

Enhancing Community Participation for Consumers of a Mental Health Service Through Partnerships

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Abstract

Whilst providing specialist clinical services and promoting recovery-focussed care for people with mental illness, the MIST (Mobile Intensive Support Team) team aims to develop partnerships that work with marginalised people with the aim of strengthening their community tenure and increasing their access to community based activities. In this paper we discuss the impact of the current discourse of social exclusion, social capital and partnerships on this marginalised population. We look at the consumer-driven Recovery framework that orientates our service delivery system and finally we look at three collaboration projects that the MIST team has been a part of and discuss how they fit within the mental health and social exclusion agenda. We conclude that the role of government funded mental health services must remain broader than core clinical business if we are to work with consumers to enhance their community participation and combat their highly marginalised position in the community.

Keywords

Mental health, recovery-focussed, partnerships, social exclusion, community

Introduction

This paper looks at the role of a recovery-focussed Mental Health Service in developing partnerships with the aim of enhancing community participation for consumers. Its objective is to explore the frameworks surrounding this service direction and the practical components that illustrate the aim. This paper is practice-orientated, and will look at examples of recovery-focussed partnerships that have been developed by a public mental health service and not-for-profit sector organisations. With the debate on the public sector role in the provision of services continuing to dominate the governance and social policy narratives in Australia and the increasing emphasis on the 'third way' discourse of spatial disadvantage, social capital and social inclusion, we believe that practice driven modes of service provision need to be explored.

The psychiatric consumer community has been at the forefront in the devolution of care from deinstitutionalisation, through to integration and community care. They are traditionally a substantially disadvantaged population, both in economic terms and in social and support networks. As a result it is important to ensure that the provision of services to this population

is designed and resourced to enable mental health consumers' access to services that enhance their quality of life. The contemporary debate around social capital and social inclusion focuses on the capacity of communities positioned as an alternate to public provision (Adams and Hess 2001). The impact of this on psychiatric consumers, that are increasingly marginalised and isolated within the community, has seen our local public mental health service look for ways to build community links that directly reflect consumer concerns.

Mental health and exclusion

The link between mental health and social exclusion has been the focus of considerable research in the past few years. In the UK, the Mental Health and Social Exclusion Report (Social Exclusion Unit 2004) identified that adults with mental health issues have the lowest employment rate of all disability groups, that social isolation increases their risk of suicide and that the impact on families can be a major stressor. The report identified five main causes of social exclusion in persons with mental health issues — stigma and discrimination, low expectations, lack of clear responsibility for promoting social and vocational outcomes, lack of ongoing support and barriers to engaging in the community especially access (Social Exclusion Unit 2004).

These points are reinforced by Australian research that identifies that the disadvantages experienced by people with mental health issues are 'multiple and extreme' (Cameron and Flanagan 2004, p. 1). These issues are seen as "factors of social disadvantage, such as living in poverty, family breakdown, social isolation, poor general health and oral health status, a high risk of homelessness or inappropriate and insecure accommodation and unemployment" (Cameron and Flanagan 2004, p. 10). Adding to this is the reality that the serious nature of their illness may inhibit social skills that further increases social marginalisation.

The Victorian Mental Health Promotion Plan (VicHealth 1999) accepts that factors including social and community connectedness, stable and supportive environments, social and physical activities, access to social and supportive relationships and physical security are essential if people are to maintain their community tenure. The need for a broad range of social support that challenges these disadvantage factors is understood at the practitioner level but continues to be difficult to achieve in the current funding environment (Cameron and Flanagan 2004).

Social capital and the seductive community

The re-emergence of the 'community' in the discourse of public policy has occurred as the limitations of managerialism and economic rationalism have become apparent (Adams and Hess 2001). Critics of the managerialist impact point to theoretical inadequacies (Considine and Painter 1997a), an oversimplification of solutions and lacking in evidence and evaluation, and an over-reliance on defining public sector activities as products (Considine 1997c).

Economic rationalists used the financial uncertainties of the globalised marketplace to justify limiting public programs, reducing fiscal outlay and narrowing output measures, that is shrinking the state to core business only (Considine 1997c). The problem with this is that as economic and social pressures increased and poverty and social exclusion grew, the need for a public policy response increased.

The government search for solutions to this dilemma has focussed on the role of the community as the field to manage market and state failure. Earlier use of the 'community' in Australia occurred in the 1970s with the Whitlam Government looking to further the aims of a social justice discourse by funding community organisations/development that harnessed the issues of interest groups. The use of community in the current context has moved significantly away from that predominantly social justice inspired position, to one that emphasises social order and cohesion (Cox and Caldwell 2000; Everingham 2001).

Social capital

The convergence of the neo-liberal discourse of social order and communitarianism has produced an unlikely alliance under the banner of 'social capital'. This concept, adapted originally from the works of de Tocqville (1988), Coleman (1988) and Putnam (1993), has been the catalyst for a concerted policy agenda in both the UK and Australia. Attractive in this notion of social capital is the use of economic discourse. Bourdieu (1986, p. 243) includes it in his forms of capital, and the language utilises accumulation of social capital as important in economic prosperity (Putnam 1993). There is also the underling implication in the use of 'capital' of the importance of the individual/community as a producer (Leeder and Dominello 1999). This resonates with the moral discourse of obligation and activity in the contemporary welfare debate.

It is, however, of little relevance to the mental health service user community. Economic disadvantage, disempowerment, social isolation and the continuing stigma and discrimination mean that this community is generally unable to engage in local community activities without considerable support from friends, peers, support agencies and mental health services. The expectation that this support can be provided by the responsive community that has an existing capacity and a willingness to engage remains a romantic notion with little practical evidence (Marston et al. 2000). Services continue to struggle with limited funding to direct considered responses aimed at developing individual connections and combating the stigma. However, as identified by McDonald and Zetlin (2004) many factors operate to disrupt the functioning of the community service delivery systems. In public mental health systems the tension between providing holistic (or recovery-focussed) care and providing core-clinical business only is an ongoing conflict with financial imperatives at its core. To develop an engaged community willing to incorporate this population then practice-based examples of an 'active state' (Reddel 2004) must be encouraged.

The seductive community

The role of the community in the language of welfare provision has played an important role in justifying the governments' withdrawal from direct service provision. Everingham (2001) traces the use of community as a term of government in Australia to the Whitlam era, where the replacement of 'state' with 'community' allowed Whitlam to direct people's perceptions of government resources as community resources. This usage harnessed the affective value of community to promote that government's agenda of public investment and provision (Darcy 1999). This view no longer holds in the Australian neo-liberal environment. Community is seen as distinct from government and, in conservative thought disproportionate, thus the replacement of government provision with community solutions in the new language of welfare.

The community has become crucial in the political debate that has repositioned welfare from a rights based discourse to a language of obligation (Everingham 2001; Adams and Hess 2001). This discourse has become one of the prime modes of legitimacy for the community provision of services. The concept of the community has been idealised and combined with a belief that they offer a cheaper alternative, have attracted considerable support from both the third way movements and proponents of small government (Adams and Hess 2001).

In this discourse the community is seen as represented by the not-for-profit or 'community' sector, organisations that are drawn from the communities identified need and formed as a community response to this need. They are positioned as naturally imbued with the positive attributes of 'good' communities such as capacity, willingness to respond, goodwill and reciprocity (McDonald and Marsten 2002; Everingham 2001; Rose 2000). Tempering arguments that question the unadulterated 'good' are marginalised throughout this debate. Negative examples of community such as the morally self-righteous view described by Sennett (1998), the 'Brazilianisation' of the wealthy with their gated communities, and the use of 'community' to exclude, as in the current refugee debate, are conspicuously ignored. This exclusive nature of the lived experience of community has significant implications for the disadvantaged groups in society (Everingham 2001). Community appears bound with rising affluence and expectation that lies close to the individual self-interest of liberalism. Those outside this socioeconomic advancement remain increasingly marginalised and unable to access the forms of community support such as trust, mutuality, cooperation, belonging and reciprocity, which the repositioned neo-liberal welfare state is relying on (Rose 2000).

Stigma and discrimination

Consumers experiences with stigma and discrimination have reinforced the view that social exclusion, poverty and isolation are common themes (Kai and Crosland 2002). Yanos et al. (2001, p. 418) indicate that "given their highly stigmatized status, persons diagnosed with

mental illness may be particularly sensitive to whether a given social interaction is reassuring or stigmatizing". It also indicates that public education interventions that target the ongoing educational needs in the community may be beneficial.

Huxley and Thornicroft (2003) argue that people with a mental illness have hopes for community participation similar to the general population and by encouraging the mental health service delivery systems to target the policy and practice based areas of social inclusion this may lead to a reduction of the impact of the stigma of illness (Evans and Huxley 2000; Thornicroft et al. 2002).

Tew (2002) argues that it is a legitimate role for social work to challenge the stigma in the wider social context as part of the supporting role played by services in facilitating Recovery. She also reminds us that the Disability movement has long argued that it is the stigma and discrimination demonstrated by society that is one of the most debilitating factors and argues that with mental illness this may be even more amplified.

Recovery

The concept of Recovery has been adopted as one of the guiding principles for mental health service delivery in Australia (Australian Health Ministers 2003). It has been used to describe a journey, a deeply personal and unique process by mental health consumers about their own or a colleague's personal accounts. Recovery acknowledges that having a mental illness is not a process of life long deterioration, and recovery has provided a source of hope and inspiration for people with mental illness, their families and carers and service providers. Mead and Copeland (2000) emphasise that the key facets of recovery are hope, the individual's personal responsibility for his/her own wellness, education, consumer self-advocacy, and peer support.

Ralph (2000) outlines four major dimensions of the recovery process. These include internal factors (awareness of the toll of the illness, recognition of the need to change, insight into how change can begin, determination to recover), self-managed care (an extension of internal factors used to describe how people manage their own mental health and how they cope with difficulties and barriers), external factors (interconnectedness with others, supports by family, friends and professionals), and empowerment (internal strength is combined with interconnectedness to provide self help, advocacy, and caring about ourselves and others).

Common themes developed from consumers' personal experiences have also assisted in explaining the meaning and significance of recovery. According to these accounts, Recovery is the reawakening of hope after despair, breaking through denial and achieving understanding and acceptance of their mental illness. It is a process of moving from withdrawal to active participation and active coping rather than passive adjustment. Despite

being a complex personal journey of reclaiming a positive sense of self, it is not accomplished alone and requires support and partnership (Ralph). Aims of the Recovery movement include decreasing stigma and discrimination, gaining recognition of the importance of self-help and social justice, understanding the impact of poverty and promoting multiple choices for the individual recovery (Torrey et al. 2005)

Recovery-focussed service delivery

More recently, recovery has gained interest from both government and non-government mental health service providers and organisations as an alternate service planning and delivery framework to traditional models of care. As Lehman (2000, p. 329) describes, “the unfortunate truth is that for too long our mental health care systems.....have taken a parental view of patients, treating them as rather passive recipients of treatment and, expecting compliance more than collaboration”.

Anthony (2000) states that a recovery-oriented service system is grounded in the belief that people have the ability to recover from mental illness, and that the system of service delivery must be based on this knowledge. He also emphasises that a mental health system guided by a recovery vision must develop and utilise policies and procedures in order to ensure that recovery occurs for both the system and the individuals it serves. Davidson (2004) discussed the importance of this by illustrating ways Recovery can become corrupted or assimilated within systems that favour hollow discourse in place of substantive practice. He is also very clear that services must differentiate between the individual and consumer owned concept of Recovery and the Recovery-focussed service delivery that incorporates practitioners efforts to support an individuals Recovery path. In an attempt to highlight the essential service system competencies which set the standard for attitudes, knowledge and skills required for a recovery-oriented service, Curtis (1993) included demonstrated respect for people with a mental illness and their families, knowledge of mental illness and support, intervention and treatment strategies, delivery of individualised services and supports, and ability to access and work collaboratively with community resources.

Anthony (2004) emphasised the importance of leadership to motivate service providers in the mental health system to action around a shared organisational vision of recovery. He draws particular attention to state-wide leadership as fundamental because “the vision of recovery is foreign to what has been masquerading as the mental health vision for the last century”. Rather than focussing on the outcome for the consumer, prior visions have been focussed on service locations and size, for example, deinstitutionalisation and continuity of care. Leadership within public mental health organisations is also essential in developing a dynamic and evolving Recovery vision at a time when the funding pressure is creating a demand to limit service to core clinical business. At a local level the development of a management team that incorporates a complex adaptive system that supports innovation as opposed to

controlling the practice environment has been an essential element in the MIST Team structure (Allred et al. 2005). This has also allowed us to develop a relationship with the not-for-profit sector that are based on collaborative working models and not the ubiquitous 'partnership agreements'.

Partnerships

The identification of partnerships in service reform and delivery as a key direction for mental health services in Australia is a reflection of the wider governance framework in public service delivery. With the trends towards the privatisation of welfare service delivery and the increasing importance of the private and not for profit sectors in the equation of governance the language of collaboration and partnership has been used to characterise these relationships. At the same time there is a degree of difficulty in defining the partnership relationship. The terms partnership, collaboration and joined-up services have been co-opted into the discourse of politicians that seek to address the issues associated with the failure of both the state and the market in public service delivery (Armstrong 2001; Glendinning and Powell 2002; Teisman and Klijn 2002). This appropriation has meant that political expediency often determines the level on which partnerships operate, and a short-term focus on outcomes to justify the political decision. While the emphasis is on an increasing cycle of privatisation and contracting out, there has been little evidence of benefits to consumers in the contested welfare areas of health and support services (Bartlett et al. 1998).

Collaboration is viewed within the general health sector as a strategic way of providing multiple services within the strict parameters of individual service budget constraint (Provan 1997; van Eyk and Baum 2002). In mental health it is acknowledged that people with chronic mental illness need a range of services and supports to maintain community tenure (Biegel et al. 1994; Froland et al. 2000). Part of the process of acknowledging these multiple needs has been the perception of the negative impact of deinstitutionalisation on people with a chronic mental illness (Biegel et al. 1994; Grob 1995). Concerns included increased stress on families, high readmission rates, lack of coordination between services, lack of resources in the community, and the difficulty in developing a social support network in the community (Biegel et al. 1994; Rosenheck 2000).

There is very limited research that looks at the impact of the changing nature of service provision on consumer determined outcomes and how the necessity for service collaboration has altered views of service responsibility. While there is a National Information Strategy under the Second Mental Health Plan (Australian Health Ministers 1998) that proposes to incorporate consumer outcomes in its measures, there is debate as to the limitations of this. With the reality of people's lives extending outside of the hospital or clinic, and their experience of life breaching the barriers of symptoms and disability, it is proposed that the formal information generating strategies have targeted a narrow definition of consumer

outcome. There is also concern that these strategies have internal priorities concerned with service funding, case-mix and clinical predominance in mental health care.

The role of support systems outside the clinical realm of the mental health service is recognised by consumers as a significant factor in maintaining both their community tenure and achieving positive health outcomes (Crane-Ross et al. 2000; Froland et al. 2000). With the establishment of the MIST Team that operates on an overt Recovery-focussed framework, the development of relations that supported these goals was seen as an integral part of our role. It was also acknowledged that these collaborations were best established by staff with a passion in the particular area and with an established relationship with the community sector.

The Partnerships

West End Community Safety Project, Mental Health component — targeting stigma and discrimination

The West End Community Safety Project involved a coordinated response by local services to a range of issues being identified by local residents, local traders, community services and the Brisbane City Council. The broader project looked at perceptions of personal safety for community members and resulted in a number of strategies aimed to begin to address these issues. A Project Support Group was established to support the implementation and development of the Project and included the following groups — Brisbane City Council, Kurilpa Kitchen, West End Traders Association, Kummara Family Association, Musgrave Park Cultural Centre, Queensland Council on the Ageing, West End Mental Health Service (MIST Team), West End Police, Westender Newspaper, West End Community House, 4AAA Kurilpa Kiosk and local elected representatives. This Project Support Group role included:

- identifying key local community safety issues
- assisting in the implementation of the project strategies
- identifying steps to enhance the impact of project initiatives
- identifying and supporting additional roles for the project
- informing local community members about the project and its initiatives
- acting as a sounding board for Community House in all aspects of implementation (West End Community House 2004).

West End is an inner southern suburb of Brisbane that has been a traditionally diverse and accepting community. It borders the Brisbane river and is home to many migrant communities, students, alternative lifestyles, boarding houses, supportive accommodation options and low-cost inner city rental. It is also home to a large number of social support services including mental health, St Vincent de Paul Homeless Hostel, Church welfare services, Indigenous hostel and welfare services and substance use services. It has a

shopping strip based around Boundary St that has a varying array of shopping options particularly cafés, bars and restaurants, tobacconists and op-shop.

In the past five years West End has undergone the process of urban regeneration, which has seen the traditional mix of low-cost residential and industry replaced with increasingly high-cost residential apartments and the associated 'upgrading' of the shopping precinct. While West End has retained substantial elements of its alternative nature, with its varied and colourful characteristics the issue of challenging, difficult or unexpected behaviour has created a challenge for the local traders both established and new. Consumers of the local mental health service were reporting that they felt more under scrutiny by the shop staff and that they felt that the stigma and discrimination of mental illness was starting to become apparent in a community they felt had previously been tolerant. The strategy of educating traders in the local area was endorsed by the consumer consultant based in the MIST Team and the consultant was to play a prominent role in the education sessions. Traders were also identifying that understanding behaviours and appropriate responses to these were of interest to them.

The West End Traders Seminar Series was one of the key strategies initiated and aimed to better resource traders to understand and respond to individuals exhibiting challenging behaviours in the West End shopping precinct. The series provided a number of seminars that looked at the following issues:

- Mental health education, resources, local services and appropriate responses, consumer focus and frameworks and stigma and discrimination of mental illness
- Information about the local Indigenous community
- Trading rights and discrimination legislation
- Policing
- Community expectations.

The Seminar Series was coordinated with the regular Traders Association meeting and promoted throughout the local area.

Outcomes

A total of 135 traders attended the Seminar Series over six seminars and feedback has been overwhelmingly positive. Previous attendance at a traders meeting had been between five and ten, which indicated a significant response to the Series. Increased trader contact with the local mental health service has seen information and referrals being provided and at times traders requesting (and receiving) onsite assessments for concerning behaviours of regular customers from the local service.

Remix Art Partnership

Art has commonly been used as a rehabilitation tool in mental illness for the purpose of regaining stability and reengaging with the community. People who suffer from mental illness may lose their major role function and feel disenfranchised from the general community that in general stigmatises mental illness. Art as a therapeutic tool has often been conducted within the health framework rather than a partnership model with the mainstream art community.

In June 2003, Princess Alexandra Hospital Health Service District MHS and Access Arts Inc. collaborated on the development of an art in mental health partnership. The MHS had already established itself as a supporter of the use of arts and culture to strengthen and deliver its services in the community but was unsuccessful in facilitating sustainable relationships between consumers and community-based art workers. Access Arts, a not-for-profit community organisation, had developed a national profile working with marginalised people in the community, especially disabled and disadvantaged individuals and groups with interest in the arts since 1983. The partnership was made possible with the support of the Community Cultural Development Fund of the Australia Council for the Arts and the PAH HSD.

The Remix art project proposed to extend the role of art to a medium by which people can become reintegrated into the community while also being creative. Remix was established as a research project in partnership with the University of Queensland, School of Rehabilitation Sciences, to investigate the effectiveness of participation in the arts on the health and wellbeing of people with mental illness. Remix was also established to provide an artistic and cultural infrastructure to consumers of our mental health service over a three-year period. The research component was designed to run parallel to art workshops facilitated at various community venues and support individual subjective feedback with clinical data on the benefits of engagement with the arts including the reduction of psychiatric symptoms. The aim of the partnership was to strengthen the health services engagement between the local community and consumers so that they may play an active role in program development and ensure sustainable links to community groups within the district.

In the pilot year, Remix had over 70 consumer participants engaged in various art projects ranging from cinematography, clay animation, dance and movement to song writing and music production. The benefits of consumers working side by side with art workers not employed by the mental health service was reflected in the narrative feedback from participants and workshop facilitators. The beginnings of sustainable relationships between consumers themselves and artists have also been observed, with some consumers receiving support from Remix consumers and artists in the form of visits and telephone calls during hospital admissions due to relapse of their acute symptoms. Small subgroups of Remix consumers have also continued to socialise outside of the designated workshops to attend sporting, art and recreational events in the general community. For example, a group of 15

consumers meet regularly to attend art galleries and exhibitions as friends rather than members of a mental health service group program.

Despite the success of the pilot year, Remix is continuing to search for funds required to continue the project and provide evidence for the impact of engagement in the arts for mental health consumers within their communities. Therefore, the remaining two years for the research project are essential in order to gain meaningful clinical, intrapersonal and interpersonal understanding of consumer experiences for future service planning and delivery.

Playgroup partnership for parents with a serious mental illness

The role of parenting can be challenging. For many parents, the process of engaging with other families in the community for support and shared experiences is crucial in surviving the new demands of parenthood. For people affected by serious mental illness this task can be extremely difficult.

This part of the paper will focus on the development of a playgroup for parents with serious mental illness that aims, through the development of partnerships with community organisations, to assist these parents in the task of community connections.

There is a significant amount of research that highlights increased vulnerability in families where a parent has a mental illness. Children of parents with a mental illness have a higher rate of behavioural, emotional and psychiatric disorder than children of the general population (Brunette et al. 2002; Mowbray et al. 2004; Oyserman et al. 2000; Zemencuk et al. 1995). There is also evidence that exposure to parental mental illness is related to poor intellectual and social outcomes in children (Murdoch and Hall 2002).

The increased risk for children in developing psychosocial disorder is attributed to a range of factors such as genetics, stress caused by parental mental illness, disruption to parenting and dysfunctional temperament or personality traits (Devlin and O'Brien 1999). A number of studies assert that ill-effects on the children are the result of correlates of the parental mental disorder, rather than the disorder itself. Such correlates include social disadvantage, poverty, and marital or family discord (Lancaster 1999).

The knowledge that factors other than genetics have an impact on the development of children of parents with a mental illness has spawned research into the area of resilience — what factors can 'protect' these children or have the ability to assist in more positive outcomes?

Devlin and O'Brien (1999) summarise a number of factors identified in the literature that enhance the resilience of children who have a parent with mental illness. Factors are divided into characteristics of:

- the child him/herself
- the family
- the parental illness
- social influences.

These factors are summarised below:

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| Child | <ul style="list-style-type: none">– Ability to sustain psychological separation from parental illness– Ability to resist over-identification with ill parent– Social competence– Intellectual competence– Low-risk temperament |
| Family | <ul style="list-style-type: none">– Effective parenting practices– Child has good relationship with at least one parent– Presence of supportive non-ill 'other' parent– Warm, emotional supportive family– Intact family |
| Parental illness | <ul style="list-style-type: none">– Parental symptomatology does not involve child– Illness is brief, mild or transient |
| Social | <ul style="list-style-type: none">– Extended adult role model– Quality peer relationships– Extended support system– Compensatory social activity. |

As previously discussed, people affected by serious mental illness are at great risk of poverty, social isolation, stigma and discrimination and these factors have been noted to contribute to poor outcomes for the children in these families. Yet studies indicate that people with serious mental illness are and do want to be parents (Hearle et al. 1999; Nicholson and Biebel 2002). Parenting is viewed as a valued life role (Bassett et al. 1999a, 1999b), and there are an increasing number of people with mental illness choosing to take on this role (Bassett et al. 2001). It is imperative then for mental health services to work in collaboration with these families and the community to improve outcomes for all family members.

As previously discussed, the MIST team is a recovery-orientated service. The development of sustained community partnerships that can assist consumers of the service achieve identified recovery goals is a key role for staff within this team. In accordance with this philosophy, staff of the MIST team, in collaboration with key community partners, have developed a proposal to establish a playgroup for people with serious mental illness who have children under school

age. The proposal was developed in collaboration with consumers of the service who are parents, a child and youth mental health service, a community agency and the Playgroup Association of Queensland.

Play is a crucial factor in childhood development. Through play children explore their environment and learn about their world (Esdaile 1996). For children, playgroups offer the opportunity to play with other children, share in new experiences, and participate in activities to learn and develop. For parents too, there are many advantages in being involved in a playgroup, including the opportunity to meet other parents, develop new friendships, learn about child development and link with resources located within the local community.

For parents with mental illness, involvement in a playgroup has the potential to enhance resilience factors identified as contributing to more positive family outcomes. Possibilities include a reduction in social isolation, enhancement of parenting skills and extension to the parents' support systems. Despite these obvious positive benefits, consumers of the MIST service identified that they felt unable to access playgroups that existed in the community. Consumers identified that their needs were different from those of the general population, they wanted their 'own' playgroup, to mix with other parents who were also battling mental illness.

Therefore as a response to this identified need, a proposal has been developed to establish a supportive playgroup for people with serious mental illness who have children under school age. It must be acknowledged that a considerable amount of experiential knowledge in establishing such a program has been gathered from an existing group on the Gold Coast (Bassett et al. 2001). In addition to staff of the MIST team, who have demonstrated a significant interest in this project, key partners essential to the successful establishment of the playgroup include:

1. The Playgroup Association of Queensland — offers our group membership to the association; a broad range of resources including toys, activity ideas, playgroup documentation; and a wealth of expertise and guidance in the establishment of playgroups
2. Cannon Hill Family Support Centre — provide the very welcoming, child-friendly community venue for the group to occur, with a range of resources including toys, tea/coffee making facilities, and volunteer child minders to assist at times when the group elects to hold an educational session
3. South Brisbane Child and Youth Mental Health Service — will provide a co-facilitator with expertise in enhancing parent-child relationships, parenting capacity, childhood development and the ability to offer early intervention to families in need.

At the time of writing this paper, we have received approval from the Mental Health Executive for a six-month pilot of the playgroup. We are currently inviting referrals for the group to commence.

Conclusion

This paper has looked at some of the topical discourse surrounding public community mental health service delivery and our teams' response to some identified issues. The projects described have been driven by consumer identified issues and have incorporated a public mental health service in collaboration with community sector agencies. They have also identified that the role of the public sector agency as either the driver or a major collaborator was essential for these projects to come to fruition and, especially in the case of the Remix Arts Project, that government funding is the determining factor for their continuation or collapse. The argument that the community as a separate and self sustaining entity would provide similar opportunities for the mental health population has serious flaws. This population is marginalised by income, illness, access and the increasing redevelopment of affordable suburbs. Without the initiative and support of publicly funded agencies, both public and community sector, initiatives such as these would fail to appear. It is also important to note that the community agencies that we work with also have other cliental groups that they service and it is often the prompting and initiative of the community mental health service that encourages them to move into this field. At present there is pressure on clinical services to concentrate on 'core clinical roles and this we believe, would further restrict the range of options available to mental health consumers.

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