

Advocacy &

Community Support

Project 23012: Close Personal Advocacy in Involuntary Treatment for Mental Illness

Aims: This project was undertaken by the ACT Department of Health and Community Care (\$113,165). The aim of the study was to test the hypothesis that close personal advocacy would lessen antagonism between clinicians and patients. This improves patient's satisfaction with treatment and consequent cooperation with after-care, and reduces the rate of early rehospitalisation.

Description: One hundred patients admitted involuntarily to The Canberra Hospital were divided into statutory (control group) or close personal advocacy (experimental group).

The control group received the statutory advocacy provided to all involuntary patients admitted to hospital. Statutory advocacy ensures that patient's legal and civil rights are protected from the time of admission as an involuntary patient to the Tribunal hearing. Advocacy does not continue actively after the confirmation of involuntary treatment.

The experimental group received close personal advocacy and also statutory advocacy throughout the period of involuntary treatment. In addition to the legal protection provided by statutory advocacy, the close personal advocate identified the patient's needs by facilitating discussion with medical clinicians, negotiating consent and ensuring that treatment decisions took into account the patient's circumstances.

All experimental and control patients rated their satisfaction with care after the first three days of involuntary care and again four weeks after discharge. Staff and participating patients reported the impact of advocacy and compliance with after-care, which was confirmed from clinical records. Rehospitalisation data were also obtained from clinical records.

Outcomes: The results of the study demonstrated that the patients in the experimental group responded more favourably to their period of involuntary hospitalisation than the patients in the control group, especially in the areas of after-care and outcome. Follow-up attendance improved significantly. The proportional hazard of involuntary rehospitalisation for the experimental advocacy group was less than half the risk of the control group.

During the period of involuntary hospitalisation, the close personal advocate's primary allegiance remained with the patient. The advocate became a companion of the patient and liaised with the clinical staff throughout the patient's experience of illness and loss of autonomy.

Nursing and medical staff also reported that the project had a positive influence on patients and staff involved in the experimental group.

Hospital staff reported that there was reduced antagonism with this group compared to the control group and therefore staff experienced an increase in work satisfaction.

In the control group, the Office of the Community Advocate was informed when the patient was admitted to the hospital. An officer from that Office visited the patient, ensured the patient was aware of his/her legal rights and attended the Tribunal hearing to represent the patient's legal interests. Once the order was made the Officer was not usually involved further. The clinician became responsible for treatment and decision making on behalf of the patient. This was often seen as coercion by the patient and led to antagonism between the patients and clinician.

The author commented that the following features of close personal advocacy are vital to its success:

- the advocate was a specialist clearly working to the best interest of the patient and adhered to the consultation and the representation principles;
- the advocate stayed with and represented the patient throughout the period of involuntary treatment;
- the advocate attempted to enter into discussion with patient and clinical staff in the manner in which consent is decided with competent and voluntary patients; and
- the advocate was answerable to and supported by a structure independent of state or agencies which have conflicting interests of community protection.

This structure implies that the close personal advocate should be a trained paid specialist whose role is backed and accountable to an independent agency which does not have interests which might interfere with a fiduciary relationship or conflict with the patient's best interests such as family or community safety.

The final report recommended that:

- close personal advocacy should be added to the statutory or legal advocacy that is presently available;
- close personal advocacy should adhere to the principles of independence and best interests; and

- close personal advocacy should be provided by a paid specialist supervised and accountable to an independent body with fiduciary responsibility to the patient.

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Project I 5003: Mental Health Advocate/Community Development Trainer Project

Aims: This project was undertaken by Advocacy Tasmania Incorporated (\$137,673). The aim of the project was to identify gaps in existing mental health services in Tasmania and to identify strategies to provide individual advocacy services, particularly for people living in rural and remote communities and older consumers effected by the downsizing and integration of local facilities. The project also aimed to develop training packages on consumer rights and responsibilities for consumers, carers and health professionals.

Description: Advocacy Tasmania Inc. (previously known as the Tasmanian Advocacy Information Service) is an independent advocacy service which supports and empowers people with disabilities and older people to obtain information and to access services appropriate to clients needs. The target group for the project was people with mental health issues, and their carers and relatives.

A range of activities were undertaken to address the aims of the project. These included consultation with consumers, carers and special interest groups (consumers with dual disability, people from a non-English speaking background, and women), advertisement of the project across the State, preparation of training packages and other materials which were circulated for comment, and the development of recommendations for further work in consultation with relevant stakeholders. The project also aimed to establish a network of mental health service providers and advocacy workers in other jurisdictions, and to strengthen the links between State-based agencies. A number of reference groups were established to assist with the project activities.

Soon after the commencement of the project, individual independent advocacy services were provided to consumers and carers, both in the

community and the hospital setting. This focus, while time-consuming, served to address a range of important issues for consumers about their rights within the health system, including issues related to abuse, freedom of information, accommodation, child custody and wardship, and access to services.

The consultation phase assisted in identifying a broad range of issues, including gaps in service provision and issues related to the structure of services.

Outcomes:

The final report of the project presents a detailed overview of the consultation process and outlines the role the consultation process had in educating and informing the participants on a wide range of issues. Group forums were identified as the most beneficial method of generating discussion, particularly among consumers and carers.

A number of issues impacted on the implementation of the project activities across Tasmania including issues related to the restriction of time for some activities and the extensive travel (and related cost) which was required to undertake regional trips. In addition, a significant amount of work was conducted via the telephone which, while necessary, was not the ideal means of undertaking some activities. As such, the project did not achieve as broad a state-wide focus as was desired.

However, a number of other important outcomes were achieved from the project. Importantly, the project increased understanding of “independent advocacy” in the mental health sector and raised its profile as a valid avenue for consumers and carers of mental health services.

The project also assisted in identifying a range of “gaps” in the provision of mental health services in Tasmania, ranging from the need for adequate and understandable information on consumer rights and responsibilities and grievance procedures, to options for consumer advocacy and participation in service provision activities.

The final report of the project includes 44 recommendations which relate to the range of structural reform issues identified during the project. The final report presents a rationale for the provision of independent advocacy to people with a mental health issue in Tasmania and to ensuring that advocacy services have a more visible role in the community. The report also notes the need for specific work in the area of dual disability and for people from non-English speaking backgrounds and people living in rural communities.

The final report overviews the development of a mental health advocacy network and other activities which could be undertaken to strengthen the network. The report notes the important role that the network had in addressing the isolation inherent in advocacy work (and

inherent in Tasmania) and in documenting the gaps in the provision of advocacy in mental health.

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Project 24032: Assertive Outreach to Forensic Psychiatric Clients and their Families

Aims: This project was undertaken by the Epistle Post Release Service (\$114,528), and aimed to provide assertive community support for mentally ill offenders released from prison and hospitals, with a particular focus on assisting the offender to regain contact and develop quality supportive relationships with family and other members of the community. The overall aim of the project was to develop a model for providing this type of service.

Description: The project provided community outreach support for mentally ill people with a forensic history, with a specific focus on providing support for their families.

The project provided services to both the person with a mental illness and their family on an outreach basis, and included components such as education and information, emotional support, practical assistance, and access to 24 hour on-call support. A major part of the project was also to research and document the needs and risk factors for both mentally ill offenders and their families, and to evaluate the effectiveness of the project in meeting these needs.

In developing a model for providing family centred support services to mentally ill offenders and their families, two approaches were tried. In the first approach, the project support worker provided support to both the client and their family. In the second approach the project support worker provided services to the family, while another outreach worker supported the client, which was a useful approach to employ if there was considerable conflict in the relationship between the client and family. Both approaches were found to be effective depending on the particular circumstances of the client and family.

Outcomes: Feedback from clients, families and staff of relevant agencies indicated that most support needs had been met, and that there was generally high satisfaction with the services provided. For some participants, clear changes in their situation could be attributed to the support the project had provided. The feedback also highlighted a range of improvements which could be made to the project, such as developing culturally sensitive strategies and researching the specific needs of female mentally ill offenders.

Overall, the evaluation of the project indicated that all the objectives of the project had been substantially fulfilled, except the objective relating to improvements in general functioning and reduction in relapse and recidivism. While modest improvements in general functioning were found, and there was no relapse or recidivism due to offending or deterioration of the mental state amongst clients supported by the project, significant limitations in sample numbers and time-frame meant little could be concluded from this.

The project fulfilled the goals of the National Mental Health Project funding in that it developed a model for working with a particularly high need and disadvantaged client group, it was community based, and also had a particular focus on the needs of families and carers. It demonstrated the need for this type of service, and provided a basis for further service developments and research in this area.

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Project 21006: Parish Groups Caring for the Mentally Ill

Aims: This project was undertaken by the Corporation of the Synod of the Diocese of Brisbane Anglicare (\$177,938). The aim of the project was to investigate the feasibility of Anglican parishes becoming involved in supporting people with mental health problems in the community by:

- gaining an understanding of the factors that isolate people with a mental illness within the community; and

- developing models that would assist in the total integration of these people in the community.

The project also aimed to develop a greater awareness of mental health issues in parish communities in south east Queensland and to establish models for parishioners to assist people with mental illness in the community.

Description:

The objectives of the project were:

- to investigate the feasibility of Anglican parishes becoming involved in supporting people who live with emotional and mental trauma in the community;
- to gain an understanding of the factors which may encourage or inhibit this development;
- to select and work with a number of parishes and investigate their willingness to become involved in the project;
- to develop models to assist parishioners wanting to include others in their lives and the community;
- to develop strategies that could support ongoing development of this work;
- to develop and support links between people leaving hospital and people in parishes;
- to work towards positive outcomes for people living with mental and emotional trauma presently situated in parishes; and
- to understand what a “sense of belonging” means to people who live with mental and emotional trauma.

The project report describes details about the project team which consisted of a leader, three project workers and two consultants. The original approach of the project was centred around getting to know a small number of patients in a psychiatric hospital and introducing them to people in the community, associated with the Anglican parish. It was hoped that once the destination of the patient on discharge from the hospital was identified, a suitable person could be found to support them through convalescence and help them find connections within the community without any expectation of the patient becoming involved in the church.

The project embraced a research component and a community development component, both of which are described in the project report. The development of the project relied on consultation with key people in similar fields of work and a review of appropriate literature. The project team worked in consultation with parishes, parishioners, mental health professionals, patients and staff at Wolston Park Hospital, Brisbane. Questionnaires were distributed to parishes and clergy in the Brisbane Diocese of the Anglican Church to estimate already established

involvement in the mental health area. Newsletters, media releases and regular workshops made people aware of the project and kept people informed and in contact with others. By sharing experiences and learning from each other, a 'movement' of people aspiring to assist in the project developed.

Outcomes:

It was learned during the project that in order for people who live with mental and emotional trauma to find a place to belong, communities need to be built which are 'more welcoming'. It was recommended that this theme be carried into institutions, parishes, our homes and our hearts.

Detailed recommendations were made as a result of the project. Recommendations were made for the church and for government. Some of the recommendations included:

- listening to people who have experienced mental illness and marginalisation in the community;
- linking, supporting and sharing lessons learned from this project with those working in other churches and with other church groups, mental health and disability workers and other appropriate health sectors;
- sharing practical, concrete ideas for welcoming and including people with mental illness in a parish community and to explore the establishment of small groups to support this development;
- basing funding decisions for projects undertaking community inclusion work similar to this project, on compassion and justice as well as on the basis of economics; and
- ensuring innovative grants are made available for the development of accommodation and treatment options to augment current hospital based clinical settings.

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