome measurement is needed to fulfil a commitment to quality service delivery across the state, as is the need to address service delivery to rural, regional and remote communities and isolation of rural workers.

Currently no model of service delivery for women survivors of childhood sexual abuse exists. Many individual services have developed their own model that tend to be specific to the service, and that does not extend beyond the bounds of the service. A model of service needs to be developed that recognises existing expertise, emphasising collaboration, partnership and interagency cooperation across and between NGOs and other health and community services.

The project recommendations detail improved dissemination of information, support and culturally appropriate counselling and therapeutic services, embodied in a model of sustainable collaboration and capacity building between a diversity of NGO services.

Recommendations for improved service provision also emphasise the need for relevant education and workplace training across areas including: mental and physical health issues; substance dependency; domestic violence; sexual assault; homelessness; poverty and problems that arise with mothering and parenting.

The *Reframing Responses* report recommends that a pilot project be developed that would aim to improve service delivery, reduce waiting times, increase the capacity of all services to deal with the complex presentation of women survivors of CSA, and develop agreements for the delivery of appropriate and timely services. From an evaluation of this pilot project, a model of service delivery with standards, guidelines, safety audit tools and outcome measures could be developed.

The primary objective of the *Reframing Responses* project was to provide unequivocal evidence that the complex needs of survivors of CSA can no longer be ignored in terms of the human and long term cost to the community.

The project identified a lack of information in an Australian context with regards to service delivery, organisational structures and the perceptions of service providers and survivor users of services. The project has sought to provide evidence in NSW that will demonstrate the need for improved access and equity to a group most marginalised and vulnerable as a consequence of mental illness, substance dependency, co-morbidity, ethnicity, socio-economic status, disability or sexual preference.

The Report and Recommendations and the Literature Review that informed the study are available on the MHCC website at: www.mhcc.org.au

Hard copies are available on request. For further information, please contact Corinne Henderson on tel: 02 9555 8388 or email: corinne@mhcc.org.au


A pilot project for young Aboriginal people has been taking place in the Tamworth, New England area of New South Wales. The project is a joint partnership, community collaboration with the following:

- Yaamanhaa Aboriginal Men’s group (Tamworth);
- School Link (NSW Health);
- Department of Education;
- University Department of Rural Health (UDRH), Newcastle University; and
- MindMatters.

‘Feeling Deadly not Shame’ – A MindMatters Approach is a program based on the MindMatters content1, and adapted to suit the needs of the Aboriginal community including the use of appropriate language relevant to Aboriginal people. It is designed to provide techniques and activities particularly for young Aboriginal people to address negative impacts and provide positive, affirmative coping mechanisms to enhance resilience, and stay ‘strong, deadly and safe’ within their community. ‘Feeling Deadly not Shame’ – A MindMatters Approach addresses a range of social and emotional wellbeing issues such as powerlessness, meaninglessness and alienation, recognising that these negative symptoms have resulted from a history of dispossession and disconnection from cultural continuity.

The first pilot program was implemented with 70 Aboriginal secondary students from towns across northern NSW including Moree, Boggabilla, Narrabri and Wee Waa, Armidale, Guyra and Inverell. A strong community development framework is being developed to involve parents, other family members and the community to strengthen the capacity for mental health promotion approaches outside of school hours.

This program is seen to have the potential for young people to develop personal skills to develop into community empowerment - ‘deadly people growing deadly communities’.

For further information about this project contact:
Kanat Wano  NSW MindMatters Project Officer
Tel: 02 9244 5520 or 0418 711 255
Email: kanat.wano@det.nsw.edu.au

1MindMatters is a mental health promotion program which supports secondary schools to promote and protect the mental health of members of school communities. The program is being conducted by the Australian Principals Associations Professional Development Council and Curriculum Corporation and is funded by the Australian Government Department of Health and Ageing. For more information consult the website at: http://cms.curriculum.edu.au/mindmatters/

Why Me? has recently been awarded a ‘Creative Excellence Award’ in the documentary section of the US International Film and Video Festival (2006) in Redondo Beach, California.

This resource was produced by Nunkuwarrin Yunti of South Australian Inc. (SA Link-Up) with support from...
Muuj Social and Emotional Regional Centre

A function was held recently at the Winnunga Nimmityjah Aboriginal Medical Service in Narrabundah, Canberra, ACT, to mark the re-signing of a Memorandum of Understanding (MOU) for the Muuj Social and Emotional Regional Centre program.

The Honourable Tony Abbott, Federal Minister for Health was the distinguished guest on the day. The Minister acknowledged the significant role of the Muuj Regional Centre program in addressing a number of significant social and emotional wellbeing issues experienced by Aboriginal and Torres Strait Islander peoples living and working in the Australian Capital Territory and South East New South Wales.

The Muuj Social and Emotional Regional Centre was established in 2000 as a result of recommendations from the Bringing Them Home and Ways Forward reports. The Regional Centre comprises a consortium of three Aboriginal Medical Services - Winnunga Nimmityjah (ACT), Riverina Medical and Dental Aboriginal Corporation (Wagga, NSW) and Katungul Corporation and Community Medical Services (Narooma, South Coast of NSW). The focus of the Regional Centre is on providing professional support, and access to appropriate training for Aboriginal and Torres Strait Islander peoples working in the area of social and emotional wellbeing in the Australian Capital Territory and South East New South Wales.

The re-signing of the MOU was a significant event celebrating a vibrant and committed partnership. Muuj has established links with a range of organisations including Relationships Australia, a number of registered training organisations, the Australian National University, Canberra University, justice services and other government departments. One of the major achievements for Muuj over the last 18 months has been the setting up of local networks of Aboriginal and Torres Strait Islander social and emotional wellbeing workers in each area. The networks are going a long way to strengthening communication between service providers across the region.

The Regional Centre is managed by a steering committee which comprises the CEO and Chair of each of the three medical services. The consortium represents a successful partnership which has continued to work together since the original MOU was signed in early 2000. The Muuj team comprises the program manager and 3 project officers. The program manager and a project officer are based at Winnunga and there is a project officer based at Katungul and Riverina Medical and Dental Service (Wagga).

The Muuj Regional Centre has also recently established a partnership with the Australian Institute for Aboriginal and Torres Strait Islander Studies (AIATSIS), Canberra. The purpose of the partnership is to undertake a data collection research project to look at access to mainstream services by the broader Aboriginal and Torres Strait Islander communities in the region. This project will also look at recruitment and retention of Aboriginal and Torres Strait Islander staff in these same organisations.

For more information on Muuj Regional Centre for Social and Emotional Wellbeing contact:

Jodie Fisher
Tel: 02 6284 6220 OR
Email winrego@winnunga.org.au
In order to help people provide initial support for someone with a mental health problem, the Mental Health First Aid (MHFA) training course has been developed. In 2000, Betty Kitchener and Professor Tony Jorm began writing a MHFA manual and an accompanying course, with the aim to improve the mental health literacy of members of the Australian community. Since then, the MHFA Training and Research Program has been developed, evaluated and disseminated nationally and internationally. This Program includes a 5-day Instructor Training Course to accredit suitable candidates to become MHFA instructors who deliver the 12-hour MHFA course to their communities. This 12-hour course is designed to give members of the public some skills to help someone developing a mental health problem or in a mental health crisis situation. The philosophy behind the course is that mental health crises, such as suicidal and self-harming actions, may be avoided through early intervention with people developing mental disorders. If crises do arise, then members of the public can take action to reduce the harms that could result.

Participants of the 12-hour MHFA course receive a course manual and a certificate at the completion of the course. Those who have completed the course have been very positive about the knowledge and skills they have acquired. Course participants have been very varied, including teachers, police, nurses, case managers, support workers, social welfare staff, employment agency staff, personnel staff, members of the general public and staff of many Australian and local government departments.

The MHFA course has been thoroughly evaluated using randomised controlled trials and a qualitative study and been found to be effective at improving the course participants’ knowledge of mental disorders, reducing stigma, and increasing the amount of help provided to others. To disseminate the course, MHFA instructors are trained from across Australia, to conduct the 12-hour MHFA course autonomously in their local region. Instructors work for NGOs (e.g. Red Cross, Lifeline, Anglicare), social welfare services (e.g. employment, housing) local area health services, places of employment, or as private practitioners. In view of the innovation and quality of the Program, it has won a TheMHS first prize and has spread to a number of other countries, including Scotland, Canada, Hong Kong and Singapore.

Since April 2005, the MHFA Program has been auspiced by ORYGEN Research Centre at the University of Melbourne. The MHFA program has begun to develop specialised MHFA courses. In early 2005, three culturally and linguistically modified MHFA courses were launched for Croatian, Vietnamese and Italian communities in Australia. In early 2007 an Aboriginal and Torres Strait Islander version of MHFA the course will be launched (more information provided below). Also early in 2007 a youth focused MHFA course will be launched. The target audience for this will be adults working with young people.

The MHFA course has been thoroughly evaluated using randomised controlled trials and a qualitative study and been found to be effective at improving the course participants’ knowledge of mental disorders, reducing stigma, and increasing the amount of help provided to others.

The MHFA team is working closely with Aboriginal and Torres Strait Islander people to develop a 15 hour version of the MHFA course for Aboriginal and Torres Strait Islander people. The 15 hour course will be mainly delivered by accredited Aboriginal and Torres Strait Islander instructors who will begin to undertake training from February 2007. The training will take place in every Australian state and territory. A specialist 3 day MHFA course is also being developed for accredited MHFA instructors who meet special selection criteria determined by the MHFA team in conjunction with an Aboriginal Advisory Group. These courses will also begin in 2007.
An Aboriginal Working Group has been established to work with members of the MHFA Team to develop the course and Aboriginal MHFA Manual. The Working Group has Aboriginal representatives from the Commonwealth Office for Aboriginal and Torres Strait Islander Health, the Victorian Aboriginal Community Controlled Health Organisation, the MHFA Team at ORYGEN Research Centre and Auseinet. Dr Helen Milroy, Aboriginal Psychiatrist from Western Australia is a member of the Working Group.

One hundred and twenty Aboriginal instructors will be accredited between January 2007 and June 2008. Once accredited, the instructors will conduct the course in a range of settings including Aboriginal community controlled health services and Aboriginal communities throughout Australia.

Many Aboriginal and Torres Strait Islander health workers and educators have expressed interest in undertaking the week-long instructor training course. At least one instructor training course per month is planned to be held in different regions across Australia until a cadre of Aboriginal instructors is available to conduct the 15 hour course in urban, rural and remote areas of Australia.

The development of the Aboriginal MHFA course fits very well with the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004 – 2009 (Australian Government Department of Health and Ageing, 2004). The Framework emphasises the need to increase the levels of mental health awareness within Aboriginal and Torres Strait Islander communities as well as take efforts to help reduce stigma around mental disorders.

The MHFA team also plans to thoroughly evaluate the Aboriginal MHFA Program in order to maintain the high standards of research and evidence maintained in the regular MHFA course. The research and evaluation program will be designed by members of the Mental Health Literacy team at the ORYGEN Research Centre in close partnership with Aboriginal and Torres Strait Islander people.

For more information contact:
Len Kanowski, Mental Health First Aid, ORYGEN Research Centre, Department of Psychiatry, University of Melbourne.
Email: Len.Kanowski@mh.org.au OR Visit the MHFA website www.mhfa.com.au
Carers NSW - Family and Carer Mental Health Program

Erica Pitman,
Senior Education & Training Officer, Orange, NSW

Background

Carers NSW (CNSW) has been delivering the Carers Mental Health Project (CMHP) as one of eight demonstration projects operating in NSW. The NSW Department of Health, through the Centre for Mental Health (CMH), funded these projects. The CMHP commenced in August 2001 covering two area health service regions – South West Sydney (renamed Sydney South West) and Mid Western (renamed Greater Western).

While the demonstration projects were being delivered across NSW, CMH undertook a strategic development process to establish appropriate statewide service planning. A wealth of evidence shows that providing support and education addresses family and carer health and wellbeing needs, provides direct health benefits to consumers, as well as benefiting clinicians and mental health services.

The program aims to assist carers to make informed decisions...

As a result of the statewide service planning a new model for service delivery, known as the Family and Carer Mental Health Program (F&CMHP), has been funded by CMH from 1 July 2006. Funding has been provided to each Area Health Service to provide family friendly mental health services. Non-government organisations (NGOs) have been funded to provide mental health family and carer support programs.

CNSW was the successful NGO selected to deliver this new service model in a collaborative partnership with three area health service regions – Greater Western, North Coast, and South East Sydney/Illawarra.

The F&CMHP will be implemented in the other NSW health regions by the local Area Health Service and the following NGOs: ARAFM (Northern Sydney/Central Coast), Parramatta Mission (Sydney West) and Schizophrenia Fellowship Carer Assist (Greater Southern, Sydney South West and Hunter/New England).

Carer Education & Training Programs

As part of the Carers Mental Health Project, Carers NSW delivered a number of carer education and training programs. Carers NSW will continue to deliver and facilitate carer participation in this suite of extensively evaluated programs within the Greater Western, North Coast and South East Sydney/Illawarra area health regions of NSW. Following is an overview of a sample of these programs.

14 Principles of Coping

Developed in the early 1980s by Dr Ken Alexander. Ken is a research scientist, the relative of a person with schizophrenia and spent 15 years as a volunteer with crisis services.

During 1992-94 Ken ran residential courses for relatives in North America and Europe and conducted workshops for mental health professionals. Currently he is the Honorary Chief Research Fellow for the European Union Families of the Mentally Ill (EUFAMI), taking his course to Ireland, France, Germany and Switzerland.

The program aims to assist carers to make informed decisions. The 14 Principles method of coping is based on the observation that carers who learn the principles of coping will successfully apply their own problem-solving procedures for coping. The program also supports the self esteem of carers which is essential for coping. It provides carers with an understanding of the underlying issues that affect consumers, carers and service providers and encourages carers to realise their needs are important and to take very great care of themselves.

Between 2002 and 2006 this program has been delivered extensively as part of CMHP. Due to copyright difficulties, it is not possible to continue to offer the program as part of the new F&CMHP. However CNSW is currently developing a new program (Foundations) which will maintain the ethos and integrity of the 14 Principles of Coping and will incorporate learning from the Carer Life Course Framework (see below).

Eight-Stage Healing Process

Hidden Victims – Hidden Healers: An eight-stage healing process for family and friends of the mentally ill was published in 1988 by Julie Tallard Johnson – a psychotherapist and author with experience of a brother with schizophrenia. She is the founder of the Siblings and Adult Children’s Network, a committee of the National Alliance for the Mentally Ill in the USA.

The program targets carers and friends of people with a mental illness/disorder and runs for ten weeks with one, two-hour session per week. 8-10 carers can participate and the
program is facilitated by one or two professionals who have a background in counselling, psychology, social work or related experience.

The program aims to assist carers to work through their own healing process by introducing alternatives to common patterns of coping – ‘it is possible to care for your loved one without losing sight of your own needs’. The process works with the notion that healing ourselves assists with healing our family relationships and our community. Our own healing process is a life-long journey and this program is a catalyst for this process.

The eight-stages contained in the program are as follows:

- Awareness: I explore the ways in which the relationship/family/issue has affected my life.
- Validation: I identify my feelings about this relationship/issue and share those feelings with others.
- Acceptance: I accept that I cannot control any other person’s behaviour, that I am ultimately responsible only for my own emotional wellbeing.
- Challenge: I examine my expectations of myself and others and make a commitment to challenge any negative expectations (silent agreements).
- Releasing Guilt: I recognise mental illness as a disease and release the attitude of blame.
- Forgiveness: I forgive myself for any mistakes I have made. I forgive and release those who have harmed me.
- Self-Esteem: I return the focus of my life to myself by appreciating my own worth, despite what may be going on around me.
- Growth: I reaffirm my accomplishments and set daily, monthly, and yearly goals.

Participants set aside at least two hours per week to work on the material between each session. During the program each participant has the opportunity to give a personal testimony relating to how mental illness in their family has affected them. This is a powerful part of the healing process.

SMILES: Simplifying Mental Illness and Life Enhancement Skills Program

This program was developed by Erica Pitman in 1997 as a result of the increasing recognition that children in families affected by mental illness are a population ‘at risk’ for developing their own mental health problems. The program is for children and young people aged 8-16 years who have a parent or sibling experiencing a mental health problem (specifically schizophrenia, bipolar disorder or depression).

The program is usually delivered over three days during the school holidays and requires 8-10 participants. It is facilitated by a professional with a thorough knowledge of and experience working in the area of mental illness. The program aims to provide age-appropriate education about mental illness and life skills to improve the children’s capacity to cope more effectively, thus increasing resiliency. It also aims to improve self-expression, creativity, self-esteem and reduce feelings of isolation.

Between 1998 and 2005, a total of 87 children participated in the SMILES Program in Bankstown, Bathurst, Canley Vale, Central Coast, Fairfield, Orange, Parkes and Parramatta as well as in Pointe-Claire (Montreal) Canada.

The full SMILES Program is now available as a free download from the Children of Parents with a Mental Illness website www.copmi.net.au (refer Services and Programs on the main menu).

Carer Life Course Framework

The development of the Carer Life Course Framework by Carers NSW was in response to the recognition that carers need a framework of support that links the length of time caring to the type of caring relationship and the carer’s own stage of life.

The Carer Life Course Framework authored by Dr Deanna Pagnini (2005) identifies six distinct phases that many carers experience, and how this can change depending on their caring relationship and their life stage or life course. It also identifies the major issues, emotions, needs and key contacts for each of the six phases and lists what carers found most helpful, or not, about the information and support they received from mental health services and other key contacts during these phases.

Carers NSW intends to develop the framework further, specifically into a web-based resource, as well as investigating its applicability to other carer populations such as those from Aboriginal and Torres Strait Islander and culturally and linguistically diverse backgrounds.

For more information about any of the programs mentioned above, contact Carers NSW on:

Tel: 02 9280 4744, 1800 242 636 (for carers), OR Visit the website:

www.carersnsw.asn.au

References


Centre for Mental Health, NSW Department of Health (2005). Family Sensitive Area Mental Health Services Business Case Guidelines, NSW.


The Recovery Toolkit is being well used by visitors to the Auseinet website and now contains a considerable collection of resources and information. We are still eliciting feedback about the style and type of resources that users would like to access and we're adding new items on a weekly basis. Here are some of the latest additions…

The Fact sheet area now includes a selection of general information relating to understanding mental illnesses, causes and treatment options. These fact sheets have been sourced from Mental Illness Fellowship and SANE Australia and are primarily for consumers, carers, family and friends.

The Policies page includes the following strategies and plans:

- Tasmanian Mental Health Services Strategic Plan 2006-2011: Partners...towards recovery. Tasmanian Mental Health Services, Hobart, Tasmania, 2006. [Link]

The Discussion Forum now has 12 separate topics including a ‘cyberspace community’ (under the heading ‘fellowship’), and some lively dialogue around care planning. Participants are sharing ideas and styles of care plans and we have included links to some existing plans. A number of the writers have a definite flair for prose and there are some quite poetic and moving messages.

We have also used the forum to pick up ideas for further resource development. For example we have increased our range of documents around the issues of peer support, including the following items:

- Implementation of Person-Centered Care and Planning: How philosophy can inform practice. Davidson L. et al. Department of Psychiatry, University of Illinois at Chicago, Chicago Ill. [Link]
- Harnessing the Lived Experience: Formalising peer support approaches to promote recovery. Bradstreet S. Scottish Recovery Network, Glasgow, Scotland, 2006. [Link]
- Recovery: Our thoughts on recovery and what helps us to recover from mental health problems. Highland Users Group, Inverness, Scotland, 2006. [Link]
The General Recovery Resources collection now contains over 200 items under the following sub-headings:

- General information
- Physical health
- Policy and related
- Newsletters
- Peer support
- Housing or homelessness
- Service provision
- Self help
- Social or vocational activity
- Personal plans or strategies
- Personal stories

We have had considerable interest in the Recovery Toolkit and are keen to maintain its appeal and relevance to a range of sectors. We are always happy to receive ideas about new resources or areas of interest, so please don’t hesitate to contact us if you have any comments.

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Information Officer
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New resources on the Auseinet website...

Auseinet has recently been involved in discussions with various members of the correctional services sector. Current research has shown that 80% of the prison population suffers from some form of psychiatric disorder (see: ‘Prisons: Mental health institutions of the 21st century?’ - details below).

As a result we have been focussing on this area in our collection development and the following items provide a few examples:

Improving the Health and Social Outcomes of People Recently Released from Prisons in the UK: A perspective from primary care.
Williamson, M.
www.scmh.org.uk/80256FBDO04F3555/vWeb/fkhAL6L5DLE/$file/health_prison_primarycare.doc

Woman at Risk: The mental health of women in contact with the judicial system.
Butler P, & Kousooulou D.
www.londondevelopmentcentre.org.uk/page.php?s=1&p=1870

Exiting the Prison System.
Farquhar P.
Community Housing Online, Melbourne, Victoria, 2006.

On the Edge of Justice: The legal needs of people with a mental illness in NSW.
Karras M. et al.
www.lawfoundation.net.au/report/mental

Prisons: Mental health institutions of the 21st century?
White P, & Whiteford H.

Interventions for Prisoners Returning to the Community.
Borzycki, M.
Australian Government Attorney-General’s Department, Canberra, ACT, 2005.

Two Auseinet staff recently provided a presentation about the Online Recovery Toolkit to a group of senior managers from the Corrections System in South Australia. We wanted to increase their awareness of the recovery oriented resources available online; and to find out from them whether there are other resources relevant to their work with people with a mental illness that we could include in the Toolkit. Research indicates that there is a high incidence of mental illness amongst people in contact with the corrections system both in remand centres as well as in prison. It is important that they are aware of the growing body of knowledge and experience associated with recovery. Furthermore research highlights that the prevalence of mental illness in prisoners is at least double that of people living in the community; many have had psychiatric contact prior to entering the corrections system; and for some their mental illness is accompanied by an experience of substance misuse.
Enhancing employment services for people with a serious mental illness

Laura Collister, Gafa Tuiloma and Tina Bourekas
Mental Illness Fellowship Victoria

People with a mental illness have the same aspirations as people in the wider community. They wish to be included in social and economic life and be viewed as valuable community members.

It is estimated that 75% of people with a serious mental illness in Australia are unemployed (Waghorn, Chant, White and Whiteford, 2004). This contributes to the significant economic disadvantage and social exclusion experienced by many people with a serious mental illness. However there is ample evidence that people with a mental illness want to and can work (Waghorn & Lloyd, 2005).

Mental Illness Fellowship Victoria (MI Fellowship) has since 1991 operated an employment service that has assisted people with a serious mental illness to obtain work. It was originally established along 'Clubhouse' lines and adopted many of the principles of the International Centre for Clubhouse Development. The MI Fellowship is currently situated in inner Melbourne and is funded by the Department of Employment and Workplace Relations to provide a Disability Employment Network service for up to 105 people with a serious mental illness. It is collocated with a range of service options funded by the Department of Human Services including home based outreach, respite and a day rehabilitation program.

Principles of the Clubhouse model

The day rehabilitation program was influenced by the Clubhouse model originally developed in Fountain House, United States. It provides an environment where members and staff work together during the day to facilitate recovery. Clubhouse membership is for life. The members carry out all the activities of the Clubhouse alongside staff members. Members are as a result provided with an important opportunity to develop specific skills such as operating the reception services, preparing and serving daily meals and maintaining Clubhouse property. These skills are thought to be transferable to the work environment.

Traditionally, staff work in generalist roles - they share employment, housing, support and the delivery of program functions. There are few distinctions between staff and member responsibilities. There are no areas restricted to 'staff only', and information is accessible to staff and members alike.

Transitional employment opportunities are a key feature of Clubhouses and have been operating from our Clubhouse since its inception. Members are given the opportunity to work in transitional positions in real workplaces for 6-9 months. These jobs are 'owned' and managed by the Clubhouse – and usually one full-time position is shared between 4-5 members. Transitional jobs are typically entry-level and take place in various work settings including supermarkets, large corporations, small factories and councils.

Pressure to change the employment approach

One of the key issues that has emerged over time, has been a pattern of members moving through a number of transitional employment positions, rather than moving onto sustainable open employment. While this produced employment outcomes from a service perspective it did not meet the recovery aims of many members – that is to obtain ongoing work in a community setting. It did not enable career progression and rarely provided enough income to make a difference to people's lives.

Employment programs operating out of the Clubhouse had traditionally been funded by the Department of Family and Community Services. With the switch to Department of Employment and Workplace Relations in 2005, two important changes occurred. Case-based funding was introduced leading to a greater emphasis on sustainable employment outcomes and higher performance expectations.

At this time the service also became aware of the growing evidence base from the United States supporting the Individual Placement and Support (IPS) approach to obtaining open employment. A survey of Clubhouses in the United States suggested that the IPS model leads to superior employment outcomes than those achieved through traditional transitional approaches (Bond, 1998). We began to incorporate some principles of this model into our program throughout 2004. In 2005 Mental Illness Fellowship Australia hosted a visit from Professor Gary Bond who challenged us to examine our current approaches and accelerate our commitment to an evidence-based approach.

Principles of evidence-based employment

The IPS model was developed by Becker and Drake (2003), and has been widely researched throughout the United States. There is a substantial and growing evidence base to support this approach (Bond, 2004). In the United States it is currently referred to as supported employment. As this term can refer to work in sheltered settings in Australia, the term evidence-based employment has been adopted (Waghorn & Lloyd, 2005) to describe this approach in Australia. There are seven key principles that define this approach.

1. Open, competitive employment is the goal

Efforts to achieve this goal require approaches that directly help the person with a mental illness to get and keep a job.
Tensions of delivering evidence-based employment

The first key tension apparent in aligning services to a more evidence-based approach existed in the pre-vocational versus rapid job search approach. Our employment service had traditionally received most of its referrals via the day program. The day program provided the opportunity for participants to practice a range of skills to assist in the running of the Clubhouse. For example, members cooked meals, answered the phone and cleaned. A culture of members ‘proving themselves’ in these positions prevailed prior to them being offered transitional employment opportunities via the employment program. This practice was not consistent with the rapid job search demanded by the evidence-based model. We believe that some participants lost focus on their original goal of open employment, while other people sought an alternative employment service that was not attached to a day program.

A second tension that emerged between the evidence-based model and the Clubhouse model concerned job ownership. Transitional entry-level employment positions were held by the Clubhouse. This presented several advantages to inexperienced job seekers. They were able to engage in employment in a relatively ‘safe’ way - that is positions would be back-filled by staff in the event of a member not being able to work, and one position could be divided into several manageable part-time positions. This was also fairly safe for the employer – the job would get done no matter what. However in relation to the evidence-based approach it meant that the positions were limited in both type and availability. Positions were not sought in response to an individual’s preferences and skills. A correlate of the Clubhouse owning and negotiating the job was that employers offering transitional positions were aware that the transitional employee had a mental illness. While this undoubtedly enabled many employers to accommodate for associated disability, it did not allow for an individual not to disclose. Many job seekers do not want to disclose their mental illness to employers – this model did not allow for this.
An additional feature of transitional positions are that they are time-limited. The implication is that no matter how well an individual performs in the job their employment will cease to make way for the next transitional worker. This enables one Clubhouse owned position to offer work experiences to several members – but does not enable a worker to stay in a job and build skills or a career. In contrast, evidence-based employment aims to place people in open employment and the individual ‘owns’ their job.

Challenges and solutions

There were multiple challenges in adopting practice that was more in line with evidence-based practice. Firstly, staff had to focus their role. The generic key worker role supported the client in multiple life domains, and this role was often adopted by the employment worker. Employment specialists now focus on employment goals with job seekers, and liaise with day program staff or case managers to address other issues with clients. Staff performance outcomes are now directly related to employment outcomes.

The physical co-location of employment and day program services has also presented challenges. This arrangement reinforces to job seekers a close relationship between the two services and the previous notion that membership of the day program was a condition of receiving an employment service. In addition, there were few private spaces to interview job seekers. Some people seeking an employment service exclusively, chose not to receive a service from us. Space is currently being rearranged to more effectively separate the employment service from the day program.

The service has now been renamed – MY Recruitment. This strategy clearly differentiates the employment service from the day program. It communicates very clearly to job seekers and potential employers the purpose of the service. It also addresses the key issue of disclosure. Disclosure becomes an individual decision of the job seeker, rather than indicated via the name of the employment provider. Positions for job seekers are sought on an individual basis, rather than negotiated with employers and then job seekers being fitted to them. This enables the service to be more responsive to individual skills and preferences. In addition, MY Recruitment has now re-located one employment specialist to a community mental health centre to deliver the evidence-based approach.

MI Fellowship is committed to improving the employment outcomes for people with a severe mental illness and is continually monitoring and developing the service to achieve this outcome.

References


Enhancing employment services for people with a serious mental illness

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The following is an entry from a contributor to the Auseinet Online Recovery Toolkit – Discussion Forum at: www.auseinet.com/toolkit/rec_discuss.php
Reprinted with permission.

It’s long been argued, mostly by insensitive bean counters twice removed from the problem, that throwing money at the mental health system will not solve the apparently insurmountable problems associated with this system. And you should excuse the depths of my ignorance of all things fiscal, but I reckon throwing money at the problem would be a really, really good place to start.

But this essay is not a call for greater government funding. I won’t waste the ink in my cartridge. Nor am I intending to further muddy already murky waters by quoting facts and figures so complicated as to be meaningless.

What I’m trying to do here is to make a cry in the wilderness perhaps, for more compassion for mental health service consumers and their carers.

There is a whole self-contained group out there who care passionately for those working through ‘psych’ disabilities and who are quite willing to toil at the psychiatric coal face without sufficient remuneration or recognition for the oftentimes difficult tasks they perform.

These are the people who, against all the odds, are actually making a difference. These are the same people who have provided something practical to hang our collective mental hats on. They are incredibly compassionate providers of the necessary nuts and bolts of all things mental and are understandably opposed to the unsustainable imbalance that people with psych disabilities face by undergoing episodes of being actively unwell or enjoying a welcome period of wellness.

It’s well that love freely given is its own reward because these people receive little else by way of recognition. And unlike money or other infrastructure you simply can’t legislate for the provision of a necessary compassion within a community that’s determined to hide its head in the sand and remain deliberately unaware of the special needs of those with psych disabilities.

Our so called ‘compassionate community’, an excellent example of an oxymoron, excluding the professionals who already perform miracles within their restrictive sphere of influence, needs to translate well intentioned but generally impotent words into action. It is one thing to say ‘stop’ but it’s another thing to do it. And it’s obvious that those of us with psych disabilities are not only the forgotten people of our community but we’re in very real danger of becoming invisible as well.

Happily the community already possesses the means to bring about these changes for the sometimes fatally under-privileged people with psych disabilities. But this empowerment is unnecessarily fragmented, and needlessly filtered through so many of our already

in-place agencies that it desperately needs to be brought together into a cohesive totality before any potentially productive change can be effective.

As I said, what we need is to engineer or manufacture a more caring and compassionate attitude from the people living happily without a psych disability. But the only way this welcome situation will come about is by positive, interactive and determined community involvement at the grass roots level of psych disabilities.

Our society, which contains our community, brings with it personal rights. But with these rights also comes obligations and responsibilities and one of these obligations and responsibilities is a duty of care for those disadvantaged people with psych disabilities.

Given the current unfortunate circumstances I oftentimes ponder on what the utopian world would be like. Would it be a place where those of us with a psych disability were happily accepted into and embraced by our community? A happy place where we could go about our day to day activities and not be deliberately stereotyped as sub-human by our print media! Or would we continue to be dispassionately excluded to the point of a practical and deliberate invisibility?

(The Auseinet discussion forum aims to promote the sharing of ideas and information around the issues of recovery for people with a mental illness. This is a moderated forum and open to all users who wish to register. More information available at: www.auseinet.com/toolkit/rec_discuss.php)
The vision of Australian Red Cross is to improve the lives of vulnerable people by mobilising the power of humanity.

Vulnerable people include those of us in the community living with a mental illness. Red Cross is helping to bridge the gaps with community services that aim to improve social access, health and wellbeing.

The Red Cross Save-a-Mate (SAM) program aims to reduce harm and fatalities associated with alcohol and other drug use in young people, through first aid and peer education. Executive Director at Red Cross in South Australia, Kerry Symons says thanks to a partnership between Red Cross and beyond blue, the SAM peer education program recognises the link between mental health and substance use.

The SAM program aims to reduce the stigma associated with mental illness among young people, raise awareness of how to support peers at risk and how to seek help. (Kerry Symons)

Sometimes as a result of a mental illness or other life impacts, people can become socially isolated and disconnected from their community, family and friends. Telecross can help - a daily phone call service made by a Red Cross volunteer to check if a person is ok. A Telecross call provides friendly human contact every day of the year, which reduces feelings of isolation, assists with wellbeing and boosts self confidence.

The Inner City Support Program was launched last year by Red Cross with assistance from Adelaide City Council (ACC) in partnership with the Multi Agency Community Housing Association (MACHA). A team of six volunteers assist 22 people at risk of homelessness to remain independent at home. Volunteer assistance includes providing practical support to participants through improved access to other support agencies and the general community.

It can be as simple as going out for a coffee or to the movies. Many of the people we support have said that this can be a huge step and they appreciate assistance in getting to this point. (Kerry Symons)

Red Cross Good Start Breakfast Clubs ensure children get a ‘good start’ at school by providing a healthy breakfast. At the same time children, their families and the community learn about good nutrition and important life skills. Volunteers, families and children who might not otherwise be very connected to their community can build self confidence, life skills, self esteem and general wellbeing. Clubs provide positive role models through volunteer participation and ‘student leader’ roles. Many new friends are made at Good Start Breakfast Clubs.

If you would like further information on these and other programs across all states and territories go to the Australian Red Cross website for information and contact details – www.redcross.org.au
Community-mindedness enriches the mind

By Helen Borger
Journalist/project officer, The Mental Health Services (TheMHS) conference

When individuals and communities have a sense of belonging, a desire to learn from the past and to look to the future, respect, trust and shared responsibility are just some of the factors underpinning their efforts to create and sustain meaningful relationships at home, work and play.

However this sense of shared power can disintegrate if the fear, stigma and lack of understanding surrounding mental illness are allowed to impact relationships. Although much has been done to debunk mental health myths and stereotypes, more effort is needed as many people living with mental illness continue to feel isolated and excluded.

Responding to the challenge, the August/September 2006 TheMHS conference and pre-conference forums and workshops held in Townsville, provided opportunities for professionals, consumers, carers and families to present and share mental health ideas, experiences and research. Highlighting the need to address a range of priorities, some of the conference contributions are discussed below. With a focus on innovative interventions, training and the mental health workforce capacity, TheMHS will continue to educate for change at its Summer Forum in February 2007.

Respecting Indigenous needs
Concerned about the lack of culturally-appropriate approaches to healing, delegates at the TheMHS pre-conference Indigenous forum passed a resolution. At the conference opening ceremony, Bindal traditional owner Angelina Akee presented the resolution on behalf of Indigenous participants to national and international delegates and guests, including the federal Health Minister Tony Abbott.

The resolution called for the establishment of Indigenous run healing centres which provide traditional healing, counseling and other interventions. It recognised the intergenerational and long-lasting effects of trauma in the Indigenous community and the responsibility of all Australians to respond. It called on federal and state governments and health authorities to take urgent action.

Reinforcing the message at the closing ceremony, Akee told delegates: ‘Non-Indigenous Australians will never feel the pain of the broken spirit; they will never feel our sorrow and grief or know our continuing struggle. However, Australia and Australians now have the opportunity to redefine the place of Indigenous people within society through anti-racist and culturally appropriate and affirming practices’.

Reconnecting on another level
Focusing on schizophrenia and bipolar disease processes and medication non-compliance, Xavier Amador (adjunct professor in Clinical Psychology at Teacher’s College, Columbia University, New York City) highlighted the need for more appropriate consumer engagement to encourage medication compliance.

As part of the solution, Amador pointed to the ‘Motivational Interviewing Technique’ (MET) where the medical model, ‘doctor knows best’ approach is replaced with consumer engagement. MET involves active listening, reflecting back an accurate understanding of what the person is saying (within the framework of the person’s ‘reality’ - not necessarily the practitioner’s), empathising, looking for common ground, and developing a partnership. The aim is to work on agreed goals. ‘It’s about developing a relationship with the person’.

Valuing the lived experience
Consumer participation was spotlighted during a conference debate - delivered with humorous overtones, but underscored by serious sentiment. Advocating ‘that mental health clinicians should get out of the recovery business and give consumers a chance to get on with it’, the affirmative team argued that consumer-led recovery was best since consumers could draw on their lived experience.

On the negative side the team argued for professional involvement, otherwise ‘recovery would fail’. One negative speaker said recovery should not be the consumer’s responsibility entirely. However he noted that mental health professionals should renegotiate with consumers and reconcile their own recovery issues. He added that it wouldn’t be easy for professionals as the ‘old expert roles’ were so familiar - but these old roles should be discarded.

Responding to diverse stakeholder needs
Highlighting the diverse interventions required to meet lifecycle and stakeholder needs, this year’s TheMHS mental health achievement award winners excelled in a range of service provision. Ngoc-Anh Nguyen of the Western Region Health Centre Ltd Victoria won the Exceptional Contribution to Mental Health Services in Australia and New Zealand Award for service provision to the Vietnamese community.

Other winners won awards for consumer-run training and publishing programs; carer-assist programs; specialist peer support programs for children and young people who have parents experiencing mental illness; services for children who have difficulty expressing strong emotions; projects aimed at better equipping families, carers and service providers to respond to the needs of children of parents with dual diagnosis; and regional services to Indigenous communities.
Also spotlighting the need for diverse interventions was the aftermath of Cyclone Larry. Phil Smith, one of the local mental health workers told the conference that while services to existing mental health clients needed to be maintained and each client was reviewed by a psychiatrist, overnight, the service transformed from a clinical to a welfare perspective. The Cairns Integrated Mental Health Services (MHS) Executive Director, Kevin Freele, pointed out that the MHS disaster response isn’t about rushing in and providing immediate individual counselling to entire communities. It’s about interfacing with other agencies to coordinate the most appropriate response. Mental health nurse, Brendan Porter, who went to Innisfail to support other mental health workers described how many local children needed support and encouragement. Rotary helped out in this case by funding mentoring sessions.

Building workforce capacity and recognising limitations
To carry out their roles effectively, mental health professionals need appropriate knowledge and skills. The Indigenous experience exemplifies the importance of appropriately trained professionals. The Charles Sturt University Djirruwang Bachelor of Health Science (Mental Health) Djirruwang program is a clinically based mental health course designed for Aboriginal and Torres Strait Islander people.

While training is essential, maintaining practitioner mental health is also vital. GPs, psychologists, nurses, social workers, and other caring professionals are at risk of ‘compassion fatigue’ - a general term applied to anyone who suffers as a result of serving in a helping capacity. ‘After sitting and listening to tales of abuse, trauma, physical pain and imminent death, we become overwhelmed by what we see or hear. This activates our survival mechanism which is automatic and unconscious and in this vicarious way we develop symptoms of trauma; it’s like our survival is affected in a vicarious type of way. If compassion fatigue isn’t identified it can cause reduced self esteem, increased cynicism, and numbing to life events’. (Psychologist, Lidia Genovese).

Recognising and responding to diverse mental health needs and working towards inclusion requires more than a one-size-fits-all approach.

For more information on the TheMHS conference and the upcoming February 2007 Summer Forum focusing on innovative interventions, training and the mental health workforce - go to www.themhs.org

Community - mindedness enriches the mind
Growing Well
Ways of noticing our emotional and mental wellbeing

The Growing Well kit is for mental health professionals, clients, students and anyone interested in monitoring their own mental wellbeing. It is made up of 50 cards (with a booklet) and 5 scaling pads. This practical and highly innovative resource is built around 50 key statements that research has shown are important indicators of mental health and balance. Accompanying each statement is a 'scale' using simple illustrations of a seed growing into a tree. A user checks the box that is relevant to them – every day or every week, perhaps. In this way the scale can be used to notice change and describe growth, even when words seem inadequate.

The creative spark for Growing Well came from the mental health team at St Luke's Anglicare who developed the tool together with staff from the Department of Social Work at La Trobe University, Bendigo, Victoria. Pivotal to the development were consultations with people using mental health services. The result is a tool that:

- Can map our pathways through depression, trauma, loss, bereavement, eating disorders; or through everyday health challenges such as stress, self doubt and low self esteem.
- Encourages a focus on strengths rather than deficits.
- Assists people to build emotional balance, mental clarity and reflective conversations.

The Growing Well kit is available (at a cost of up to $75.00 depending on the purchase) from:
St Luke's Innovative Resources
Tel: 03 5442 0500   Email: info@innovativeresources.org   Web: www.innovativeresources.org

No One Is an Island – You Are NOT Alone:
A Pacific youth suicide prevention resource

'No One Is An Island – You Are NOT Alone' has been a project to promote depression awareness and access to mental health care services among young people from Pacific communities in the Mt Druitt and surrounding areas, NSW.

A key activity of the project has been the development and distribution of a depression awareness poster and pamphlet information resources available in English and three Pacific community languages - Fijian, Samoan and Tongan.

These pamphlet resources are now available to download on the Sydney West Area Health Service website at: www.swahs.health.nsw.gov.au/services/publicaffairs/publications.htm
Kindling the Flame: Promoting Mental Health and Wellbeing

February 21st-23rd, 2007
The Hyatt Hotel, Perth, Western Australia

This international conference is an initiative of The Clifford Beers Foundation, UK in association with Mental Health Promotion Action Link, Western Australia.

Who should attend?
The conference provides an opportunity for leaders, experts and practitioners from a range of disciplines to discuss effective promotion and prevention strategies and influence policy makers and administrators.

Conference aims
• To profile innovative initiatives within mental health promotion
• To provide successful partnerships and practices within mental health promotion
• To enable the establishment of links between those engaged in promoting mental health and wellbeing across different sectors
• To challenge and extend current perceptions of mental health promotion.

Keynote speakers
• Margaret Barry
  National University of Ireland, Galway
• Richard Eckersley
  Australian National University, Canberra
• David McQueen
  Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia
• Juan Mezzich
  President of the World Psychiatric Association/Mount Sinai School of Medicine, New York University
• Rob Moodie
  Victorian Health Promotion Foundation (VicHealth)
• Beverley Raphael
  University of Western Sydney
• Martin Shain
  Founder and Director of the Neighbours at Work Centre

For more information contact:
Clifford Beers Foundation

Email: michael_murray@charity.demon.co.uk
Website: www.cliffordbeersfoundation.co.uk/perth.htm
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