**Presbytery Yarra Yarra, Synod Vic/Tas.**

**25/06/2019**

**To: Royal Commission into Victoria's Mental Health System**
**PO Box 12079**
**A'Beckett Street**
**VICTORIA 8006**

From: Rev. John Tansey
Mental Health Ministries,
Presbytery Yarra Yarra, Synod Vic/Tas
6 Williams Rd Olinda,
Victoria. 3788

Dear Commissioner,

Please see attached the Cover sheet for the formal submission to the Royal Commission, and a research report our network produced last year into the mental health needs from our ministry base. These cover the services we do in three locations in the north east of Melbourne, revealing many of the current gaps in the mental health system and particularly the need people living with mental illness have for community.

Please contact me at [redacted] if we can answer any further questions.
Regards

Rev. John Tansey
[redacted]

**Your contribution**

***Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.***

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

**Please see the accompanied report "Creating Welcoming Communities" as a response to this royal commission.**

The report points to the human need for community and finding places that are safe, affordable, and inclusive and where informal supports can be received and through the development of community a sense of belonging can develop. This report points to how loneliness and isolation due to stigma and discrimination has a detrimental effect on mental health and recovery. The current systems of care have denied many suffering illness the ability to access "drop-in" style services or gathering places where a sense of community can develop. Whilst some sufferers access groups such as a walking group, art group, etc, these are few and far between and rely on a person's state of well being at a certain time of the week. Mental health does not function for many in this way. The individualisation of the service to clients has contributed to isolation for many sufferers.

3. What is already working well and what can be done better to prevent suicide?

In the current system again pointing to the need for gathering places with informal supports, people having access to services when they need them rather than "their next appointment with a worker that may be a week away". Again, people's mental health does not often function according to a timetable. Nor does it function well in an environment where you may or may not have access to services depending on your "package" through NDIS. Services have become more inflexible and so concerned about where the money to pay for the service is coming from or if the client has the money in their package that there is a huge reduction in service availability and access.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

A good mental health service will have a range of options for people seeking services. This includes places where they can spend their day with structured activities and a welcoming environment. Since the move away from the drop in centres this has been a distinct lack of service provision within the services provided.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

6. What are the needs of family members and carers and what can be done better to support them?

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

We need to accept that community is important to a person's well being. In an environment where since 2014 where almost all Gathering Places (Drop-in centres) were closed and defunded with the individualisation of services, it was like the government threw the baby out with the bath water.
Having a sense of community is pivotal as people with in that and very often rejected from general community groups due to their mental illness. Gathering places where they can support one another, meet new friends provide,

somewhere to go, finding a place to belong, be connected, and can give them a reason to get out of bed in the morning. In Mental Health to be able to access this when they choose is crucial. If this can work in conjunction with the NDIS or individualised services then this will value add to

current services and produce good outcomes for peoples wellbeing.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

11. Is there anything else you would like to share with the Royal Commission?

Please note the accompanied research "Creating Welcoming Communities" as evidence based research conducted in 2018, investigating the Mental Health Services funded by the Yarra Presbytery of the Uniting Church. This research looked at the needs in mental health provision and what we as a church could do better

[redacted]

Creating
Welcoming
Communities

# RESEARCH REPORT

Yarra Yarra Presbytery
Mental Health Ministry

**FINAL REPORT**
**April 2018**

# Contents

# EXECUTIVE SUMMARY

The Innovations in Community Mental Health Support research project was undertaken to assist the Yarra Yarra Presbytery to better articulate the role and impact of current mental health initiatives, and to identify possible directions for the further development of the Mental Health Ministry.

The stated objectives of the research project were to:

- Provide an overview of the current mental health policies and their impact on the provision of community support for people living with serious mental health issues
- Identify gaps in the provision of community support for people living with serious mental health issues
- Recommend strategies for the Yarra Yarra Presbytery to respond to gaps in community support

The research examined the work of the ministries from a number of perspectives including people living with mental health issues, congregation members, ministers and deacons, volunteers, mental health professionals, community workers, local council workers, and representatives from the VicTas Synod of the Uniting Church and Uniting VicTas. A review of literature was undertaken, and relevant literature is referenced in the research report.

The research report describes the key elements of the mental health ministries; summarises the benefits that people derive from their participation; identifies key challenges and opportunities; and proposes actions to support future development.

A model has been proposed that articulates foundational concepts and frames the approach in terms of the mobilising power of a sense of 'mission', including application of community development practice principles and strategies.

## What is the Yarra Yarra Mental Health Ministry?

The Yarra Yarra Presbytery has identified ministry to those whose lives are impacted by mental health issues as a high priority. This ministry, which has had the support of the Presbytery and congregations for over 25 years, began primarily as a response to the issues in community arising from deinstitutionalisation in the late 1980s and early 1990s, when large mental hospitals in north-east Melbourne were closed and people were relocated into the community. In addition to outreach, the ministries have always included activities to foster more welcoming and supportive congregations.

The mental health ministries have a long history in responding to gaps in the community supports for people living with mental health issues. This research project was prompted by the increasing demand on the current ministries resulting from the Victorian Government Recommissioning of the Community Mental Health Support Services in 2014 and the subsequent closure of many social group support programs. There is particular concern that there are now very few social support initiatives in the Outer East as a result of these changes. There are

also concerns that the introduction of the NDIS may result in some people living with serious mental health issues losing access to support services, particularly those which address social isolation.

The tensions between individual and collective solutions were given an eloquent and insightful analysis by renowned poet and writer *Sandy Jeffs* at the launch of the research project. Her presentation titled the *The Shopocratic Oath* focused on the tendency to construct people living with mental health issues as consumers of services rather than as citizens and valued members of our community. Sandy's full presentation is included in the report as Attachment 1.

There are four key components of the Mental Health Ministry within the Presbytery:

- *hope springs* open door community - based in Heidelberg Heights and supported through the Banyule Network of Uniting Churches.
- Boroondara Community Outreach (BCO) – open door community and outreach - based at the Kew Uniting Church.
- Outer East Mental Health Ministry, Pastoral care (Chaplaincy) with Eastern Access Community Health (EACH) and with Eastern Health – pastoral outreach ministry.
- Building welcoming congregations. Over the years there have been various capacity building activities with congregations including:
    - congregations developing more flexible and inclusive approaches to worship and congregational activities
    - community education and awareness raising to build the capacity of congregations to welcome and embrace all people – including people who live with mental health issues
    - developing avenues of support for family members and others who care for a person living with mental health issues, including 2 carer support groups that have also been supported for many years – by congregations in Eltham and Mount Waverley.

## Open Door Communities supported by the Ministry – BCO and hope springs

Core elements of the mental health ministries are the *hope springs* and BCO 'open door communities'. Central to the idea of the open door community is the opening up of the church and its congregations to embrace people who live with mental health issues and others who are struggling to find support and a valued place in community life. The open door communities offer a place where people can choose to come along and participate at a level that they are comfortable with, without having to disclose, and can find acceptance within a caring community. Within this place of affirmation, people can also build social networks and friendships, and participate in the range of structured activities that the open door communities offer.

The research which sought the views of participants, volunteers, ministers and paid staff involved with the open door communities, identified a rich narrative celebrating the dynamic and responsive nature of the approach as a community creating strategy. While the ministries do provide individual support and pastoral care, their key objective is to connect people who are isolated into a welcoming and supportive community. The presence of ministers and members of congregations also increases the potential for people to explore spiritual and existential questions, and to connect with church congregations – if they wish. These unique opportunities are highly valued by some people who participate in the open door communities.

These can be described as 'communities of hope', which affirm the inherent value of the person, and embrace individuals regardless of their particular difficulties. The open door communities include a wide range of people who are socially isolated, including some who live in insecure housing or are homeless.

In the nuanced descriptions of how people experience the support provided through the Mental Health Ministries we more fully understand just how and why the open door communities are valued by those who experience loneliness, isolation, poverty and sometimes despair in their day to day lives. Many of these people live constantly in the shadow of stigma associated with mental health issues, and in these communities they find a place of acceptance and affirmation.

While the open door communities are a central part of the ministry, this is not the whole story. The complementary strategies around the open door communities are very important elements of an informal and effective model of community care and support for people living with mental health issues.

These include:

- Various structured activities:
  - Art and recreation programs
  - Music – singing groups, BCO community choir, and bands
  - Women's social and activities groups
  - Excursions
  - Occasional activities eg outings and camps
- Meals provided as part of the open door community
- Individualised support and referral to services
- Outreach to rooming houses (BCO)
- Active involvement in community planning networks to develop joint initiatives to address gaps in the local community services and supports
- Volunteer recruitment and training – supporting people to volunteer in the open door communities and associated activities
- Advocacy for individuals and systemic advocacy on wider social policy issues.

## The Outer East Mental Health Ministry:

The Outer East outreach pastoral care ministry is jointly funded by the Yarra Yarra Presbytery and EACH (Eastern Access Community Health), with the minister based with the EACH team at Ringwood. The minister provides pastoral support to individuals who are referred by EACH worker, and also has direct contact with participants in the weekly EACH men's group at Ringwood. Training in mindfulness has also been offered to inpatients at Maroondah Hospital and Upton House in Box Hill.

The flexibility and wide range of strategies employed by the Mental Health Ministries means they can connect with individuals in many different ways, to find a meaningful place in the community. The reality for many people is that they experience many challenges to their sense of well-being. They may also have tenuous access to opportunities and resources to create lives that are meaningful and manageable.[1]

[1] Aaaron Antonovsky's (1979; 1987) sense of coherence concept picks up on the idea of comprehensibility, manageability, and meaning as key factors which enable someone to manage the stress of life. According to Antonovsky, the sense that things happen in an orderly and predictable fashion, and that you have the skills, ability and support at your disposal to respond to challenges, and that your life experiences are a source of satisfaction and meaning, provides a stronger sense of coherence resulting in improved well-being. Meaning is the most important factor in promoting a sense of coherence – it provides the motivation to comprehend, respond and manage life's challenges and opportunities. There are cues here for the work of the missions in how they might design opportunities and environments that promote comprehensibility, manageability and meaning in people's lives to facilitate better coping mechanisms and to strengthen people's sense of coherence.

## A Conceptual Framework - Describing the Mental Health Ministry and articulating the approach

Three theoretical frameworks underpin the work of the mental health ministries:

- Christian compassion and friendship – grounded spirituality
- Citizenship, and
- Social models of disability and health

These three frameworks resonate with the spirit, commitment to mission, values and practice of the mental health ministries. Building on these foundational theoretical frameworks, the ministries need to further develop their community development practice and community building strategies to strengthen their work and position it within the congregations and their local communities, and across the Presbytery. In particular the Asset Based Community Development (ABCD) framework provides a powerful set of strategies to analyse current capacity, and to mobilise people and resources to respond more effectively to the needs and aspirations of congregations, and all those who benefit from the work of the ministries.

## Challenges, Opportunities and Recommendations

In this section of the report a number of key issues are briefly described, and strategies are recommended for consideration. Key community development approaches underpin the suggested strategies, including information sharing, community awareness raising and community education, skills development, community mapping and collaborative planning, networking and partnership development and advocacy. **In summary the recommendations are:**

### 1. Articulating the approach, value and impact of the Mental Health Ministries

**Recommendation 1a:** Articulate and describe the approach and develop information resources, and a communication strategy to engage in a more systematic way with current and potential supporters.

**Recommendation 1b:** Work with others across the Synod who are developing congregational community outreach initiatives to develop the theological framework underpinning community creating initiatives.

**Recommendation 1c:** In the future consider developing an approach to capture the impact of the ministries for individuals, congregations and networked organisations.

**Recommendation 1d:** That the Yarra Yarra Mental Health Network consider ways to affirm and strengthen the role of congregation members and Presbytery representatives in the management and future planning for the mental health ministries.

**Recommendation 1e:** That the Yarra Yarra Mental Health Network engage with Uniting to explore whether there are avenues through which Uniting could support the work of the mental health ministries.

### 2. Strengthening the connection between the Mental Health Ministries and the congregations

**Recommendation 2a:** Convene a time-limited network across congregations in the Presbytery to consider innovations in the liturgy and other approaches to 'welcoming' people living with mental health issues into congregations. Ensure that the network include members of congregations who live with mental health issues. The network could consider whether specific liturgical content, referencing mental health, should be included and whether there is merit in special services during mental health week or at other times of community celebration eg International Women's Day.

**Recommendation 2b**: That the Presbytery of Yarra Yarra Mental Health Network convene a sub-committee with members of congregations, and volunteers and participants of the open door communities to develop/source community information resources and community education opportunities for congregations, including:

- General information on mental health issues and information for carers
- Information sessions including personal stories and updates on highlights from the Open Door communities, and other initiatives across the Presbytery
- Mental Health First Aid training offered to members of congregations and other community members - consider using this opportunity to also promote the open door communities and to invite people to consider volunteering
- Partner with EACH and/or other services to develop and provide community education
- Explore options for Open Days and other special events (eg to showcase the music and arts) hosted by volunteers and participants at the BCO and *hope springs* open door communities
- Organise forums and/or an annual 'showcase' or conference in the Yarra Yarra area, working in conjunction with participants, key partners and similar initiatives to profile and promote the approach

**Recommendation 2c**: That the Presbytery Mental Health Network undertake a process to explore the extent to which there is a need for additional support for carers within the congregations, or whether suitable options for carer support exist within the wider community.

**Recommendation 2d**: The Presbytery of Yarra Yarra Mental Health Network convene a working group with interested ministers from the Presbytery, and representatives from Synod and Spiritual Health Victoria to scope possibilities for mental health training and awareness-raising for ministers in the Presbytery, and within the Synod. The working group should include people with lived experience and carers, and the training should draw on the experience of congregations and the BCO and *hope springs* open door communities.

## 3. Developing the Outer East Outreach Ministry

**Recommendation 3a**: It is recommended that the Presbytery undertake a feasibility study to explore opportunities to develop one or more open door communities in the Outer East area.

**Recommendation 3b:** Review the jointly funded position with EACH to review the interests and expectations of both EACH and the Presbytery, and develop a clearer role description and action plan.

## 4. Building the capacity of the Mental Health Ministries across the Presbytery

**Recommendation 4a:** BCO and *hope springs* coordinators and committees actively explore potential partnerships to support any extension of activities. Potential partners might include members of congregations (Uniting Church or other churches), neighbourhood houses, schools, community interest groups, sport and recreation clubs, service clubs, local government, etc

**Recommendation 4b:** That the Yarra Yarra Mental Health Network engages with Uniting Prahran to explore whether there is potential for a mutually beneficial collaboration

**Recommendation 4c:** That the Mental Health Ministries seek to strengthen partnerships with local government contacts and seek community grants to support specific projects.

**Recommendation 4c:** Undertake a survey of Uniting Church congregations and other church networks in the Presbytery, to identify other relevant initiatives and congregational activities

**Recommendation 4d**: Undertake a networking project to identify other Uniting Church lead mental health initiatives across Victoria and develop a network for the exchange of information, capacity building and strategy development.

**Recommendation 4e:** That the Presbyteries provide consultancy to congregations and other initiatives drawing on the expertise within the mental health ministries.

**Recommendation 4f:** That Presbytery consider seeking funds to establish a capacity building role to work across the Presbytery to support the further development of the Mental Health Ministries and other congregational initiatives.

### 5. Developing a stronger advocacy role in relation to policy and service design to improve community supports.

**Recommendation 5:** Strengthen the advocacy role of the Presbytery on matters relevant to the work of the ministries by developing a deliberate approach to advocacy to influence:

- Decision-makers within the Synod, and Uniting – to explore avenues for funding for community development and capacity building roles within the Presbytery to strengthen the capacity of congregational community initiatives
- Interfaith/ecumenical networks in the Yarra Yarra area
- Local government – mayors and councillors in local government areas within the Presbytery
- Current policy discussions about the NDIS and support for people living with mental health issues, working in collaboration with VICSERV, VMIAC
- State Government contacts including the Minister of mental Health, Martin Foley (who reversed a funding decision to continue support for the St Kilda Drop-in, St Mary's House of Welcome and other similar initiatives)
- Local members of parliament

## Conclusion - Be a beacon of hope for all

The research found that the BCO and *hope springs* open door communities are highly valued by those who are involved, including participants, volunteers, local workers in the community who refer people to attend, staff and supporting congregations. The report describes the many ways in which these communities provide a place where people can thrive, regaining self-confidence, fostering friendships and to some extent, shake off the stigma of mental health issues which shadows them in their everyday lives.

In the Outer East, there is a need to further explore the possibilities for developing the mental health ministry to provide for open door communities or similar opportunities.

The Mental Health Ministries are cherished as an embodied expression of Christian mission by participants, volunteers, the co-ordinators , members of the congregations and other stakeholders. The ministries are imbued with inspiration and commitment which provides a unique motivating force and focus. While maintaining the ministries presents certain challenges, they should also be considered 'resources of hope and inspiration' within the Presbytery, and an important means for strengthening congregations and affirming their sense of mission and important place within the broader community. This 'mission' is recognised by others beyond the congregations as being uniquely valuable – this was summed up by a community worker who refers people *to hope springs:* 'Be a beacon of hope for all'.

Combining the proposed community development strategies with the inspiration and motivation associated with this strong sense of Christian mission, will enable congregations and others in the Yarra Yarra Mental

Health Ministries to fulfil their aspirations for building more welcoming congregations, and creating more inclusive and affirming communities.

Acknowledgments: This research gathered the reflections and observations of a wide range of people who are associated with various aspects of the ministries. The report seeks to represent these many perspectives, and we hope we have succeeded in capturing the essence of the ministries. We thank everyone who contributed to the research, particularly the members of congregations, volunteers, and members of the open door communities at Boroondara Community Outreach and *hope springs*.
*Paul Dunn & Marie Hapke, Transition Concepts*

# ABOUT THE RESEARCH PROJECT

## Background to the research project

### Brief overview of the Yarra Yarra Presbytery Mental Health Ministry

In August 2012 the Yarra Yarra Presbytery adopted missional principles. In abbreviated form these are:

- Missional communities – Presbytery seeks to cultivate the growth of missional communities of the Holy Spirit that reflect the compassion, justice, and peace of the reign of God;
- Diverse Ministries: Presbytery recognises that different expressions of church community require different approaches to ministry;
- Innovation, Imagination and Intentionality: Presbytery will seek to nurture and encourage innovative and imaginative expressions of church which seek both to hold the heart of the faith and find ways to engage with the changing context; and
- New Forms of Church: Presbytery will be open to new expressions of church which are not just located geographically but relationally.

These principles are aligned with the Vision and Mission Principles of the Uniting Church of Australia. These include "... seeking community, compassion and justice for all creation, God in Christ is at mission in the world and sends the Church in the Spirit to:

1. share the Good News of Jesus Christ
2. nurture followers of Christ in life-giving communities of reconciliation
3. respond in compassion to human need
4. live justly and seek justice for all
5. care for creation
6. listen to each generation and culture so as to live out the Gospel in fresh ways
7. pursue God's mission in partnership " [2]

The Yarra Yarra Presbytery has identified ministry to those whose lives are impacted by mental health issues as a high priority. The ministry has had the support of the Presbytery (and the former presbyteries in the region) for over 25 years.

This mental health ministry finds expression in:

- Providing pastoral ministry
- Delivering practical emergency assistance to those with unmet needs
- Attracting volunteers and equipping them to support the mental health ministry
- Engaging Presbytery members and ministers to support the mental health ministry
- Raising community awareness through information gathering, seminars and distribution of information
- Monitoring trends in delivery of mental health services, identifying emerging needs and advocating for better provision based upon sound evidence
- Highlighting the impacts of government policy on service provision

[2] https://www.victas.uca.org.au/Pages/Home.aspx

Four key Mental Health Ministries operate within the Presbytery:

- *hope springs* – open door community - based in Heidelberg Heights and supported through the Banyule Network of Uniting Churches.
- Boroondara Community Outreach (BCO) – open door community and outreach - based at the Kew Uniting Church.
- Outer East mental health ministry - Pastoral care (Chaplaincy) ministry with Eastern Access Community Health (EACH) and with Eastern Health – works with individuals to support spiritual perspectives in context of mental health care.
- Welcoming congregations, community education and carer support - various capacity building activities with congregations to raise awareness about mental health issues, and to improve their capacity to welcome and support members who are living with mental health issues. Two carer support groups are supported by congregations in Eltham and Mount Waverley.

Some other congregations in the Presbytery support smaller scale activities – these have not been included in this research project.

## Objectives of the Research Project

*Creating Welcoming Communities* is the report of the **Innovations in Community Mental Health Support Research Project** which was undertaken to assist the Presbytery to better articulate the role and impact of the Yarra Yarra Mental Health Ministries, and to identify possible future directions.

The stated objectives of the project were to:

- Provide an overview of the current policies and their impact on the provision of community support for people living with chronic mental health issues
- Identify gaps in the provision of community support for people living with chronic mental health issues
- Recommend strategies for the Yarra Yarra Presbytery to respond to gaps in community support

See project brief at Attachment 2.

## Funding and management of the research project

The project was initiated by the Presbytery's Mental Health Network, and funded by a one off grant from the Uniting Church's Board of Mission and Resourcing (BOMAR).

The Mental Health Working Group of Yarra Yarra Presbytery provided oversight and direction to the project. The project steering group members were:

- Lionel Parrott (member of Yarra Yarra Presbytery Mental Health Network)
- Rev John Tansey (Outer East Mental Health Ministry)
- Rev Natalie Dixon-Monu (Minister, Boroondara Community Outreach)
- Jon Rumble (Coordinator, *hope springs*)

Following an expression of interest process, ***Transition Concepts*** (Paul Dunn & Marie Hapke) was appointed to undertake the research. Both Paul and Marie have many years' experience working in the community and government sectors, and developing innovative community support initiatives in mental health and disability. See further detail at Attachment 3.

# Research Methodology

**Project launch**

The research project was launched on 17 August 2017 at the Kew Uniting Church hosted by Boroondara Community Outreach. The launch was attended by a wide range of people, including members of congregations, participants and volunteers from Boroondara Community Outreach and *hope springs*, and staff and elected representatives from the Boroondara Council. The program included music by participants, and a presentation by Sandy Jeffs, poet, writer and communicator who lives with schizophrenia. The title of the presentation was *'A 4am Rant: How Neoliberalism has Highjacked the Recovery Model'*. See text of presentation at Attachment 1.

**The research data**

The research focussed on the four key initiatives of the Yarra Yarra mental health ministry. The research data was gathered through interviews and focus group discussions with key stakeholders. A limited number of surveys were also completed.

Focus group discussions were held with representatives of the following stakeholder groups:

- Participants of the *hope springs* and Boroondara Community Outreach open door communities.
- Volunteers who support the *hope springs* and Boroondara Community Outreach
- Mental health workers and other workers who refer people to *hope springs* and Boroondara Community Outreach
- Members of the Banyule Network of Uniting Churches
- Members of Uniting Church congregations in the Ringwood, Montrose and Lilydale areas
- Rev Deacon John Tansey, Rev. Deacon Natalie Dixon-Monu and Jon Rumble

Interviews were conducted with a number of people including:

- Rev. Deacon Andy Calder, Disability Inclusion for the VicTas Synod
- Paulo Reid – Coordinator, 101 Engagement Hub formerly St Kilda Uniting Care Drop In
- Rev Peter Sanders - founder, former Coordinator and now volunteer at *hope springs*
- Rev. Deacon Pam White – Maroondah Presbytery Mental Health Ministry (Outer East) and former Coordinator at BCO
- Peter Ruzyla – CEO, EACH
- Scotty Maxwell – formerly Co-ordinator, Halcyon, and volunteer at BCO
- Stav Stathanopoulos (General Manager Services) and Janet Charalambakis– Prahran Uniting
- Gavin Blakemore and Sieu-Kim (Mission and Ethos Partner Eastern Division, Uniting )
- Lionel Parrott (a co-opted member of Yarra Yarra Presbytery Mental Health Network )

A workshop was also conducted with Ministers, Deacons and members of congregations at the November Presbytery meeting at Mooroolbark Uniting Church.

Survey responses were received from 8 individuals

See attached:

- Information provided to research participants at about the Project - Attachment 4
- More detail about the consultations - Attachment 5
- Questions for Focus Groups and Surveys - Attachment 6

## Review of relevant literature

A review of literature was undertaken on the following themes:

- Challenges experienced by people who live with mental health issues
- Liberation theology, Christian mission, Christian Companionship/Friendship
- Community, belonging, and friendship
- Citizenship
- Models of Community Development including Asset based Community development (ABCD)
- Social model of disability/ health
- Current policy and funding for community mental health services including anticipated impacts of the NDIS

The literature is referenced in footnotes throughout the report, and a full list of references is provided.

## Key considerations

### Exploring the role of the congregations in supporting the Yarra Yarra Mental Health Ministry.

The various initiatives which comprise the mental health ministry have all been initiated by congregations and supported over many years. Changes in the size and membership of congregations will present challenges into the future.

### Funding and resourcing of the outreach initiatives

The initiatives supported through the Yarra Yarra Mental Health Ministry are funded by the Presbytery and contributions from congregations in Yarra Yarra, local government grants, and one-off project grants. The pastoral care position with EACH is jointly resourced by EACH and the Presbytery.

While the absence of government funding has enabled the Yarra Yarra initiatives maximum flexibility in terms of how they have been developed and how they operate, limited funding and resources is a significant constraint in terms of what can be provided.

### Responding to increasing demand due to changes in community mental health support services

Both the *hope springs* and Boroondara Community Outreach initiatives have experienced significant increases in demand as other social group mental health support activities have closed. The 'redevelopment' of the community mental health services from 2014 saw the withdrawal of government funding from a wide range of social group programs formerly provided through community mental health services. With the exception of a small number of group programs which have been re-funded under special arrangements with the Victorian government, community mental health services now provide highly individualised support services.

### Responding to gaps in the provision of community mental health services

Given the limited resources available, the Presbytery is keen to ensure that resources are used in the best possible way. Based on the success of the *hope springs* and Kew BCO social support activities, there is a question about whether similar activities are needed in the outer eastern area, where such activities are not currently available. The research focussed on exploring and articulating the current approach at *hope springs* and BCO to enable the Presbytery to engage with key stakeholders, and actively advocate for resources if further development of current activities and establishment of new activities are prioritised.

### Exploring potentials and challenges relating to the introduction of the NDIS

With the introduction of the NDIS there is a high level of uncertainty about whether individuals with mental health issues will be eligible for support, whether support will be provided long term, and if so at what level. There are concerns that the type of support provided through NDIS packages is prescribed, and will not provide the type of social support which many people living with chronic mental health issues require. Other impacts of the NDIS include the replacement of smaller local services by larger and more 'corporate' services, and the impact that a 'market' approach will have on the level of collaboration and co-operation between services at the local level.

# ORIGINS OF THE YARRA YARRA MENTAL HEALTH MINISTRY

The Mental Health Ministries have a long history in responding to gaps in service provision and a lack of community supports for people living with mental health issues.

## The Mental Health Ministries – congregational responses to gaps in mental health support

In the late 1980s and early 1990s the large mental hospitals in north-east Melbourne were closed and people were relocated to the community. The Yarra Yarra Mental Health Ministries developed in response to the community issues which arose from deinstitutionalisation and the limitations of community care for people living with mental health issues.

More recently, the Victorian Government Recommissioning of the mental health community services in 2014/15 resulted in the closure of many social group programs. As a result of these changes, BCO and *hope springs* have experienced a significant increased in demand for their open door communities and the other supports they offer.

*'I think the horse has bolted and programs like Mosaic have closed down for good and like a lot of reforms where this has happened there was nothing else put in its place. The theory coming from some ivory tower that people would be better off out of a day program - where, it is assumed, all they do is sit around smoking - and instead are 'integrated into the community' going to a neighbourhood house and things like that was all very well, but there was no support available to enable them to go to a neighbourhood house or a community centre. So that's what I think is the flaw in that model. As I said there was a lack of understanding about the value that these programs did have and how long it takes to engage someone and to gain their trust'.* ([redacted] worker, [redacted])

There is a strong view that with reduction in the supports available through mental health services and the introduction of the NDIS that the church programs are the one constant in many people's lives. For those in the church who have been involved in the Mental Health Ministries for many years, there is a sense of 'déjà vu'; with the church again responding to widening gaps in the community support available for people living with mental health issues.

*'I think [redacted] tries to fill the gap with the outreach case management work that she does. This is quite a big gap in [redacted]. We don't have a lot of caseworkers or community development workers that are funded to do that work. We've got a lot of great services like Camcare that try to fill that gap but they don't have that flexibility in case management to respond to people with more complex issues and who may not be connected to other services that can assist them on their service journey and connect them to local programs. I've had a number of conversations with [redacted] about that gap running across all these programs at the moment and she is trying, as one full time person, to do some of that casework as well as everything else she does'.* ([redacted] worker, [redacted])

*'Context shapes the nature of what ministries do - here in the [redacted] we had links with the hospital - in [redacted] ministry was also shaped by context – in their case the number of rooming houses and SRSs in the local community'.* ([redacted] – formerly minister with the [redacted] outreach ministry)

In seeking to respond to the chronic isolation and loneliness of many people living with mental health issues and the resulting poverty that they experience, the church ministries continue to grapple with a set of complex challenges, with very limited funding and resources.

In choosing mental health as the focus of their ministry, the congregations were under no illusion as to how difficult this might be, but were motivated by the message of the Gospel - a message of unconditional love, respect and care for those who are marginalised in our communities.

## The establishment of Boroondara Community Outreach

Boroondara Community Outreach

The Kew Regional Ministry in Kew, now known as Boroondara Community Outreach (BCO) was established in 1993. At that time research showed that the Kew and Hawthorn area had the second highest number of rooming houses and Supported Residential Services in Melbourne. The majority of the people living in rooming houses and supported residential services (SRSs) had a primary diagnosis of mental illness, many people having been moved into the community from Willsmere and other mental hospitals. The Community Outreach initiative was a response by local congregations to the loneliness, isolation and poverty experienced by people with mental health issues living in precarious housing situations.

*'I was part of the congregation that started the program 25 years ago. The Methodist Church and Presbyterian Church sold a property which provided funds which we were able to get hold of to start the Boroondara Community Outreach Program. The vision was for a dedicated congregation that would support people living in rooming houses and SRSs. A the time there were 12 rooming houses, plus Willsmere and Kew Cottages based in Kew and Hawthorn so there was a real need for community support for people living with mental health issues. We were also aware of the issue because there were always people dropping into the church on a Sunday. We responded by developing a project of Presbytery focussing on how to be more effective in ministry to people living with mental health issues. We wanted to create a community where people living with mental health issues felt they belonged; we wanted to develop an environment of love, care and support within the church. The former minister [redacted] was appointed by the Boroondara Community Outreach Program. A key role for [redacted] was to go out and visit many of the rooming houses. This was one attempt by the church to be inclusive'.* ([redacted] Volunteer, [redacted])

As well as providing outreach, BCO also developed an open invitation lunch, now known as Good Grub and this open door approach is a key to promoting belonging and companionship in a welcoming community.

As part of the BCO, the key Uniting Church congregation also established a special worship service which has been running for over 20 years. The more relaxed and inclusive format and liturgy regularly attracts a congregation of over 50 people from the local community and beyond.

## The establishment of *hope springs*

In the Rosanna and Heidelberg area, members of local congregations had been visiting patients in nearby mental hospitals (Larundel, Mont Park and Plenty Hospitals) since the 1960s. This included liaising with the hospital chaplains, organising activities for inpatients, and hosting weekend holidays. During this period local congregations welcomed some of these people to join them in worship services. As de-institutionalisation progressed through the 1990s the visiting program changed to providing support to people as they moved into the community, and also developed a carer's group in response to the needs of families who took on the care of their family members. *hope springs* was instigated by the Rosanna Uniting Church, and commenced in 1998 when Uniting Church BOMAR provided funds to support the appointment of Rev Deacon Peter Sanders as the Mental Health worker.

The initial focus for *hope springs* was on providing individual support and pastoral care to people living with mental health issues and their carers. A training program on mental health issues and the needs of people living with mental health issues and their carers was provided to interested members of congregations across the presbytery. Advocacy for better responses to needs was undertaken, and activity and mutual support groups were established, including carers' support groups in Rosanna and Eltham. The Eltham Support Group has continued to meet monthly over nearly 20 years.

*hope springs* emerged in response to deinstitutionalisation which resulted in many people being cast into the community with very limited support. The submission to the Uniting Church for funding to employ the Mental Health worker described the needs at that time:

*'For many years Rosanna Uniting Church members have been acutely aware of the needs of people affected by mental disorders - sufferers and carers. For 38 years our Service Group has provided social and practical support for psychiatrically disabled people. The consequences of recent rapid change in the way mental health services are provided has led to the conviction that there is an urgent need to provide more help for those affected by mental disorders, hence this proposal. The proposal has been discussed with the Yarra Valley Presbytery Officer, the Presbytery Strategy Committee, the North East Community Mental Health Service and the Mental Health Chaplains, who are all supportive of it'.* (From original Proposal for a Pastoral Worker for people affected by mental disorders, 1997)

The funding of the Mental Health worker resulted in the development of *hope springs,* enabling people to connect and engage in meaningful ways in their local community:

*'.....So that a community need was identified and it was agreed amongst our volunteers that this was the thing to do because it is this group of people who have a need and we can respond to that need in a particular way. Basically, it's really pastoral caring in the broadest sense but there was also a need for companionship and friendship as they were negotiating big changes in their lives. This was important. This equally applies to those who are newly diagnosed and also facing changes in their life'.* [redacted])

The response included support groups for carers of people living with mental health issues.

*'When we established hope springs one of our aims .... was to support the families who were supporting people who are coping with mental health issues. Some of the instigators of hope springs were dealing with family members who were struggling and it was apparent that there were limited supports that were available and I still deep down feel that that is an unrealised potential to provide support to families'.* ([redacted] *hope Springs*)

*'What we found at the time was that many families were only just surviving and barely had the time to go to a support group. That was one of the problems. Having said that, there is a small group in Eltham which is still going. It's been meeting since the beginning of hope springs for nearly 20 years now - about 6 to 10 people who still meet regularly'.* ([redacted] *hope springs*)

The establishment of *hope springs* was a response to the complex nature of issues associated with deinstitutionalisation and community care and the impacts that it had on families, friends and carers.

*'....we define our role and find areas of greatest need and go there and respond to that need. There are social structures you can't change easily but you can always respond to individuals within a community. That's really guided the development of the ministry - going to the people who are most isolated, the people in a locked ward, the people who are really isolated at home and find it too difficult to get out'.* ([redacted])

*'hope springs came from the ground up. In this sense it was our calling - we felt this was the right thing to do at the right time because people coming out of the institutions were in all sorts of trouble at the time'.* ([redacted] *hope springs*)

Since the beginning, *hope springs* has been actively supported by several congregations in the Banyule area.

## Establishing the Outer East Mental Health Ministry

### *Now based with the Eastern Access Community Health (EACH)*

In the late 1980s community managed mental health services were developed across Victoria, and the Outer East Mental Health Services Association was formed, setting up Halcyon in Ferntree Gully. Halcyon was one of the first Psycho-Social Rehabilitation Support Services (PDRSS) which provided a range of services including social groups programs to support people living with mental health issues. Similar services were established in Ringwood – Lifeworks - and Rivendell in Healesville.

The Maroondah Presbytery employed Rev Pam White in 1998 to reach out to people living with mental health issues. Halcyon, Lifeworks and Rivendell provided points of contact for the outreach ministry, providing opportunities to make informal contact with people using these services. A collaborative relationship was also formed with the Rev Ann Wakeling (then chaplain at the Maroondah Hospital) and regular visits were made to the psychiatric ward at the hospital.

*'There was an extraordinary development of community based mental health services at that time.....Initially we focussed on a community education component because of stigma and the need to support people who were supporting people living with mental health issues. We were giving people permission to tell their stories. And we were running forums and seminars as well as providing 1 on 1 contact with people in the hospital and the PDRSS system – eg Halcyon and Life Works.....We started to become involved in a journey with people, especially those living in rooming houses and SRSs. We had afternoon visits to a special accommodation in Ringwood East. Pam White set up a Depression Support group at St John's in Mt Waverley and we had community gatherings in people's homes once a month including a Carers Training Day'.* (Rev Deacon [redacted]

From the beginning in the Outer East there was a strong emphasis on community education within the congregations regarding the needs of people living with mental health issues. Community education sessions were held, with the aim of improving understanding about mental health issues, and supporting members of the congregations to respond to the needs of people living with mental health issues. Information sessions for carers were developed in partnership with the then Schizophrenia Fellowship, and a carers support group was established at St John's in Mount Waverley.

Around 2005 the outreach role was reduced to half-time due to funding constraints within the presbytery, and the partnership with Eastern Access Community Health (EACH) was negotiated soon afterwards. Frank Tinney, long serving member and chair of the management committee of EACH, and member of the Ringwood Uniting Church was instrumental in negotiating this partnership. EACH was first established as the Maroondah Social Health Centre (MSHC) in 1975, as a visionary initiative of the St Stephens Methodist-Presbyterian church in Ringwood East. MSHC soon attracted funding to become one of the first community health services in Victoria. It is pertinent to note that the first person appointed to provide services was Rev Peter Mackie, as Pastoral Counsellor and Consultant.[3]

Around this time the weekly afternoon drop-in at East Ringwood was established.

EACH had taken over the management of PDRSS programs so there was a natural fit with the established role of the Maroondah Mental Health Ministry in linking to people using the services of Halcyon, Lifeworks and Rivendell. The partnership with EACH has been enduring, with the pastoral role bringing a spiritual component to programs and service delivery, and pastoral support to staff.

Since 2014, significant changes to the funding of community mental health services, has seen the closure of the PDRSS services, and their associated social group programs. This development has reduced the opportunities to make more informal contact with people living with mental health issues who are using the services of EACH. The ministry with EACH is now aligned to a more traditional chaplaincy role within the community health service. The chaplaincy work with Maroondah Hospital has continued, and is now under an arrangement with Eastern Health.

## Fostering Welcoming congregations

Developing more inclusive congregations and extending opportunities for people living with mental health issues to participate in worship and the life of the church has been an enduring commitment across the mental health ministries.

The ministry has utilised a number of approaches to supporting people to explore their spirituality, including working with people individually, and in small groups, as well as welcoming people to join with congregations in worship. Fostering inclusion and sharing and promoting more flexible worship rituals has been an important element of the ministries. [4]

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[3] *'Just a Small Show'* A History of the Maroondah Social Health Centre 1973-1994 p12

[4] There are number of resources that the ministries can draw on to support capacity building work within congregations. This includes training in mental health awareness-raising and other ministry start up and lived experience information and resources.
See for example:
*No Stigmas Project* – people with mental illness writing stories across a range of topics/themes to challenge stigma https://nostigmas.org/nostigmas-project
*Mental Health Grace Alliance* - http://mentalhealthgracealliance.org/
*Fresh Hope* - http://freshhope.us/
*Pathways to Promise* - http://www.pathways2promise.org/
*Hope for Mental Health* - http://hope4mentalhealth.com/
*A Nouwen Network* - http://nouwen-network.com/aboutus.html (Australia)
*Pathways to Promise* - http://www.pathways2promise.org/
*Mental Health and Pastoral Care Institute, Sydney* - http://www.deaconessministries.org.au/mhpci/
*Being Alongside* - https://beingalongside.org.uk/
Essex Mind and Spirit - http://www.essexmindandspirit.org.uk/index.html
The Croydon Association for Pastoral Care in Mental Health (UK) - http://www.apcmhcroydon.co.uk/
The Strengths Model: A Recovery-Oriented Approach to Mental Health Services, Core Training Manual October 2013 Version St Vincents Mental Health. This 2 Day Training Manual provides a comprehensive framework for developing and

From the beginning, in addition to addressing the social isolation experienced by people living with mental health issues, the mental health ministry has recognised the damaging impact of the stigma associated with mental health issues and has undertaken community education activities within congregations, and for the general public. These activities have sought to build understanding and the capacity of congregations to respond to, and embrace people living with mental health issues.

In more recent years, with increasing community awareness about the prevalence and impact of mental health issues including depression and anxiety, the mental health ministry has continued to provide community education activities within congregations to assist them to recognise mental health issues, and to support and welcome members and visitors who may be experiencing difficulties.

Study guides have been used by some church groups, public information seminars held regularly, and a newsletter on current mental health issues has been circulated through a network of 50 or so interested people in the Outer East.

The needs of carers were also recognised, with support sessions for carers offered at various times, with ongoing groups established in Mount Waverly and Eltham.

With the establishment of the outreach ministries at Kew and Heidelberg, members of congregations have volunteered to support various aspects of these programs. A number of volunteers have continued their involvement for many years.

From the beginning, each of the ministries has received a level of dedicated financial support from the congregations, and there is a regular giving program across the Presbytery to support the mental health ministries.

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delivering recovery oriented practice - http://recoverylibrary.unimelb.edu.au/__data/assets/pdf_file/0007/1391551/the_strengths_core_training_manual_june_2014.pdf

*Heart and Soul Matters: A guide to providing spiritual care in mental health settings*. Spiritual Health Victoria, 2016 - http://www.spiritualhealthvictoria.org.au/our-publications

*Building Capacity for Spiritual Well-Being. Analysis of the training package offered to mental health workers in East Gippsland in 2015*. Spiritual Health Victoria (2017) - http://www.spiritualhealthvictoria.org.au/our-publications

Royal College of Psychiatrists London - *Spirituality and Psychiatry Special Interest Group (SPSIG)* - http://www.rcpsych.ac.uk/workinpsychiatry/specialinterestgroups/spirituality/publicationsarchive.aspx

Faith Ability - http://www.faithability.org/ has a range of resources and articles on religion and disability

Vanier, J. & Swinton, J. (2014) *Mental Health: The Inclusive Church Resource,* London, Darton, Longman, & Todd Ltd.

# Brief summary of key dates for the Yarra Yarra Mental Health Ministry

| | |
|---|---|
| 1960s | Members of congregations regularly visiting Larundel. Plenty and Mont Park hospitals |
| 1993 | Kew Outreach ministry (BCO) established – Rev Deacon Maree MacDonald appointed |
| 1998 | *hope springs* established – Rev Peter Sanders appointed as 'mental health worker'<br>Maroondah Presbytery appointed Rev Deacon Pam White in mental health ministry role |
| 2002 | Rev Deacon Natalie Dixon-Monu commenced in position at BCO<br>Rev Deacon Mandy Blacker appointed to the Maroondah mental health ministry role |
| 2005 | Rev Deacon Ainslie Bos commenced in the Maroondah mental health ministry (half time) |
| 2005-09 | Dana Robson-Garth assisted Peter Sanders in Co-ordination role at *hope springs* |
| 2006 | Rev Deacon Pam White commences at BCO (half time) position<br>Auspice arrangement with Uniting Care in place.<br>Partnership arrangements with EACH established including the chaplaincy role |
| 2007 | Rev Deacon Ainslie Bos finished at EACH and was followed by James Godfrey |
| 2010 | Around this time Uniting Community Care withdrew from the auspice arrangements for BCO |
| 2011 | Jon Rumble commenced as Co-ordinator at *hope springs* |
| 2012 | Rev Deacon Natalie Dixon-Monu returns to position at full-time at BCO.<br>Uniting Community Care hands the ministry back to the Presbytery. |
| 2016 | Rev John Tansey appointed to the EACH pastoral ministry |
| 2018 | *Jon Rumble – continuing as Co-ordinator hope springs*<br>*Rev Deacon Natalie Monu-Dixon continuing as Co-ordinator at BCO* |

# DESCRIPTION OF THE MINISTRIES

There are currently three key elements of the Yarra Yarra mental health ministry:

- Boroondara Community Outreach (BCO) and *hope springs O*pen Door Communities:
- EACH Outreach and pastoral care ministry
- Welcoming congregations

## Boroondara Community Outreach (BCO)

Boroondara Community Outreach (BCO) ministry continues to be a place of welcome, offering love and hospitality to people who often feel excluded from the broader community

The primary focus of the ministry is to provide social connection and support to people who are living with mental health issues and to those who are socially isolated. People who attend BCO live in a range of social housing in the area – rooming houses, Supported Residential Services, public housing and community housing. A small percentage of people who attend live with family, private rental, or own their own homes. Some experience primary and secondary homelessness.

Governance

The BCO is overseen by a Reference Group appointed by the Presbytery. The Reference Group meets monthly with the Co-ordinator to receive updates on the program and to discuss any issues, oversee policies, and receive treasurer's reports.

Funding

BCO is supported by a number of funding sources, with the fulltime ministry position supported through the Uniting Church (various sources). The funds to run the programs and provide material support are received from a variety of sources. The Boroondara City Council provides funding through triennial and annual community grants; a number of Uniting Church congregations provide financial support; and various community groups including service clubs, schools and individuals provide funds and material donations. These funding sources provide approximately one-third total program funding.

Staffing & volunteers

BCO is co-ordinated by the BCO Outreach Minister (Rev Natalie Dixon-Monu) who is employed full time, and supported by a large number of volunteers (approximately 90). The volunteers come from a number of Uniting Church congregations (approximately 50%) and the remainder are from the local community, including a number of parents of students at the local Trinity Grammar School. Volunteers are rostered, with some

assisting on a monthly basis, and some having regular weekly commitments in different aspects of the program. Volunteers play a very significant role in supporting the various activities offered at BCO.

Participants

People who are engaged through BCO hear about the program through word of mouth, or are referred through a wide range of local community services including mental health services and Boroondara Council – including Prahran Uniting. It is not uncommon for people to travel a significant distance to participate in the BCO activities, with a key reason for attendance being the desire to be part of a community in a place of safety with like-minded people. While many people attending BCO are living with mental health issues or issues associated with homelessness, there are many others who attend for the social interaction and the desire to feel part of an accepting and diverse community.

Alongside mental health issues there are a number of other issues which impact on the lives BCO community members, including poor physical health, various disabilities, drug and alcohol issues and other trauma. People who are socially isolated, stigmatised, financially disadvantaged and have very limited support networks find welcome and a sense of belonging at BCO.

What BCO provides

Individual support is provided including pastoral care/counselling, advocacy, material aid, and informal case management including referrals to other services. A number of regular activities are provided to create opportunities for people to socialise and engage in the wider community, including community events such as choir and music performances. The activities currently offered by BCO include:

Good Grub – drop-in lunch each Tuesday – average attendance 50 (49 weeks)
Drop-in art with lunch – average attendance 15 (40 weeks)
Singing lessons - average attendance 10 (40 weeks)
Women's Group - average attendance 20 (25 weeks)
Connect – Weekly outreach in different rooming houses – average attendance 20
Bible study - average attendance 8 (25weeks)
Ukulele Group - average attendance 12 (40 weeks)
Sunday church service - average attendance 45-70 (11 services annually)
Social outings - average attendance 20 (5 annually)
Pizza restaurant meal – shared dinner with Trinity volunteers - average attendance 40 (10 annually)
Habitat Art Studio – peer led art studio– 4 afternoons per week - average attendance 10 (40 weeks)
Drop in at Hawthorn Community House (joint initiative with local agencies) – weekly average attendance 20 (49 weeks)
Community Choir - average attendance 23 (40 weeks) plus 6 choir performances annually
Community dance event - average attendance 45 (4 annually)
Mental Health Week events – Art exhibition, Concert etc – average attendance 150
Other special events
eg. Cup Day BBQ, Womens Health & Pamper Day - average attendance 80-100 (3 annually)
Christmas Day lunch - average attendance 85
250 Christmas Hampers provided by local congregations and broader community donations

On average around 30 hours of activities are provided weekly (over 40 weeks), and with average weekly attendances around 150. In addition to weekly and fortnightly activities, BCO organises a number of special events during the year, including choir performances which are open invitation events, and are well attended by members of the local community.

As well as these activities, the BCO Co-ordinator makes regular outreach visits to 5 rooming houses each month, providing regular contact with around 155 residents. Many of these people do not attend any of the programs at BCO and have very few supports or engagement with other services.

Key partnerships:

BCO is well connected with a wide range of mental health and other community and health providers, such as the Boroondara Mental Health Alliance, the Community Recreation Outreach Program, housing services, local service clubs, Trinity Grammar, ACCESS Health and community houses. This network of relationships provides referral pathways to and from BCO, and also generates opportunities for partnerships and joint projects. BCO has always worked collaboratively with other community agencies in the area and it is highly valued and respected in the mental health sector and with local government workers and the community in general.

At BCO there has been very intentional work to develop links within the broader community and through these joint initiatives create new opportunities for people attending the drop-in to form connections with people in the local Kew community. For example, through a formal arrangement with Trinity Grammar, students come to the Good Grub lunch and get to know some of the regulars. Every month parents from Trinity share a meal with BCO participants at the local pizza restaurant, and Trinity also hosts a special 'soiree' for the BCO community at the school. This active approach to breaking down barriers and creating community connections is something that the old drop-in model did not do. Similarly, the BCO choir members include people from Trinity, the local community, congregations, and regular BCO participants. This relationship is also highly valued by Trinity, as a source of local community engagement for students which raises awareness about the difficulties experienced by many people in our communities, and brings students into contact with people with whom they would not otherwise have any connection. During the week it is not uncommon for the boys to bump into the people on the tram or at the shops and they stop and have a chat.

All of the BCO activities seek to foster broader community participation and the involvement of people from the local community and church congregations as volunteers sharing in activities with participants. This is a real shift away from the 'us and them' divide seen in formal services, and in traditional drop-in approaches. BCO brings together a community of people who do a whole 'heap of fun stuff' together.

Connections with congregations

BCO has strong connections with a number of local congregations, through long term volunteers, involvement in choir and other BCO community projects and events, and donation of Christmas hampers, as well as regular donations to support the BCO activities.

## *hope springs*

*'hope springs continues to offer a unique service in our region providing community-based support and activities. Many participants rely heavily on hope springs for friendship, ongoing recovery-focused activities, and access to a supportive community of people who "look out for each other". This leads to better outcomes in terms of "quality of life", but also assists with monitoring mental health and general wellbeing. This results in a reduction in morbidity and potential for hospital (psychiatric inpatient) admissions by early detection of warning signs related to a deterioration in mental state, thus facilitating early intervention. hope springs also assists participants in their recovery by providing social inclusion opportunities, creative outlets, hospitality, mutual support and self-help. We are also the first line of support for many individuals in crisis, and we always endeavour to empower people to self-manage their physical and mental health issues. We also work closely with mental health services (both community and clinical) to jointly provide the holistic care needed for ongoing recovery. In our local mental health network we provide an important "piece of the puzzle" for care and recovery. One-to-one support, including advocacy and practical help, is also offered. Group settings allow opportunities for people to meet and make friends within a safe, non-judgmental environment, building confidence to engage more actively in the wider community'* [redacted] *hope springs*)

Values

The values underpinning the *hope springs* approach are: companionship on the journey of recovery and growth towards wholeness, compassion, patience and kindness, hospitality, creativity, affirming the central place of spirit, mutual support, personal strength and self-help.

Governance

*hope springs* operates as an initiative of the Joint Church Council (JCC) of the Banyule Network of Uniting Churches. The *hope springs* Management Committee provides governance, budget oversight, risk management, and strategic planning for the future. The *hope springs* Advisory Committee focusses on service delivery issues and future planning for programs.

Funding

*hope springs* is one of the major community support programs of the Banyule Network of Uniting Church who provide significant funding support. Donations also come from congregations and individuals to support the *hope springs* community. There is a constant task writing submissions for one off grants in order to cover the full cost of the program. Currently there is funding support for the womens access program through a BOMAR grant from the Uniting Church Mission Support Fund and a one off grant from the Collier Charitable Foundation.

Staffing and volunteers

The *hope springs* activities are supported by a Coordinator [redacted]e) who is employed 0.8EFT and a womens' program co-ordinator is employed 0.2EFT. During the 2016-17 financial year around 120 participants attended, which was supported by 30 volunteers, many of whom come from the Cross Gen Congregation in Heidelberg Heights, and the Rosanna congregation. Other volunteers are recruited from the local community.

Participants

People who attend *hope springs* experience a range of challenges, including mental health issues, with a common theme being the need for social connection and interaction. People find their way to *hope springs* through word of mouth, and formal referral from local community and mental health services, and local supported residential services.

Activities

*hope springs* provides around 15 hours of activities each week, with an average of 120 attendances every week. Regular activities include the Open Canvas Art Group, Marimba and Percussion Music Group, Womens Group, Drop-in, Worship Service, and Springboard Activities & Outings Group. A carers support group also meets each month in the Eltham area

What people say about the activities:

*"I have attended the* ***art group*** *for over 12 months and during that time I have found it extremely beneficial to me. Prior to attending, my interest in art had waned because of a number of issues which I am still dealing with. Initially I was reluctant to attend, but from day one I have become very passionate about it. It has sparked up my passion in art again and has made me feel good. The group is very inviting and has a good, positive atmosphere. The people who run it, along with all the different volunteers and students have been great. I enjoy the group and like talking art to the other people who attend."* [redacted](from HS Annual Report)

**Womens Group** *"The friendships flourish amongst the ladies. When someone is unwell or not having a good day, the other ladies rally around them and it makes a world of difference in their recovery. To have a place where they feel accepted and not judged..... It means a lot to the ladies to have a place to feel comfortable to talk with their friends about more sensitive topics" (*[redacted] former Women's Program Coordinator)

*The* ***Drop-in on Wednesday*** *afternoons at Heidelberg Heights is well attended by people who have formed a supportive community who look out for each other and accept each other for who they are. It is a very relaxed and unstructured environment where people can engage in a variety of recreational activities, such as play pool, play music, access the internet, have a coffee, do some art therapy, and/or just sit around and chat. It is a 'safe' place where people can discuss issues in their lives without fear of judgement or stigma. Participants enjoy each other's company, battle it out in footy tipping, occasional pool competitions, table tennis, celebrate birthdays with cakes, and enjoy BBQ sausages or sausage rolls.....Drop-in programs have fallen out of favour in recent*

*years but we believe strongly that they are a vital point of engagement for socially isolated people - providing a less threatening environment for participants in which workers and volunteers can identify the needs of participants and provide the relevant referrals and support they require. The large numbers of participants we see is testament to the fact that drop-in provides something that people need; not least, the sense of belonging and a supportive community.* ([redacted] – *hope springs* coordinator)

**Worship on Thursdays (WOT)** *These services meet a pastoral need for some who do not feel able to call by a regular worship service with larger numbers.* [redacted]–volunteer convenor)

**Springboard outings** provide opportunities for participants to get out, take part in community activities, and visit places that they may not otherwise be able to get to. Many of the participants are quite socially isolated and find it very difficult or impossible to access the places *hope springs* visits, or even to catch a train or bus to travel to places. Much of Springboard is about going places and having fun with friends.

**Participation in the Sunday worship services with the CrossGen congregation at Heidelberg Heights**
Even before the establishment of *hope springs* local congregations were welcoming people with mental health issues to join in worship services. Several people who attend the *hope springs* activities also attend Sunday services.

**Eltham Carers Support Group** meets each month to support those who have a loved one living with a mental health issue. The longer-term members of the group have a wealth of experience to share with those who are relatively 'new' to caring:

> *My fellow carers have seen me through many tough months/years over this time. I am touched by their empathy and compassion.*
> *We meet monthly to share (or not) how we've been travelling the past month.*
> *We listen without judgement. We know how tough it can get.*
> *We have even cried together.*
> *We all know the importance of laughter and have shared many funny moments.*
> We laugh A LOT. ([redacted] quoted in the *hope springs* 2017 Annual Report)

Key partnerships:
The *hope springs* co-ordinator is well connected to local mental health services though the North-East Mental Health Alliance, with local health services and with several local SRSs in the area and the opportunities offered are recognised as unique, and highly valued by these services.

Connections with congregations
*hope springs* is strongly connected with congregations in the Banyule Network of Uniting Churches through its governance arrangements, and the many long term volunteers it draws from a number of local congregations.

## Outer East Mental Health Ministry, pastoral care (chaplaincy) with Eastern Access Community Health (EACH) and Eastern Health

The focus of the ministry in the Outer East has changed considerably over the years, in response to changes in the service delivery approach to community mental health services.

The Outer East outreach pastoral care ministry is jointly funded by the Yarra Yarra Presbytery and EACH, with the minister based with the EACH team at Ringwood. The Rev John Tansey has been leading this ministry since mid-2016.

The majority of the current work is with EACH, particularly through the Community Mental Health service. The minister provides pastoral support to individuals who are referred by EACH workers, and also has direct contact with participants through some regular group programs including the weekly men's group at "Lifeworks" Ringwood. Training in mindfulness has also been offered to EACH staff as an introduction to spiritual awareness, with the possibility of expanding this to wider audiences.

The long standing work with Maroondah Hospital has recently been formalised in an agreement between the Presbytery and Eastern Health. This pastoral care ministry with Eastern Health provides a point of contact with people at the hospital during the acute stages of their mental health issues, in addition to individual pastoral care, spiritual reflection groups and regular meditation sessions with patients. The role enables a more informal connection with people, bringing an active pastoral presence to the psychiatric wards at Maroondah Hospital, and more recently Upton House (Box Hill Inpatient Psychiatric Unit) and a transition house/program in East Ringwood PARC (Prevention and Recovery Care – managed by MIND).

The ministry also includes speaking with congregations about mental health issues and the role of the church. Rev John Tansey is currently chair of the Presbytery's Mental Health Network and a member of the Resourcing Committee.

The Outer East Ministry is managed by the Presbytery through a reference group comprising members of Uniting Church congregations in the Outer East.

## Welcoming congregations, community education & carers support

The financial support (regular giving) and volunteering by members of congregations in the Yarra Yarra Presbytery have been critical contributions to the Mental Health Ministries for 25 years.

The CrossGen congregation in Heidelberg includes a number of people who also attend *hope springs*, and in Kew a 'relaxed' worship service is held every month and attended by around 50-70 people.

Other congregations also seek to be welcoming, and 2-3 seminars are held annually to raise awareness in the congregations about mental health and the needs of people living with mental health issues.

A newsletter is prepared regularly with information about media articles on mental health, with the aim of raising awareness of issues within congregations, including how to best support members in developing their part in the ministry.

The Carers Groups in Eltham (an initiative of *hope springs*) and Mount Waverley continue to meet regularly.

# THE CONTEXT

## The Christian Mission – the Gospel in Action

The Uniting Church has a strong sense of mission: *"Following Christ, walking together as First and Second Peoples, seeking community, compassion and justice for all creation."* Three of the mission principles are particularly relevant to the mental health ministry:

- respond in compassion to human need
- live justly and seek justice for all
- pursue God's mission in partnership

The commitment to mission is integral to the Christian community, and is described as a key dimension of the 'Christian life':

*'Mission is not optional or secondary to the Christian community, but is at the heart of its calling in the power of the Spirit to follow Christ.....this is the nature of Christian maturity, the following of Jesus Christ to those marginalised and oppressed.....Mission describes the very nature of the Christian life in all its communal, liturgical, institutional, spiritual and service dimensions'.* [5]

The Mental Health Ministries demonstrate the commitment of a living church which is dedicated to service and supporting people who are marginalised from community life and their families, and who are in need of companionship, social connection and friendship. The *Gospel in action* is the core narrative underpinning the mental health ministries. There is a strong commitment to 'being with', and 'standing beside' people, and at times taking personal and organisational risks to be open to and responsive on their terms.

People associated with the ministries (members of congregations, participants, volunteers and workers) are very clear about the ministries and the way they enable the Uniting Church to demonstrate its values and Christian faith. There is also a strong sense that the ministries enable people to live in a way which expresses and fulfils the Christian calling to care for and embrace others.

*'In Matthew, Christ says you are here to help the poor because when you do you are helping me.....If you want to know Christ that's where you will find him....'* (Adapted from Matthew:25:31-46) (David, volunteer BCO)

The ministries also provide an opportunity for deep dialogue when people are at their most vulnerable or are feeling troubled. By bearing witness to pain and suffering, the ministries are a vital source of support that responds to people's deep yearning for peace of mind. The church, as a community in and of itself, provides a potential for people to find 'shelter from the storm' of a tumultuous life.

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[5] Quoted in *'Theological reflections on Vision and Mission Principles'* http://www.victas.uca.org.au/aboutus/Pages/Vision-Mission.aspx

*'I think it's about being a place to belong where people are accepted no matter what. You just have to keep telling them that. You have to keep reminding them. So that people know that they can always come here and come back to God. This is really important.....In terms of conversations about God I think there are a lot of people with mental health issues, when they are unwell, who have a spiritual experience and are sorting those things out. A lot of people say I've done some bad things and I am not good enough for God. I think we have those conversations a lot with people because you're allowed to talk about those things here. If people talked about those things with a psychiatrist I think they think they would be judged but here we are very open to talk about these things'.* ([redacted] volunteer, *hope springs*)

*'What is the motivator for this ministry? It's a lot of things. From a faith perspective, I see Christ in the people I meet with at the hospital. It is our mission to work with people who are doing it tough just as Jesus did. This is something that welfare organisations can't bring into someone's life. It's very easy for welfare organisations to follow the money and in doing that you can be basically doing what the government wants you to do. It can be very controlling. The outcome driven model of funding tends to have the effect of limiting the focus of attention, and defining the desired outcomes for a person who has very complex needs in very narrow terms– there may be a whole range of desirable outcomes which are not in scope for the 'funded' service. Very often the focus is on 'independence', but this neglects the social and spiritual dimensions from which people derive a sense of connectedness, wholeness and meaning.* ([redacted])

There is clarity in the mission as well, because the need is often 'in your face'. Many people are lonely, poor, troubled, living in substandard accommodation or at risk of homelessness, or are actually homeless. It is often very clear that they are doing it tough and there is a need to do something about that.

The power that derives from the mission of the Gospel when it is delivered through ministers, laypeople, volunteers and other members of the church community, who are 'committed to the call', is considerable. If we were to describe the profession of ministry we would probably start by identifying its capacity to go to places that others, in the 'welfare professions', are not be prepared to, or mandated to go. Again this was evident in the responses from many participants in the programs, the sense that the ministers and the ministries they lead would follow people to some very dark places and sit with them through those times.

The gospel in action is a great source of hope and it inspires an optimism that something can be made of every person's life - that no matter how wretched one might feel, in the eyes of God, and therefore in the hearts of those who do God's work, there is always a possibility for love and friendship.

*'I feel it is about relationships and seeing the goodness in everyone. We can call it different things, God or Christ. But for each of us it is important that we see it, that we see the goodness. And if this is the basis of our relationships everything will be alright'.* ([redacted] volunteer BCO)

Many of the volunteers associated with BCO and *hope springs* spoke about the richness of their experiences as volunteers, and the affirmation and inspiration that derives from embracing others, and sharing with them in relationships of care and mutual respect.

# Current funding approaches & delivery of community mental health services

## Recommissioning of the Psychiatric Disability Rehabilitation and Support Services (PDRSS)

In 2014, the Victorian Liberal government recommissioned the community mental health support sector with the stated aims of streamlining access to services, to improve the responsiveness of services and delivering more flexible funding arrangements to service providers. The reform processes were controversial and received significant criticism from the sector. For a review of the recommissioning process see the research conducted by Latrobe University in 2015[6] and the *Independent Review of Mental Health Community Support Services and Drug Treatment Services Final Report* conducted by the Andrews Labor Government. [7]

Our research with the Yarra Yarra Mental Health Ministries found that the Recommission and the resulting closure of many group based rehabilitation programs in the community mental health sector significantly increased demand for the activities offered through BCO and *hope springs*.

As the Mental Health Ministries are not reliant on funding from the state government, the impact of the recommissioning process saw an increase in demand on the services and supports provided through BCO and *hope springs*. With the defunding of state government funded drop in programs and group based programs run by psychiatric disability support services, a number of people were drawn to the open door communities of BCO and *hope springs* and the structured group programs that they offer. At times this has led to a level of frustration within the ministries because, in the past, they have struggled to attract funding and operate on very slim resourcing, but were receiving referrals from a range of other relatively well-funded mental health services that no longer had other referral options.

At a more symbolic or ideological level, the Recommission was seen as a threat to the work of the ministries because it challenged the validity of the open door community models which the ministries have been running for over two decades. This was despite the testimonies of many people who participate in these communities - people with lived experience of mental health issues, volunteers, ministers and workers from a range of organisations who either refer people to the programs or were engaged in highly valued and productive project partnerships with the Ministries. A frustration expressed by a number of leaders in the two congregations was the sense that, whilst some mental health services readily let their group programs go, they were referring their clients to the BCO and *hope springs* communities as an alternative.

*'Well, first the Mental Health Community Support Service Recommission and now the NDIS is shaking up the sector and other local services have had to restructure and rethink how they're operating. But the thing is they are still referring people to hope springs. There is this idea that hope springs is great and we will send our people there'*. (Rev [redacted]

[6] Silburn, K, (2015), *Recommissioning Community Mental Health Support Services and Alcohol and Other Drug Treatment Services in Victoria: Report on Findings from Interviews with Senior Personnel from Both Sectors,* Australian Institute for Primary Care and Ageing, Latrobe University,

[7] *Department of Health and Human Services Independent Review of New Arrangements for the Delivery of Mental Health Community Support Services and Drug Treatment Services Final Report September 2015. Aspex Consulting, East Melbourne, Victoria.* Some of the key issues raised in the report, relevant to the work of the ministries include: the removal of 'walk in' direct access to services; the disincentive for people to have to re-tell their story to different agencies/workers including concerns with reliance on phone based intake; the hollowing out of the range of interventions available to people with move to more individualised approaches; the loss of expertise within the sector as experienced staff were made redundant; reduced opportunity to access group activities compounding social isolation; disruptions to service relationships, partnerships and networks; and uncertainties in relation to transition to the NDIS.

In this context, the 'open door' approach at St Kilda Parish Mission (now 101 Engagement Hub with Uniting Prahran), BCO and *hope springs* are described as 'voices in the wilderness' by Paulo Reid, Manager at the 101 Engagement Hub.

## National Disability Insurance Scheme (NDIS)

*'Mechanisms like the NDIS are predicated on concepts like 'autonomy' and 'choice', permitting governments to absent themselves from their previous responsibility for service planning and delivery. Instead, responsibility is handed over to individuals and their 'brokers' to arrange care. Longer term contracts or block funding arrangements between governments and non-government service providers are becoming rare, which makes planning and workforce development in the community mental health sector impossible'.*[8]

As the biggest social reform in Australia since the introduction of Medicare, the National Disability Insurance Scheme (NDIS) has inspired a high-level of optimism about the possibility for people with disability to live meaningful lives, where they can exercise a level of control and choice about the types of supports they wish to access. However for people living with mental health issues there is scepticism about the capacity for the scheme to deliver on its promise. Research and evidence emerging from the experience of mental health consumers, carers and practitioners in relation to implementation of the NDIS has highlighted a number of gaps and issues of concern.

For example, research recently conducted by the Sydney Policy Lab compiled in the *Mind the Gap* report revealed gaps in a number of critical areas in relation to psychosocial disability. Some of the key areas included:

- Poor consumer and carer knowledge of the scheme
- Language of disability and permanence does not fit well with the language of recovery and is alienating for people who do not wish to consider themselves as having a life-long disability
- Difficulties around gathering evidence required for the application resulting from an individual's transience, health issues and the fluctuating nature of psychosocial disability
- Poor quality of NDIS assessments due to a lack of understanding about psychosocial disability
- Plans once made are not activated due to confusion, poor support coordination, or a lack of appropriate service providers
- Limited support for people when their plans are being reviewed; and reviews (and plans) conducted by phone
- Plans are inflexible and difficult to review quickly when situations change or people become unwell
- Organisations with expertise in psychosocial disability are collapsing, merging and electing not to engage with the NDIS due to an inability to provide effective services within the NDIA costing structure
- Organisations are losing staff with expertise in psychosocial disability because the level of funding provided by the NDIA for instances of care does not match the cost of employing trained staff or providing training and supervision to new staff
- There is a dramatic loss of services for the vast majority of people living with mental health issues. This creates a second class of people with psychosocial disability who now receive much poorer support because they are not eligible for the NDIS
- Peer support, community-based rehabilitation and recovery services are not being funded.[9]

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[8] Sebastian Rosenberg in *Challenges and Opportunities for Community Mental Health in Australia* in New Paradigm Summer 2017 p.12

[9] From Smith-Merry, J, N. Hancock, A. Bresnan, I. Yen, J. Gilroy, G. Llewellyn (2018) *Mind the Gap: The National Disability Insurance Scheme and psychosocial disability. Final Report: Stakeholder identified gaps and solutions.* University of Sydney: Lidcombe. (p. 5-6)

This extensive list of issues reflects a growing consensus that the scheme is struggling to respond and be relevant to the needs of people living with mental health issues.[10] What this consensus points to is the feeling that the scheme is a much better fit for people with physical and/or intellectual disabilities and that the criteria for eligibility based on lifelong disability does not reflect the episodic nature of mental health issues. It is also seen to buck the trend in mental health which focuses on a narrative of recovery and psychosocial rehabilitation. In this context people with mental health issues bring a narrative of the possibility for recovery to the NDIS planning negotiations rather than a narrative based around lifelong, permanent impairment or disability.

Simon Duffy (2013) from the Centre for Welfare Reform in the UK raises a number of issues in relation to the design of the NDIS. One of the key issues in the context of research for this project is the way the NDIS potentially compromises people's citizenship status by forcing them to negotiate a plan through a facilitator which 'imposes restrictions and invasion of privacy which are inconsistent with the UN Declaration of Human Rights for People with Disabilities'.[11] For Duffy one of the central flaws of the NDIS is that it does not start with an assumption of citizen capacity.

*'People with disabilities are people who already make a positive contribution to Australia. With the right system of entitlement they will be able to make an even greater contribution to Australia. This needs to be the starting point of the design. Systems of planning or facilitation sound good – but they disguise an underlying failure of trust in Australians with disabilities.*

*No system should assume that everyone needs a facilitator, nor does everyone need a plan. Sometimes plans or facilitation will provide a useful, but limited, role in ensuring good support. But they should not be hard-wired into the system'.* [12]

For many of the people we spoke to, their experience of the NDIS reflected these concerns. They felt confused and constrained by an overreliance on negotiating access to plan resources via a deficit narrative rather than through a strengths-based narrative that demonstrated their capacity to contribute and be a part of their local community.

Our discussions with mental health service providers also revealed concerns with the NDIS pricing structure for support, which they believed is premised on attendant care rates rather than the higher costs for more qualified workers usually employed in psychosocial rehabilitation and support. This is reducing the ability of the mental health sector to provide the type of professional support and expertise which is expected in mental health services to adequately care for people living with mental health issues.

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[10] For example see – *'Broken promises and missing steps in mental health reform'* published in Medical Journal of Australia – article by Patrick McGorry and Matthew Hamilton https://www.orygen.org.au/About/News-And-Events/2017/MJA-editorial?utm_source=Orygen+Newsletter&utm_campaign=944472546 5-ORYGEN_NEWSLETTER_JULy2017&utm_medium=email&utm_term=0_aa4d112403-9444725465-345261641
*'More people need to get in'*: Allan Fels calls for radical rethink of NDIS on mental illness. July 25 2017 - 5:02pm Article on Sydney Morning Herald Website
http://www.smh.com.au/federal-politics/political-news/more-people-need-to-get-in-allan-fels-calls-for-radical-rethink-of-ndis-on-mental-illness-20170725-gxlags.html
*Challenges and Opportunities for Community Mental Health in Australia* by Sebastian Rosenberg in ***New Paradigm*** Summer 2017 p.12 (VICSERV Newsletter)
*Mental Health in the NDIS A Mistake* by Patrick McGorry in ***The Australian*** 6th April 2017
CMHA President Liz Crowther – *What needs to be done in the context of the NDIS?* https://croakey.org/roadmap-for-reform-in-community-mental-health/
VICSERV Submission to The Joint Standing Committee on the NDIS
http://vicserv.org.au/images/NDIS_Joint_Standing_Committee_-_VICSERV_submission.pdf

[11] Duffy, S. (2013) *Designing NDIS: An International Perspective on Individual Perspectives*. Centre for WelfareReform. www.centreforwelfarereform.org p.18

[12] Ibid. p.19

The way funds are allocated in the context of an NDIS plan, requiring people to have a sense of how their life would play out over a year and to allocate support to match the person's aspirations lacks the flexibility to respond to the episodic nature of mental health issues. This type of planning leaves little room to draw on extra resources in times of crisis which could not possibly be predicted as part of an annual planning process. For example, as one manager described it, block funding provided a 'reservoir of resources' that a service could draw on to allocate support flexibly and quickly to respond to individuals when they were in crisis or at risk of harm to themselves and others in the community.

The NDIS as a highly individualised model of funding means that it is much more difficult for services to provide the kind of group programs that many people living with severe mental health issues have found to be valuable in the past.

*'Can I ask you - is the NDIS going to provide for the social side of things'?* ([redacted] BCO)

*I know in terms of the services themselves they are feeling really worried about the NDIS in relation to mental health because it's not the sort of care model that they're trying to promote if they're trying to develop recovery models.* ([redacted])

NDIS eligibility issues are particularly problematic for the people who access the communities at BCO and *hope springs*. Some of these people who are not accessing formal services, and who are homeless, or at risk of homelessness, have limited contact with family and friends who can help them negotiate the NDIS referral pathway, plan negotiation, and plan implementation process. The potential for this group of people to 'fall through the cracks' and not receive appropriate supports is seen to be a serious risk associated with the NDIS reforms.

People attending BCO and *hope springs* expressed a level of confusion and concern about the NDIS and how it will impact on them. From the perspective of participants at *hope springs*, some of whom had experienced its rollout across the North East Metropolitan Area, the NDIS engagement was an unsettling experience. It was described as the 'NDIS nightmare' and while people did not elaborate in great detail about what that nightmare involved it was clear that they felt a significant level of confusion and unpredictability about their NDIS support.

For the ministries, and other organisations they were networking with to develop new opportunities, there were key concerns and a level of scepticism about the NDIS. Firstly the preoccupation with more individualised approaches was seen as detrimental to the community creating work of the open door communities and other group work approaches. Secondly, these organisations were also witness to a change in the service landscape in their local areas, including a move away from networking, partnerships and other collaborative strategies aimed at addressing needs and responding creatively in a more 'whole of community' context. It was felt, at least in the short term, that the NDIS would impact on the capacity for organisations to co-produce and develop coordinated community responses to local needs.

*Networking is so valuable but it's so difficult now* ([redacted])

*Now organisations don't have staff who are paid full time to do the job. It like a lawyer thing - every hour is accountable so how do they fund someone to come and network when they are not getting an income from that person's work when they are networking. That's where the problem is now. They used to have a permanent staff team of 10 full time people, now they probably have a manager who contracts out hours. So all that networking is something that will fall by the wayside because of the NDIS.* ([redacted])

*'Under the NDIS organisations have got bigger. Agencies that were once Boroondara specific now might be based in Ringwood. You lose all of that connection and identification of local need with that expansion. At Boroondara we used to know all of the workers, now I get calls from NEAMI in Maroondah or Glen Waverley. So I think there will be a disconnection to all of that local networking work we used to do'.* ([redacted])

A further element of the NDIS is the Information Linkages and Capacity Building (ILC) program, which provides short term grants for a range of initiatives including engagement of mainstream services to include people with disabilities, and other community capacity building strategies. These grants will become available in Victoria in 2019, and may present an opportunity for the Presbytery to apply for funding for a capacity building demonstration project.

It is unclear how the NDIS will develop over time, but there are significant concerns at this point. No doubt it will take time for the 'dust to settle' and to see whether opportunities for more cooperative, whole of community-planning and capacity building strategies, that link formal mental health services with the efforts of local communities, will emerge in the new NDIS world.

Currently though, for a number of leading advocates in the mental health sector, the 'jury is still out' in relation to the NDIS.

Writing as far back as 1992 in the United Kingdom, Barham outlined the tensions associated with moving towards more individualised and 'marketised' responses to mental health issues and the 'promise' they hold for people to realise full community membership:

*'The promise that is held out is of a framework for social care which parts historical company with narrow patient bound conceptions of the subjects of care and locates health-care needs within a richer and more nuanced understanding of the social needs of the person. In breaking from professional institutional monopolies, the 'contract' culture offers potential scope for a far more pluralistic and accountable array of service forms. But we may be justly sceptical as to whether it will promote a real step forward in the revaluation of people with mental health issues and their struggle for citizenship, or simply deliver the renewal of outdoor relief under more diverse auspices.'*[13]

Barham's quote resonates with much of the feedback we received about the NDIS and the tensions and ambivalence many people expressed in relation to its implementation.

[13] Barham, P. (2000), *Closing the Asylum*, p138

## Critiques of the Drop In approach

Critiques of drop-in approaches focus primarily around the idea that they create a culture of dependency, and that they 'capture' and pauperise people, creating essentially what is a culture of poverty. These criticisms are partly derived from the observation that many drop-in programs support people over long periods, often for years. There is an assumption that people attending for long periods are not progressing in terms of their independence or 'recovery'[14] and that a lack of formalised individual goal setting in the drop-in programs are in part the reason for this 'lack of progress.'

*'The main criticism (of drop-ins) is that they foster dependence and that we should be enabling people to move into more normal activities in the community. There is an element of truth to that. But people need a safe place free from stigma and life's crap where they can be themselves and de-stress, and this can be a launching pad to find their passions and interests; a launching pad to get into more normal community activities. Without a level of good support though, they haven't got a hope and without the support they can get from volunteers and peers in a supportive community they will struggle.'* ([redacted] *hope springs*)

There is also criticism of the way that drop in approaches only bring people with mental health issues together and that there is not enough emphasis on creating pathways to other mainstream settings in which people can further develop their interests and aspirations. A further criticism is that they attract a narrow range of people and that they tend to be spaces that are not welcoming and inviting to women.

Others however have shown the benefits of open access to an accepting and affirming community for many people who would not be comfortable in attending more formal support services.

*'..... there is Drop In and then there is Drop In and they're not all the same..... So we need to be careful to articulate what we mean by Drop In - keeping that sense of openness and inclusiveness in a community. One of the criticisms is that they can be male dominated, mostly middle-aged and older and people sort of prop there and don't move on. In the recovery model they look like they're not going anywhere. Drop Ins become the thing in themselves and there is nothing else to offer people. But at St Kilda Drop In we developed a range of groups and program opportunities like the Gardening Group, the music group, the writing group, the theatre program and people could engage in this depending on their health and their interests... As well as providing a safe space to build trust with people, there are always these extended parts of the program and all the different things, the offerings that were coming from the community as well, which were all a really important part of it being a holistic program. Often when people talk about drop in they are not talking about all of that - they're talking about a narrowly described program model – that old cliché about blokes playing pool or sitting around smoking'.* (Rev [redacted])

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[14] There is an extensive body of research on the concept of recovery as it is the central model associated with Victorian and national community mental health policy and practice. Originally developed by consumers of mental health services, it emphasises a strengths based approach which focuses on an individual's capacity to live a productive and meaningful life. There was a level of ambivalence about the concept of recovery in our discussions with many people associated with the ministries. This included volunteers and participants with lived experience of mental illness. Central to this ambivalence is the onus of responsibility the recovery concept places on the individual to change without drawing enough attention to the impact that social conditions exert on people's well-being. For an overview of recovery the work of Patricia Deegan is a good place to start. You can also see how the concept is used to guide policy and practice in Victoria through the Framework for Recovery Oriented Practice cited below.

*Recovery and the Conspiracy of Hope by Patricia Deegan Presented at: "There's a Person In Here": The Sixth Annual Mental Health Services Conference of Australia and New Zealand. Brisbane, Australia, September 16, 1996*
https://www.patdeegan.com/pat-deegan/lectures/conspiracy-of-hope
*Recovery Stories Website* - http://www.recoverystories.info/recovery-from-mental-disorders-lecture-by-pat-deegan/
*Victorian Government Framework for Recovery Oriented Practice*
https://www2.health.vic.gov.au/getfile?sc_itemid=%7b47D2GEAC-5A2C-44FA-A52A-2F387F3C4612%7d&title=Framework%20for%20Recovery-oriented%20Practice

### *Evaluation of St Kilda Uniting Care Drop-In, 2009*

In an evaluation of the St Kilda Uniting Care Drop In, a strong case was made for the critical role that drop-in or **open access** programs play in providing support to people living with serious mental health issues. This includes:

- An effective ways of engaging with hard to reach groups and individuals
- A sense of community membership and connection
- A safe and secure place to belong
- Access to a skilled and experienced staff team
- A broad range of program engagement activities
- Central location
- Links with the Uniting Church
- Early intervention and referral strategies

The program was not without its challenges which included the tendency for people to rely on the St Kilda drop-in as the sole source of support and connection in their community. Other challenges associated with this issue included a narrow range of referral pathways, limited opportunities for self-advocacy and consumer leadership and a need for more dynamic partnerships and strategic alliances to promote more effective community collaboration and capacity building.

Despite these challenges the community creating work of St Kilda Drop In was powerful and a key to its success:

*Staff engage in what might be described as 'community creating' work – the development of a culture or social world that is welcoming and promotes a sense of community membership, affiliation and belonging. The supportive environment of the Drop In motivates people to connect - participants attend because they want to be involved, because they have friends at the centre who might expect them to be there and because it is a place they can turn to in times of trouble and stress.*

*Maintaining an environment that is supportive and nurturing, where people feel safe and secure, is extremely important. Many people who attend the Drop In are in desperate situations. Issues associated with homelessness, drug and alcohol abuse, unemployment, loss of contact with friends and family and discrimination in the broader community mean that at times people feel extremely frail and vulnerable. Staff must exercise great care and concern in responding to these feelings of vulnerability. The ability to respond to people 'where they are at' requires flexibility, patience and empathy, an ability to listen and connect, and being non-judgemental and ready to proffer advice when the time is right.* [15]

### *Sacred Heart Mission Evaluation of Open Access Programs*

In 2015 Sacred Heart Mission commissioned a study of four 'open access' programs which in the past were formally known as drop-in programs. The renaming of the drop in programs as open access programs or, more recently, in the case of St Kilda Uniting Care drop In, as an engagement hub reflects a desire to distance these programs from the stigma associated with the idea of traditional drop-in. [16] The study by the University of Melbourne was timely and conducted in the context of the mental health community support services reforms [17] and the defunding of drop-in programs and group day programs across Victoria. As a result of lobbying about

[15] St Kilda Uniting Care Drop In. An Evaluation of the Service Model. Jackie Moden Consulting, 2009. (Authors Jackie Moden & Paul Dunn)

[16] It also reflects an intention to try and capture the dynamic nature of a program or activity which is to provide unconditional access to a community space based on an interest and to just 'be there' without the procedures and regulations associated with more formal support services.

[17] It is important to note here that St Kilda Uniting Care Drop In through the work of the Rev John Tansey was a key player in lobbying the new Labor government to provide funding to reopen the defunded drop in programs. Another key player was Arts Access Victoria who drew attention to the impact the recommission had on arts programs delivered through psychiatric disability support services, primarily in the context of their day programs. Nearly all of these arts programs were

the closure of the drop ins and group programs, the new Labor government agreed to refund four open access programs - these were previously known as drop-ins.

Open access programs were identified as services *'characterised by an 'open-door' policy where each person is welcomed to access the available services without assessment of need, without obligation to contribute information about themselves or their situation, and generally, without an appointment. Services offered may include meals, showers, clothing, practical advice and support, medical and mental health support, information and advice, all provided in a safe and supportive environment that facilitates connection and support'.* [18]

The research identified a number of benefits of open access programs backed up by evidence from an international literature survey. This evidence showed that:

- the centres acted as important instruments of social inclusion for people who experience high levels of social and economic marginalisation;
- the ability to co-locate and partner with a range of agencies provided access to essential services that people would not otherwise have been able to access; and
- they provided improved quality of life in the areas of physical and mental well-being, social inclusion, housing and enhanced life skills.

defunded including celebrated studios like Splash and The Stables. As we note in the report many of the artists who used The Stables at Prahran Mission found their way to programs like BCO that operated outside the formally funded mental health sector and were therefore not threatened by the funding cuts.

[18] *Open Access Evaluation: An Appraisal of Four Open Access Centres in Melbourne.* University of Melbourne, Melbourne School of Population and Global Health, 2015. (Authors-Prof Margaret Kelaher, Dr Camille La Broy & PeterFeldman).

## The open door communities of *hope springs* and BCO

Whilst acknowledging that there have been some limitations with drop-in models and day programs, interviews with participants at BCO and *hope springs* were rich with detail about the value they derive from being part of these 'open door communities'.

On more than one occasion it was suggested that ***'the baby has been thrown out with the bathwater'*** and that critiques of informal 'drop-in' approaches failed to explore what these types of activities mean to the people who attend.

At both BCO and *hope springs* there were stories of people who have attended for long periods with very minimal participation in activities, but in the medium and longer term they had taken big steps in the level of their participation and their interactions with others in the community. Some of these people are now actively contributing to welcoming others:

*'People are understanding and accepting of one another. I have anxiety about talking to people, and one of the things I do when I get overwhelmed is that I lie on the floor. Obviously that can be an issue for some places. But hope springs is one of the few places where people understand what I am doing and why I am doing it. And everyone is really friendly. I love having coffee and it's great to have a laugh in the Womens Group... [redacted] has also given me a voluntary job recently meeting and greeting the new people..'* ([redacted] *hope springs*)

The current research found that the *hope springs* and BCO Open Door Communities were described by participants, volunteers, ministers and paid staff as dynamic and responsive, engaging a wide range of people and creating welcoming and inclusive communities. While individual support, pastoral care, and a number of structured activities are also provided, the key objective is clearly to connect people who are isolated to a welcoming and supportive community.

These communities can also be described as 'communities of hope and reconciliation', which affirm the inherent value of the person, within 'a politics of difference' [19]and that 'embrace' individuals regardless of their particular difficulties, differences and life circumstances. In the personal and nuanced descriptions of how people experience the support provided we can more fully understand just how the 'open door communities' are valued by those who experience loneliness, isolation, poverty and often times despair in their day to day lives.

While BCO and *hope springs* are communities where people can bring their concerns and difficulties and expect to receive assistance and support, they are also places in which people experience a 'lightness of being', in the company of friends, and free from the stigma that shadows them as a person living with mental health issues. Many people attend to participate in one or more structured activities, following their interests with others in areas such as painting, singing, theatre, photography, and music.

Within the BCO and *hope springs* communities there is awareness that a level of challenge is important, and that while it is important that people feel secure and safe, it is also important to encourage people to challenge themselves:

*'.... I'm a firm believer that we all should encourage people to go beyond what they think they are capable of.... I'm all for encouraging a bit more challenge. I feel it a responsibility of mine. I believe that everybody is responsible for themselves as well and that this is the environment to do that. Say for instance the women's group we had a very small group in the beginning and people were hesitant to do things but it's grown so much now there are so many more women in the group and we are all making friends from it. The thing is a lot of people will just sit there and not participate .... but I think we need to encourage them to get involved as well'.* ([redacted] *hope springs*)

[19] Wolf, M. (1996) Exclusion and Embrace. A Theological Exploration of Identity, Otherness and Reconciliation, Abingdon Press, Nashville, p.19 -20.

These are also places created in a spirit of altruism where people get to receive and TO GIVE. There is power in service and kindness towards others to transform lives and to create community - to build a sense of individual well-being and self-worth through the gifts and ***generosity freely provided to a community.*** As many social commentators have identified, the opportunity to give and serve, is one of the keys to a meaningful and happier life. [20] By facilitating an environment and culture where love, compassion and a commitment to being there for others is invoked at all times, BCO and *hope springs* are well-placed to inspire a call to service and the creation of community.

*'Well I think it's both quantity and quality, the fact that there are over 100 attendances at hope springs each week, for eight active groups - that's a measure of quantity. The other thing is the qualitative measure of people having a good time, sharing stories, feeling comfortable and relaxed, developing relationships and caring for each other. There are people who value the presence of other people and miss them if they're not there and follow-up to find out where they are; so, a measure to me is about community, and the way people relate together; the way they support each other and their personal growth and self-management. That can be accessed by just talking to them where they can tell us the difference it's made in their lives. You can't put figures on that, but you can see it and you can hear it.'* (Rev [redacted]

Finally, it should also be noted, that the churches are informal mainstream community groups, providing opportunities for people to connect with a range of volunteers and representatives of other organisations in the local community. The BCO has been working effectively to create opportunities for people to connect with other local community groups and organisations, through the partnership with Trinity Grammar and the links with Barking Spider Theatre, the CROP program, the Kew and Hawthorn YMCA, Access Health, Hawthorn Community House, the District Nurse Homeless Service, a range of mental health services, and Boroondara Council. These are just some of the examples of the way the broader community is brought into the church community space and able to connect with the work of the congregation. This is an example of 'bringing the community in' rather than always expecting people living with mental health issues to negotiate the difficult pathway into a world where they so often are stigmatised and marginalised.

The research found that the informality and open door approach at BCO and *hope springs* are highly valued by people who attend, creating an environment in which people can flourish. The Findings section of this report contains more details about some of these outcomes.

[20] See for example - Mackay, H (2013) *The Good Life. What makes a Life worth living?* Macmillan,??? (For a review of The Good Life Centre for Public Christianity review by Simon Smart - https://www.publicchristianity.org/the-good-life-what-makes-a-life-worth-living/ Ricard, M. (2013) *Altruism. The Power of Compassion to Change Yourself and the World*, Atlantic Books, London. Sennet, R. (2012) *Together: The Rituals Pleasures and Politics of Cooperation*, Penguin Books, London. Segal, L. (2017) *Radical Happiness. Moments of Collective Joy*, Verso, London. Monibiot, G (2017) *Out of the Wreckage. A New Politics or an Age of Crisis*, Verso, London.

## Uniting VicTas

*".. sometimes I might not like what I see in this mysterious area of community development, and because of that, I believe the experience of exploring it can be rewarding".* [21]

The Uniting Church has a long history of providing community services, and nearly all of these originated as initiatives of local congregations or parish missions.

In July 2017 Uniting Church service agencies across Australia were amalgamated to form Uniting VicTas. The new entity Uniting VicTas has brought together 22 Uniting Care agencies, Wesley Mission Victoria, some Parish Missions and two VicTas Synod Business Units. Uniting (at the national level) is now one of the largest community service organisations in Australia. This new phase of corporate development is largely in response to changes in the funding approach by state and federal governments which favour large scale organisations.

Uniting Church congregations have been significant supporters of the Uniting Care agencies and parish missions, in terms of financial support, contribution of volunteer hours and the use of church properties. Uniting estimates the value of this support from the congregations in the Synod of Victoria and Tasmania (the VicTas Synod) to be in the range of $13m each year.

An important consideration for Uniting is to maintain this relationship with the congregations.

In addition to this contribution to the funded Uniting services, it is estimated that Uniting Church congregations in Victoria and Tasmania directly provide approximately 1,000 community initiatives which support to 60,000 – 100,000 people annually. These community initiatives range widely, and including activities such as community gardens, men's sheds, English classes, homework programs, playgroups, op shops, cafes, meals programs and open door communities such as BCO and *hope springs.*

In effect there are two streams of 'community service' supported by the Uniting Church:

- Small scale community initiatives instigated and supported by congregations as an expression of mission and service by members of the congregations with their local communities. There is typically an informality in the way these initiatives are 'delivered' with a high level of voluntary effort, few if any paid staff, and little if any government funding.
- Funded community services delivered through Uniting VicTas and other Uniting Church agencies. These are large scale operations with services delivered primarily by paid staff, often on a regional or statewide basis. Some of these services are supported by volunteers assisting in specified roles and managed by paid staff.

The VicTas Synod undertook a Major Strategic Review in 2016, and has outlined a number of considerations relevant to the relationship between Uniting Church congregations and Uniting VicTas in the discussion paper, *Towards a Model of Mutual Engagement Community Programs across the Uniting Church in Tasmania and Victoria* (August 2017).

Key points from the Discussion Paper include:

- Uniting Church congregations are ageing, and reducing in size and number. This presents challenges for many of the community initiatives which are currently managed and supported by the congregations and/or presbyteries, and also the level of support that congregations will be able to provide for Uniting VicTas in the future.

[21] Hallahan, L. (2004) *"Believing that a Farther Shore is Reachable from Here". Mapping Community as Moral Loving Journeying* p.35, in Newell, C. & Calder, A. (eds) *Voices in Spirituality from the Land Down Under. Outback to Outfront.* London, Routledge.

- Ambivalent attitudes of congregations towards Uniting VicTas and the implications of this for future sup ort for Uniting VicTas.
- Concern about the extent to which congregational initiatives represent potential liabilities for the Uniting Church and Uniting VicTas. There is a sense that while congregations initiate small scale initiatives, once these programs grow and take on more substantial responsibilities they should be transferred to and managed by Uniting VicTas.
- Possible options for strengthening the relationship between congregations and Uniting, with a view to ensuring ongoing congregational support for Uniting, and to identifying mechanisms whereby Uniting VicTas might support congregational initiatives.

The paper outlines four types of relationship between Uniting's founding agencies and Congregations/Parish Missions across Victorian and Tasmania:

- **Partnering Congregations** share significant physical, personal or financial resources with the founding agencies and now Uniting VicTas. These congregations actively partner through multiple channels including prayer, advocacy, the provision of goods and money, access to properties and facilities, and volunteers working to support Uniting's Identity and direction.
- **Supporting**: congregations provide some level of support to Uniting including financial assistance, food and goods donations, volunteering, referrals and prayer
- **Incubating:** congregations are evaluating their community ministry and/or investigating deeper involvement in community services and innovation
- **Others:** those which receive Uniting VicTas information, but may not support Uniting VicTas or may support other organisations.

Whilst accepting that Congregations will choose their most appropriate connection, Uniting will aim to move all congregations toward the "Partnering" relationship.[22]

*" While congregations and Presbyteries are responsible for the direction, structure and objectives of their programs, Uniting aims to provide resources, guidance and support to ensure these programs are successful, minimise risk and positively impact the community."* [23]

There may be situations where a transfer of responsibility to Uniting VicTas could be desirable; however, it would be important to examine the extent to which members of congregations and presbyteries would be able to maintain:

- responsibility for the direction, structure and objectives of their programs, and
- maintain their sense of 'fulfilling their mission'.

With the general trend toward increasingly corporate and centralised community services, there is a growing divide between the culture of these funded community service agencies, including Uniting VicTas, and the emergent culture in which local community and voluntary initiatives grow and thrive.

It can be assumed that these different perspectives account in part for the significant level of ambivalence in the attitudes of congregations toward the newly formed Uniting VicTas (36% feel unsure or certain that Uniting VicTas does not positively represent the mission of the UCA). [24]

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[22] Martin J Cowling, 29.08.2017 (Uniting VicTas),*Discussion Paper: Toward a Model of Mutual Engagement - Community Programs across the Uniting Church in Tasmania and Victoria*, p23

[23] Discussion Paper, p6

[24] Martin J Cowling, 29.08.2017 (Uniting VicTas), *Discussion Paper: Towards a Model of Mutual Engagement Community Programs across the Uniting Church in Tasmania and Victoria* (August 2017). p.16

The Discussion Paper references the important work of Dr Ian Bedford who has written papers on successful congregational community programs. He notes that while *"community services [have been] occasionally studied ...the process by which they come into existence and then operate...has been poorly recognised or understood."*[25] He outlined three factors that must align in a congregation for a community ministry to be successfully established and sustained:

**Culture**: The presence of a culture within the congregation which endorses and legitimates the inclusion of community ministry. Some congregations see these type of programs as a "distraction" from the "real business" of preaching and teaching whilst others see them as emerging with or in response to those practices.

**Coach**: The availability of a person or group of people with time and capacity to nurture such a development. This person may be the paid minister of the congregation or a layperson or a group. They will feel "ownership" and have commitment to the success of the opportunity.

**Catalyst**: The awareness of the need for the work which triggers this development, at this point in a congregation's history. This is usually the awareness of a need within the congregation or community through observation, experience or external request.

It is suggested that to this could be added a fourth: **Capability.**

In an insightful article: *Outlining a Framework for Understanding Congregational Community Services Processes, Urban Life Together: Inhabiting Our Neighbourhoods*, Ian Bedford presents two case studies of congregational initiatives. The first initiative follows a common trajectory of instigation of a community initiative by a local congregation, and its growth into a funded community service, resulting in a loss of local ownership and sense of mission associated with the service. In the second case study, the congregation makes strategic decisions to ensure that the initiative remains as a congregational initiative: *"A strategic intent which.... offers a future that may well help ensure an important community ministry that expresses a congregation's quest to be a people of faith in their particular location can indeed be retained, if that remains the congregational goal. "* [26]

It is understood that the Synod was to have distributed the Discussion Paper for consultation with congregations in late 2017 and that a forum will be held in March 2018 to:

- explore views about the role which the newly formed Uniting VicTas may have in relation to community initiatives currently supported by congregations, and
- test the proposal for Local Engagement Groups as a mechanism for building the relationship between Uniting VicTas and congregations. [27]

The VicTas Synod recognises the importance of raising "awareness of the size, scope and value of community programs being provided by congregations and celebrating across the church and wider community this success story. .... and to work with the newly established VicTas Synod Mission and Capacity Building Unit, to assist in developing strategies for congregations to involve new expressions of church, traditional congregations, the wider community and Uniting VicTas to help build and maintain sustainable local programs. [28]

In the context of these discussions and deliberations, it is important that the work of Dr Ian Bedford be considered, and that his specific advice on partnerships between congregations and funded church agencies is heeded:

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[25] Bedford, I.A., 2015, Outlining a Framework for Understanding Congregational Community Services Processes, Urban Life Together: Inhabiting Our Neighbourhoods, Urban Seed, Melbourne, p. 10. See https://www.urbanseed.org/publications/articles/2015/11/12/u9md70cm61esig18awanfoo12f633p

[26] Bedford 2015

[27] Discussion Paper, p23

[28] Discussion Paper, p12

*"It is crucial, however, that any partnerships developed genuinely recognise and respect the intrinsic attributes of congregations, among which are their potential for less formal and more flexible involvement, their access to supportive community with its various resources, and their stronger connection to ... spirituality"* [29]

Like many other aspects of church life, the Yarra Yarra Mental Health Ministry, faces a choice between remaining informal, and largely voluntary, but imbued with a very personal sense of mission; or seeking and accepting funding to provide a more formal type of service.

The particular place of congregational initiatives is highlighted by Rev Andy Calder (VicTas Synod):

*'The church should be about finding ways to be receptive to difference – we need to redefine the margins* ***where we are prepared to go*** *where the rest of the community won't go.....that's the potential strength of the church. But this is particularly complex when you dovetail with bureaucratic requirements – how can you not be thrown off the central game? That's the challenge.'* (From Interview with Rev Andy Calder)

The Yarra Yarra Mental Health Ministries may find the work of Dr Ian Bedford valuable in forming a view and developing strategy on behalf of the Presbytery to guide the future development of the ministries. See further comment on these issues in the Challenges and Opportunities section of this report.

Further exploration of the potential for a relationship with Uniting VicTas should be undertaken, but with a clear view about the importance of maintaining the vital connections with the congregations, and strategies to ensure that the 'spirit' which vivifies the Mental Health Ministries is maintained. The current approach is cherished as an embodied expression of Christian mission by participants, volunteers, the co-ordinators and a wide range of other stakeholders.

Further exploration of a possible relationship with Uniting Prahran (UP) should also be undertaken, as UP now has responsibility for Eastern Victoria (mental health), and has indicated a willingness to explore potential for collaboration with BCO and UP BCO and *hope springs*.

[29] Bedford, I.A. 2004, REACHING OUT BEYOND ITSELF A Framework for Understanding the Community Service Involvement of Local Church Congregations. p266

# KEY FINDINGS

## Summary of key findings from Focus Groups and interviews

The points below are some of the things people from the different sets of focus groups told us about the activities at *hope springs* and BCO

## Participants at *hope springs* and BCO

Participants expressed very high levels of satisfaction with their experience of BCO and *hope springs*. In particular the following aspects of the program were identified as the keys to a quality experience:

- The welcoming atmosphere – anyone can choose to come along and drop in
- The strong sense of community – no sense of 'us and them'
- Feeling safe and secure
- The opportunity to 'be myself' and feel acceptance even when feeling unwell
- Strong appreciation for the church as the provider – respect for the way that the program aligns with mission
- Opportunities to explore spirituality and existential questions
- The sense of being empowered which was identified as stronger than more formal services
- The opportunity to share a healthy meal in the company of others
- Opportunities to take on more responsible volunteer roles
- Opportunities to engage in structures programs with others who share their interests
- Knowledge of community and resourcefulness of program leaders which can facilitate access to other supports – District nurse , Centrelink etc
- The power of being able to give back to others at *hope springs* and BCO and the broader community
- Opportunities to make friends
- The opportunity to connect with others who understand your lived experience of mental illness and/or marginalisation and to tell and share your stories
- The Fun!

## Volunteers at *hope springs* and BCO

- Ability to explore different roles - Bringing different gifts & skills to help shape the communities
- The feelings of reciprocity – the power of giving **and** receiving
- Being a listening and empathetic ear in dark times - and also hearing the joy!
- The opportunity of fulfilling personal and congregational mission
- The value of being able to make a long term commitment – leading to rich friendships and associations and a sense of being part of a movement in response to an important community issue
- The ability to explore linkages and partnerships with community organisations – eg Trinity
- The sense of solidarity between volunteers
- Informal support, limited training (not apparently problematic)

- Importance of inspirational leadership and role-modelling by program co-ordinators and others and the reliability of this leadership
- Concerns regarding the sustainability of the leadership given the incredible commitment shown by program coordinators and limited funding available to support the program

## Local workers in Inner East and North East

- The uniqueness of the program which is now in short supply due to the changes in direction in mental health and the introduction of the NDIS
- The informality of the program which makes it accessible to people who may not engage with more formal services
- The ability for the programs to address issues of chronic social isolation and to develop meaningful connections for people
- Concerns regarding program sustainability - would like to see the capacity of BCO and HS increased
- The power of the church to play a role in advocacy to do things that other more formal services are not able to do
- The ability to engage with people who are homeless or marginalised through outreach and a quasi-case management approach
- Capacity to understand and know the community was the church is based in the local community and is a key player in local planning and development
- Capacity to work with those who 'fall through the cracks' despite having limited funding
- Commitment to fulfilling mission through service to those most in need and not evangelising

## Congregations

- The mental health work's obvious link to mission is critical
- The potential to mobilise support within the church and of others in the wider community to engage with people living with mental health issues
- The range of opportunities the church congregations provide on a limited budget including drop-in, structured programs, outreach, visiting hospitals in a formal chaplaincy role, arts programs, adapted liturgy, advocacy etc
- The sustainability of the programs, the rich history, and the fact that they are still going and that people have hung in there
- The capacity to explore and innovate
- The number of people with mental health issues who are valued members of congregations
- The ability of the congregations to deal with and work through the issues of inclusion
- The need for more information and capacity building for congregations
- The potential to explore network development across congregations in each 'sub region' and the Yarra Yarra Presbytery
- The need to better articulate the model and identify different ways in which congregations can support the work of the mental health missions
- The challenges associated with getting people to understand what is being done and why it is important when finances and resources are limited

# Findings - *hope springs* and Boroondara Community Outreach

## What these Open Door Communities provide

Despite the limited funding base the three ministries have developed a sophisticated practice model that responds to people living with mental health issues. Guided by the ethos and principles of Christ's message of service in the Gospel, this practice model is a powerful way of connecting with people who are marginalised and in need of support and engagement in a community that cares.

Often the work of the Mental Health Ministries is described in a narrow way, as merely providing a drop-in and/or meals program. With the reform of the mental health community support system and its preoccupation with more individualised service responses, drop-in and other group programs were either defunded or discredited.

Our research in relation to the open door approach as described by participants, volunteers, ministers and paid staff identified a rich narrative describing the dynamic and responsive nature of the approach as a community creating strategy. While the ministries do provide individual support and pastoral care, the key objective is to connect people who are isolated to a welcoming and supportive community – through the 'open door' outreach communities, and to also provide the option to connect with welcoming congregations. These could be described as 'communities of hope', which affirm the inherent value of the person, and embrace individuals regardless of their particular difficulties. These 'objectives' are very different from the individualised approaches in the mental health services, which focus on reducing symptoms/health issues, and so establishing 'independence' and a reduced reliance on services. While the optimism of this 'recovery' model is appealing, for many people who experience chronic and severe mental health issues, expectations regarding recovery need to be grounded in a community which is politically alert to their needs and aspirations.

The assumption is that the quality of life issues for people living with mental health issues will be resolved if they have fewer symptoms and require fewer mental health services. However, the experience of severe mental health issues has wide and deep impacts on the person's sense of themselves, their self-confidence, social relationships, and very often their economic status due to long term unemployment, and associated housing instability. Highly individualised approaches can have significant limitations addressing the broader quality of life issues for people, their social isolation, and the stigma they experience as a result of mental health issues.

In the rich and nuanced descriptions of how people experience the support provided through the Mental Health Ministries we can more fully understand just how the open door communities are valued by those who often experience loneliness, isolation, and poverty as well as mental illness.

While the drop-in/open door communities are a central part of the ministry, this is not the whole story. The complementary strategies around the open door/ drop-in communities are very important elements of an informal and effective model of community engagement and support for people living with mental health issues.

## *Bearing Witness and Sharing Stories*

*Changing the story isn't enough in itself, but it has often been foundational to real changes. Making an injury visible and public is often the first step in remedying it, and political change often follows culture, as what was long tolerated is seen to be intolerable, or what was overlooked becomes obvious. Which means that every conflict is in part a battle over the story we tell, or who tells and who is heard.* [30]

[30] Solnit, R. (2016) Hope in the Dark. Untold Histories, Wild Possibilities, London, Cannongate. P. xiv

*'The thing that often doesn't get mentioned is that in this space somebody knows my name and knows my story. We, in this space, bear witness to people's stories in a different way to a clinical setting. You and your story get minimised in a clinical setting to a narrative of mental health issues. So if you want to talk about what's good for recovery, that's what's not good for recovery, because everything is about the mental health issues. They come with a framework that is about mental health issues. They say that it's not but it is. But here your narrative is way bigger than that. Here we are all human and we've all got stuff – you've got schizophrenia I have other things, whatever. People can become known as artists or play their guitar and can be musicians. Half the time we don't even know what their diagnosis is. But most importantly people get to share their stories'.* (Rev [redacted] BCO)

Having a place where you can share your stories with others who have similar experiences who understand what you are talking about is extremely important to creating a sense of personal well-being and community.

This can be described as biography work – a 'facilitated' conversation which supports an inquiry into people's lives about what matters to them, what works best for them, what helps them to discover hope, and how we might work together to respond to those hopes.

*'We had exactly that story with [redacted] sister [redacted] almost word for word what you just said. [redacted] (a long term member of hope springs) had lung cancer and was dying - he had been estranged from his sister for a long time. The church community and the hope springs community visited him in hospital, looked after him and made sure everything was okay at his house until he passed away. [redacted] was there throughout this time and I went to the hospital to visit him.....But we had no way of contacting his sister - we had no connection to her. When he died the State Trustees rang her and I eventually got her number and I was the first person that his sister spoke to. I talked to her about [redacted] and our connection with him and explained what we had done and how we looked after him. There had been estrangement with the family and [redacted] had a lot of anger towards them. However we then had this wonderful opportunity to get together with the family and others who were close to [redacted] including [redacted] and we talked to his sister about his life. We then planned the funeral together, and then we scattered his ashes at the church camp in October, which was something [redacted] always looked forward to. So that there was this wonderful healing opportunity for her after-the-fact; it was quite an extraordinary thing. She said she had never expected that there would be any possibility of mending the relationship with her brother - to be able to put that down and deal with it there and for us just be able to kind of give Ian him back to her. For us just to be able to say the things about her brother because we knew him when he was well or in much better shape after the break with the family... This was so important. We were able to talk about the way he cared for other people. He was always the one who would ring and say so-and-so is not well and you need to do something about it [redacted] He was able to provide wonderful care for all sorts of people, he was very generous. So if you get the idea that it's us caring for them it's patently untrue it's happens in both directions. That's part of it being a community'.* (Rev [redacted])

This moving story told by [redacted] demonstrates the capacity of the ministries to engage and connect with people in deep and meaningful ways as friends and companions. It is only through this deep connection that you discover the essence of people's lives and develop a capacity to stand beside them and to listen to their story. There is something deeply moving in [redacted] story because it is redemptive - it gives [redacted] back to his sister and to his family. It is a process of re-storying[31] [redacted] life revealing a tale of meaningful contribution and a capacity to be loved and centred in a community which previously Ian's family may never have thought possible.

[31] This capacity for 'restorying' is captured in the work of sociologist Arthur Frank (1995). For example in *The Wounded Storyteller* (1995) he describes the way medicine colonises the ill or disabled body reducing the personal narrative to a story prescribed by the parameters medical professionals. Frank alerts us to the potential for stories to expand the sense of meaning we attribute to illness and suffering when we centre 'the wounded storyteller' as the central player and author in their own lives. By approaching the illness narrative from a range of perspectives and listening deeply to the meaning in the story from a range of contexts we open up all sorts of possibilities for people and their families to find hope. The act of listening deeply, and without prejudice, is the basis for an ethical practice, and a political project, which centres people with mental health issues as the central storytellers around which relationships, supports, resources and communities are mobilised.

This process of re-storying can be very liberating for people because it is based on trust, friendship and investment in relationship that is ongoing. It centres people in the narrative of their own lives, a narrative which is elicited and reinforced through relationships with fellow participants, volunteers and paid workers.

The capturing of collective narratives [32]through artistic expression is also a powerful way to centre stories in people's personal experience.[33] The art activities, writing, and the annual performance at Kew (supported and facilitated by professional community arts companies like Barking Spider Theatre)[34] provide an opportunity to transform personal stories into powerful collective narratives which can be drawn on to politicise mental health issues and promote awareness in community of the needs of people living with mental health issues.

## A Resource of Hope

*To be able to hope for me is a huge thing. People need to have meaning and some sense of identity, and belonging and hope - those things are really huge for people. Hope and meaning holds onto people; they grip people. It holds on to me; it holds on to you. People are trying to find an anchor. They have got no family and very fragile social networks so they need to anchor on to something so they can cope with the storm. That's why people come here and present when they're really unwell. They present because they know I will ring the CAT team but that's okay if I ring the CAT team. They know they will be alright. You couldn't do this if you didn't have this space to develop those long-term trusting relationships. You can't do this stuff without this context. You can't do it in a clinical setting.* (Rev. [redacted])

The communities at BCO and *hope springs* represent a resource of hope for people because they are able to negotiate membership into these contexts and cultures without having to disclose about their health issues. This is liberating for people because there is a sense that they will be seen as a person first and not as a mental health patient. The opportunity to negotiate the terms of their community membership based on more deeply held aspirations, convictions, shared interests and sources of meaning and connection provide a powerful sense of hope for the future.

## Beyond Brokenness

*'What is really important about these open door spaces is that you don't have to pretend about anything. Out there, every time you are on a tram people have got to manage their social phobia, manage the voices, make they sure don't look so weird, make sure that they do this and they do that. There is incredible burnout there*

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[32] Narrative theory and the art of story capture may be worth investigating across the three missions. Arts and cultural development projects provide exciting and imaginative ways into story capture. The stories across the three missions are rich and would be very enticing for skilled and experienced arts and cultural development workers contracted to work across the three ministries. Borderlands at the Augustine Centre also runs workshops focusing on story capture. These are one-day workshops which could provide a framework for working across the communities to develop processes for eliciting stories, finding the meaning in the narrative and documenting them in exciting and accessible formats.

[33] Many arts program were defunded with the Recommission of Community Mental Health Support Services in 2014. This included long-standing and highly reputable programs such as NEAMI'S Splash Studios and The Stables Art Studios at Prahran Mission. The power of the arts to transform individual lives and communities is well founded in national and international research. Armed with this research and evidence from their extensive range of programs, ***Arts Access Victoria(AAV)*** lobbied the State Government about the demise of art programs in mental health and received funding to establish the ***Connecting the Dots*** program. Resources from Connecting the Dots are now available on the AAV website. They draw on the lived experience of artists with mental illness about the value of artistic engagement in their lives and its importance in mental health and well-being. https://www.artsaccess.com.au/connecting-the-dots/
Other resources which promote arts and mental health and well include:
https://www.arts.gov.au/sites/g/files/net1761/f/arts_disability_0110.pdf; Promoting Mental Health through Accessing the Arts, Prepared by John McLeod for VicHealth, September 2006; Making Art with Communities: A Work Guide. May 2013, https://www.vichealth.vic.gov.au/media-and-resources/publications/making-art-with-communities-a-work-guide - This is an excellent resource for inspiring and guiding community cultural development practice;

[34] http://barkingspidertheatre.com.au/

*with all of this. There is nowhere they can go to feel safe. Well here, there is a sense that I can be as mad as I like and I know it's okay and when I relax into that I actually feel quite good and not as mad as I think I am because, actually that feeling of madness comes from the anxiety and stress of living in a community where I am so stigmatised'.* (Rev. [redacted]

[redacted] description of the welcoming community resembles the old idea of 'asylum', or 'sanctuary' - the provision of a place in community where you can go for timeout and experience a sense of being unburdened and released from a world where you feel disabled. The sense of being broken is exacerbated by the stress associated with living in a world where you feel marked by your health issues. It's not that you are not feeling unwell when you're at BCO - it's just that in this place they accept you for who you are because there is a capacity for this community to provide empathy and mutual understanding for how you are feeling – to embrace you and not to exclude.

*'I think over time we have developed a very strong sense of community at hope springs which people feel when they come along. I think people find it fairly easy to fit in because it is a safe place where they can quickly develop a sense of belonging. And by looking around they can see that there is a lot of friendship and caring and understanding. Some might be just sitting having a smoke or a coffee, others might be playing pool but all these things are just provided by ordinary people like themselves. So there is a sense that I'm okay here even if in other places I am not so okay. I'm okay here, however I am feeling today. And people support each other to ride those ups and downs. I also think you get your mental health issues overemphasised by comparison to others in the community but here they are played down because you are in a position to contribute to the well-being of other people too'. (anon, hope springs)*

## *A Safe Place*

*The feelings of safety here are legitimate because people with mental health issues are the victims of crime; they cop crap all the time; look at that psycho over there; here comes the crazy woman into my shop when she is only going into look at a pair of shoes. That bombardment of negativity and criticism is so disabling. In that context safety is so important and that is often overlooked as one of key benefits of drop-in. Even where they live - Rooming houses are not safe places; there is no privacy there; things are stolen. Here they come to a safe place and know there are staff and volunteers who will keep them safe with no judgement. The unravelling of that life stress and the ability to relax in a safe space creates wellness for people because otherwise they can't get off the treadmill. Where are the community spaces where you can sit and just be and not be afraid of being asked to move on? At the pool you can be just sitting there and be suspected of watching the kids but really you are just gazing in a catatonic state. All of this creates stress. Whereas here at BCO we create this incredible relief of coming to a safe place where you are just held, and in that sense of being held, there is a knowing that someone will keep you safe. This enables you to tune out of the survival mode. I don't have to watch my stuff here. I don't have to watch my back. This is a space I can actually engage where I can move from survival to actually living. That's just completely dismissed because Drop Ins or open door communities are looked at in this narrow isolated way. But you've gotta put it into this context to really understand what shifts for someone when they come here.* (Rev. [redacted], BCO)

One woman who lives in a large SRS attends *hope springs* regularly, and mentioned the sense of relief at being able to relax and enjoy the friendly and supportive environment, which is different from her 'home'. Many people who attend the Open Door Communities live in insecure or large group housing arrangements where there is little sense of sanctuary, and no assured safety.

## *A place for self-expression - and "to be myself"*

*A bird does not sing because it has an answer; it sings because it has a song.* ([redacted] BCO)

This opportunity for self-expression resides in the opportunity to just sit and be and feel a part of the place. It also includes the opportunity to be part of the choir, to tell your story through your emerging visual arts practice, to be part of the band and engage in regular weekly practice, as part of that band to hear your music on 3CR and/or perform your music with the band on special occasions at Christmas time or during National Mental Health Week.

*I don't think it is the art so much, I think it's being in the group its acceptance. There is no pressure; if you don't want to draw you can just sit there. We don't push them. We set up things for them to do. That works as often people have their own practice. It's often good to just let people go and encourage them and help them so that they end up with artwork that they are happy with. There is a lot of quiet when people are working and this brings about a sort of mindfulness. When you're working with this mindfulness you are dwelling on the work, and that can help to deal with the feelings of negativity. I think it's great that anyone can come, and there are no criteria that you have to meet to be able to come and participate here.* ([redacted] volunteer, *hope springs*)

In a spiritual context it is about the ability to engage in conversations where participants can express their spirituality through inclusion in mainstream church services or in church services which have developed an adapted liturgy based on people's particular needs, capacities and interests. The opportunity to express oneself in deep and meaningful ways through engagement in church services and to position your personal story within the collective in the presence of God, or at least a higher authority, is a very powerful means of affirmation and self-actualisation.

People bring a diverse range of needs, abilities and aspirations to the ministries. Whilst at times this diversity creates challenges it also provides an opportunity for the church community to develop flexible and creative activities and responses which reflect the expressive diversity of their congregation. In this context the challenge for the congregations is not to be too prescriptive and to realise the opportunity for the development of new church rituals and spiritual expression that are responsive and meaningful for people living with mental health issues. A sign of an inclusive community is when people can see their needs and aspirations reflected in the programs, events and rituals that shape the church culture.

## *'God Hospitality'*

*'Consequently, because people are working long hours, they don't have enough time to volunteer or show an interest. People are not interested in our plight in life. Places like hope springs are ideal because we have a place here where we can relate to one another. This does not happen out there'.* (John, *hope springs*)

The power of the Open Door Communities is the welcome and hospitality extended to all in the community who need a place to feel connected and to find friendship.

[redacted] described this as extending *'God Hospitality'* to those who are most vulnerable and isolated – to the strangers in our midst who for whatever reason are experiencing difficult times.

*'We talk a lot about hospitality that's a really key thing for us. Our aim is to offer hospitality particularly the hospitality of God. God's food; God's compassion; God's care – God Hospitality is a really big theological ideal for us. The hospitality of God is offered in the bread and in the wine - that's a really important point for me. Hospitality for me is welcoming people regardless and not because they deserve to be here. All the barriers disappear it is about unconditional welcome no matter who you are, where you are from or what your label is, you are just accepted for who you are. That grace enables you to come here and you are welcome, you are accepted for who you are'.* (Rev. [redacted], BCO)

*'Hospitality is one of the most important things - even if you look at our Leunig symbol that we use for hope springs it's all about using this as the symbol of hospitality. This is part of the culture of hope springs – it is one of the most powerful parts of the culture. It is about accepting all people for who they are'.* ([redacted] *hope springs*)

In shaping and building places that provide this sense of welcome lies the key to restoring hope and meaning in people's lives. Providing food and a meal such as the Tuesday Good Grub lunch at BCO is God hospitality in action. People spoke very enthusiastically about Good Grub - the quality of the meals and the companionship inspired by sharing the Good Grub meals is very important. A healthy and generous meal provided by willing volunteers who have a long-term commitment and connection to the people in the program, sets the tone for the hospitable culture that is so alluring for people who otherwise might feel reluctant to engage and get involved.

## *A 'Diagnosis Free' Space*

*'..... I have five clients who come here to the Monday group which is just sensational. There is no criteria - I can just say to* [redacted] *'can I bring some around to have a look', and there is no paperwork to fill out at all. There are no criteria that you have to fit before you can join in and there is no judgement'.* ([redacted]).

*'There is something clean and clear about this model - you don't get a sense that it's a mental health service; you just get a sense of walking in and saying G'day and being with people..... And the other great thing about hope springs is that it is mental illness nomenclature free'.* ([redacted])

*'You don't have to worry about what people are diagnosed with in a place like hope springs. I just want to emphasise that the great thing about the groups here is that you can come when you want to - it can be every three months or every week or twice a week or whatever. If you come to the group you don't have to join in, you can sit outside, and even if you're in the group, physically in the group, you don't have to participate - you can participate in your own way. I have people who come here, but won't go anywhere else because they know here they have no pressure on them. It's just so important to be able to come somewhere and this is the place; and I have not been able to find in 12 years anywhere else like it. There may be other places like it, but I don't know them'.* ([redacted])

The stigma associated with mental health issues is often exacerbated by the need to constantly provide a diagnosis and history of your health issues to get access to services and support. One of the benefits of the approach at BCO and *hope springs* is its capacity to engage and connect without putting people through the rigours of disclosure. This 'open door' approach provides a different starting point where you connect with people first, and then in time, when people are comfortable, you begin to find out about their lives and can create a response which best supports them to meet their needs.

*'People are free to be there because they want to be there. People using clinical mental health services get thoroughly sick of going over and over this story of their health issues and are constantly reminded of their condition and their dependency on the service. hope springs says to people, 'we are different to that', we are not a clinical service. We are here because we want you to enjoy each other's company and to do something that you find relaxing and enjoyable. And also, just to be yourself and get in touch with some of your previous interests and to develop new interests too. It's different; it's not clinical and that's why the government won't fund it because they're focused on cure and recovery - so that they can get you out of the system and off the books'.* (Rev [redacted])

The support provided adds depth to people's lives in terms of relationship to people and to place. Having somewhere you can go along to, where your involvement is unconditional, which is part of your regular routine, and where you are valued, provides an undeniable source of meaning and purpose in your life.

*'A farmer brings life to the desert – that is what this place has got. They are little oases in the desert. You don't need professional people who just don't understand – there is a place for them but this place adds something special to people's lives. I used to believe in the medical model but it was stuffing me up. When they got rid of the psych hospitals places like the Boomerang Club started up in response but then they got rid of them. It's a bloody mess'.* ([redacted] BCO)

*I like the fact that they remember your birthday and provide birthday cakes on the day. And I also love the fact that I have my own special chair here.* ([redacted] *hope springs*)

This also extends to the connection with volunteers who are also there to provide support and friendship and are marked as clearly outside of any formal service system response. The fact that they have taken the time to care is not lost on participants in the programs.

*There is a lot of giving here. The volunteers are focussed in that direction and you are treated civilly, and we like it.* ([redacted] hope springs)

## *A More Egalitarian Approach*

*'Can we just have more places like this. If only other places were run more like Kew, with love and without all of the rules. Here it is all in together like a family'.* ([redacted] BCO)

*Even though there is a hierarchy it's not what you see. You see that we're all one community working together with different abilities and capacities. We all know who the leader is though and we all know what our roles are but it's a very flat structure..... it's the same stuff that you would do in a much more rigid, vertically oriented organisation. It's the same stuff, with the same quality with a different look about it and a different feel about it - that's a lot of what this leadership is about.* ([redacted] *hope springs*)

One of the key disincentives to engaging in the formal mental health system is the 'us and them' nature of the relationship with professionals – the client/doctor (dis) connection. Participants at both BCO and *hope springs* feel a great sense of relief that the lines are blurred and there is not a feeling of 'us and them' , but rather a sense that everyone has a place, and a contribution to make in that community.

The power of the ministers' role is greatly enhanced by the flexibility around the way the role is interwoven with multiple responsibilities of community worker and community leader, friend and volunteer. [redacted] role as the minister is far from the stereotypical role of minister, and this enhances her ability to engage with and influence participants, local workers, community leaders and other stakeholders:

*'She is a minister but she is just so laid back'.* ([redacted] BCO).

*Everyone is in it together – I liked it because for ages I was coming along and I didn't realise* [redacted] *was a proper Minister because she does everything but when I went to church I realised she was a proper Minister when I saw her dressed in her robes.* ([redacted] BCO)

[redacted] *is like a mediator she helps you to talk through your troubles. She is a friend as well. I've tried talking to a psychologist when I have felt stressed or unwell but they just tell me to take deep breaths or go for a walk when I am stressed. Psychologists can't react to what you go through personally – they just offer prescribed solutions.* ([redacted] BCO)

*She helps to facilitate us doing things for ourselves. We are empowered by realising we can make choices. Talk is important too - it helps to facilitate dialogue between [redacted] the volunteers and ourselves ...it is not a top down approach. ([redacted] BCO)*

And [redacted] speech at [redacted] father's funeral is also appreciated and an example of the sense of companionship between staff and participants: *"At hope springs they cross boundaries – [redacted] spoke at my Dad's funeral".* (T[redacted] *hope springs*)

## *Working 'out of the square' – flexibility and boundary 'busting'*

Boundary busting refers to the empathetic style of work adopted by the ministries inspired by the ethos of the Gospel and Christ's example as a rule breaker and challenger of the orthodoxies that constrain and oppress. There are situations in which boundaries need to be challenged in order to address the structural and organisational systems that make peoples everyday lives so difficult.

Rule breaking and boundary busting also opens up opportunities for a stronger politics of mental health focused on whole of person responses which are cognisant of the whole of community structures and systems which disable and/or enable people to live manageable and meaningful lives.

The ministries are also more open to flexible and creative responses and are not as constrained by the focus on risk that is more present in formal organisational cultures. The role of the minister opens up possibilities to connect with people in ways which are outside of the usual role of 'worker.' The minister has opportunities for forming relationships based on openness, and a shared humanity which produces a sense of 'companionship' which is not available to other 'workers'. In contrast to other workers, the role of the minister is not as strongly mediated through the organisation.

*'[redacted] is the personification of a minister. She tries hard to include everyone in her work. That's what I mean about the social side of things. When I was in hospital it was so special when [redacted] came to visit me with her daughter. It was so important to me that she bothered to come and visit me.'* ([redacted] BCO)

The multi-faceted role of the minister working in the community is captured by Laurel, a worker at the Community Recreation Outreach Program in Hawthorn:

*'Even though she is connected to the Uniting Church [redacted] work is also non-denominational. And its non-judgemental .....She performs her role as chaplain – she still does the pastoral care and engagement but in a really subtle way. It's not conditional for Nat. The religious side of it is not conditional for how she works. And because she lives in the community in Kew I think she connects really well with it. She can see the gaps. So that, when she advocates, it is from a position of knowledge and experience'.* ([redacted] CROP )

[redacted] *has no label for her role. .....what she does from one thing to the next or from day to day changes depending on what people need.* ([redacted] BCO)

*When Jesus walked the earth he knew about accepting people. He knew when to go forward and reach out and when to hold back. That's a bit like here at hope springs.* ([redacted] *hope springs*)

That is not to say that there are no rules and no boundaries but they are much broader than is usually the case in formal government funded programs. In these 'communities' there are tacit norms and expectations, and high levels of mutual respect which mean that people in the community generally understand and respect the boundaries – it is rare that overt intervention is required to moderate individual's behaviour.

*'This doesn't mean that there are not expectations about how people should behave. People do have rights and responsibilities and there is an expectation of respect for one another. It's not that you can come and do*

*whatever you want. Everybody's welcome but there is an expectation that people are respectful towards one another. One of the things we do is the mentoring of social behaviours. A lot of people have learnt antisocial behaviours just to survive and then their lives become a bit of a self-fulfilling prophecy where they are rejected by family and community. These learnt antisocial behaviours enable them to become streetwise and this helps them to get by and they go to a more formal service and they find that that they get banned. And then hope springs is the only place that will end up having them.....I think that what happens is that when someone is banned, if you take the time to respect them, and sit down and have a conversation, then they get a sense that, despite what they have done, you're prepared to talk to them, then they feel valued. What I often say is that if 'someone does that to you then I will kick them out too', and then they understand it. When you respect someone enough to have a conversation with them, they feel valued. There is a sense that if we value them enough to try to work it out, then they trust you and will want to come back and do the right thing by you.* ([redacted] *hope springs*)

*'It is not that there are no boundaries but there is a mutual reciprocity where some of the boundaries compared to other professionals are different. Some people's support workers won't share anything personal....but people at BCO love to see – for example - funny pictures of something my family did on the weekend. But they are so respectful of my family's need for space. They all know where I live, yet I can count on one hand in the last 5 years someone turning up to my front door - and they were really serious crisis situations. They don't ring after 6pm and weekends except to leave a message asking me to call asap on Monday. Our experience confirms that genuine human reciprocity in our relationships translates into respect for personal boundaries. We also see it playing out in respectful relationships and interactions between participants in our activities. It is a very different approach to the way workers in the funded community services deal with boundaries.'* (Rev. [redacted] BCO)

The contrast between the experience of receiving services provided in a professional context and the more open relationships fostered at BCO and *hope springs* was mentioned often by people in the focus group discussions.

*You can go to a social worker for help but it's not like coming to a community.* ([redacted] BCO)

*They can't put themselves in our shoes..... what we have here is fantastic. You need places like this to make things work for us.* ([redacted] BCO)

In her statement below, [redacted] highlights the difficult terrain of relationships with workers where the personal nature of the more 'professionalised' relationship is not properly acknowledged by the worker:

*With mental health services you can't cross boundaries. They want you to be as independent as humanly possible. But when you have been with a worker for 3 years you develop a relationship with that worker and when you lose that worker you go through a grieving process.* ([redacted] *hope springs*)

## *"A Place to Use My Skills"*

There is pride in people being able to develop new skills and use those skills in the context of the BCO and *hope springs* communities and also more broadly in community events or through arts and cultural development activities. Seeing your skills are used to help build community is also a source of great pride for people. Here people can use their skills and experience in a number of ways.

*'I've been coming to the art group for 2 years. I have always done art ever since I was very young. I like abstract and surreal art. I like to do my own thing and also offering comments to other people in the art groups because often they don't have much confidence. My motto is that there are no mistakes in art. I feel like I am a bit of Svengali here. I really enjoy wandering around and helping others. Before joining here I was in a bad space. But I was invited in and met Jon and instantly liked him – he is a really good guy'.* ([redacted] *hope springs*)

*'I came here when The Stables closed down. When it closed down I decided that we didn't need staff. Someone put me on to* [redacted] *and that's how those of us who were involved in the art program at The Stables came across to here. We now have an art studio here. We changed our name to Habitat Art Studio which is run by participant artists. It's great – it helps me to feel like I have something to offer. Having many different types of roles is important. It is very different to the staff/client relationship in mental health services. People here give and they participate at a level they are confident with'. (*[redacted] *BCO)*

And skills are also offered to the broader community through activities like the community choir at BCO which regularly visits nursing homes to sing for the residents.

## *An environment for fostering friendship*

*'People I have met at the church are like friends for life. There are 50 friends at the church. Nobody judges. We've all got there for different reasons; everyone treats one another well. It's more community than church. And if people don't turn up they are missed'.* ([redacted] BCO)

*'It's a lot of intangibles, and this might not be what you're after, but one really big indicator of things going in the right direction for people is the formation of friendships and good friendships, not just friendships with people who are sucking them dry, but genuine friendships. For example in the women's group there are some really strong friendships that have been formed. People have said to me 'it's amazing that so-and-so is a friend now and she actually listens and cares about what I think, and asks me how I'm feeling, and what I am thinking. She just doesn't want to get money off me for drugs and she is not one of those who only wants something from me and then I never hear from them otherwise'. The formation of healthy, strong, enduring friendships are critical .....And I think for a number of people who have really kicked goals in the last 12 months, they are the ones who form strong bonds with other participants and the benefits they are getting from those healthy relationships as opposed to their unhealthy relationships is fantastic. These are healthy relationships with their friends here at hope springs. And again I would say that this is because we are providing the community space where this stuff can happen and when it happens you get good outcomes for people'. (*[redacted] *hope springs)*

Friendship is a critical source of support and connection that helps to reduce people's sense of isolation and loneliness. The communities create a culture that stimulates the key ingredients for friendship development including:

- Promoting higher levels of self-confidence and self-esteem;
- Promoting higher levels of social competence and insight;
- Building capacity and opportunities for expressions of altruism;
- Opportunities to foster new interests and to identify areas of shared interest;
- Providing a safe environment for testing friendship potential;
- Opportunities for developing better communication and listening skills. [35]

Many of these key ingredients are not a deliberate focus, but they are facilitated indirectly through the social atmosphere cultivated within the two communities.

[35] For resources and research on friendship see:
http://www.open.edu/openlearn/health-sports-psychology/health/health-studies/mental-health/why-friendships-are-vital-your-wellbeing; https://www.sbs.com.au/topics/life/health/article/2017/09/15/why-having-best-friend-good-your-health1; https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/friendships/art-20044860 - a brief article from The Mayo Clinic which includes tips for making friends.
Swinton, J. (2000) *Resurrecting the Person. Friendship and the Care of People with Mental Health Problems*, Nashville, Abingdon Press.

*It's a place where you can belong.* [redacted] *and* [redacted] *are really nice people. It's great meeting other ladies and making friends. Friendly places provide the motivation for getting out of the home. And it's a clean and safe place to come.* ([redacted] *hope springs*)

In time friendships have the potential to extend beyond the context of the open door community:

*Over time people increasingly start to invite you to things and start to call you. At first you don't expect anything but eventually you develop friendships. I have some of my best friends here now.* ([redacted]

*Friendships are readily formed here. The good thing is it's getting people out of the house, out of their home, otherwise they are on their own feeling isolated. They often can't drive somewhere so they're stuck but they can come here and all of a sudden there is this whole group of people doing different things. People are outside, in the summer, just sitting on the lawn enjoying themselves in the sun, others are playing pool or table tennis and really good friendships can be formed. Some people also meet outside of here on weekends and do their own thing. There is definitely the opportunity to make friends outside of here.* ([redacted] Volunteer, *hope springs*)

## *Peer Support and Leadership*

*'It helps to be able to talk to people who have the same issues as me – it's sort of like doing a workshop. I couldn't go a week without coming here. It helps so much and is motivation for me to get out of my unit and to be around people and to function properly. It also helps with my anti-social behaviour – I can get out and meet people and change my life and fill it with good stuff'.* ([redacted] BCO)

*'I think peer led activities led by participants rather than by staff, I'm all for that. I think it has to be supported and directed to some extent but only to the extent that people want the support and the resources. Often what is missing is the organisational structure to support it – it needs to be clear what the supportive environment is. In a way I've tried to do that at hope spring – for example the drop in started off as a peer led group. There was a person who was enthusiastic about it and wanted to get it going and to do the brochure - but it wouldn't have happened if we hadn't organised an opportunity to produce the publicity. So peer initiated and led, but also a collaborative effort with whatever support is needed'.* (Rev [redacted], *hope springs*)

'Open door' approaches provide an opportunity to develop peer support [36]and leadership to assist with planning and the design of programs through the missions. There are many examples of peer support and leadership at both *hope springs* and BCO. It includes involvement and management of the arts programs and choir at BCO

[36] The following quote from Sheri Mead in relation to peer support resonates with the type of approach developed at Hope Springs and BCO:
"Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. When people find affiliation with others they feel are 'like' them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships." From: *Peer Support: A Theoretical Perspective* by Sheri Mead, David Hilton and Laurie Curtis (2001) http://www.intentionalpeersupport.org/wp-content/uploads/2014/02/Peer-Support_A-Theoretical-Perspective.pdf
Other Peer Support Resources that the ministries can draw on to inform their work in relation to peer support include:
*The Centre of Excellence in Peer Support in Mental Health*
http://www.peersupportvic.org/index.php/2014-12-15-22-41-32/2014-12-15-22-46-46
*The Understanding & Involvement Project (U&I)*: 1991 -20011 - By Merinda Epstein for Our Consumer Place.
http://www.ourcommunity.com.au/files/OCP/TheUnderstanding.pdf
*On our Own, Together: Peer Programs for People with Mental Illness* (2005) Eds Sally Clay, Bonnie Schell, Patrick W. Corrigan , Ruth O. Ralph, Vanderbilt University Press, Tennessee.

and design and development of alternative liturgies in both congregations. Peer support builds on shared personal experience and empathy, and focuses on an individual's strengths.

The benefits associated with peer support include shared identity and acceptance, increased self-confidence, the value of helping others, developing and sharing skills, emotional resilience and wellbeing, and challenging stigma and discrimination. Peer support can also play a role in building community capacity and is a basis for campaigning and political activism and advocacy.

## *Building a Community*

*'It's good to feel part of a community in your local area. People can be a bit older or a bit younger, it doesn't matter. There are nice people to connect with, and it's great to feel part of something'.* (Bec, *hope springs*)

For many of the participants at *hope springs* and BCO the key to feeling welcomed is the level of informality associated with the communities. These are places you can literally drop in and take your time to connect and feel a part of the place.

*I wouldn't go off with other people who are strangers, people I don't know very well. It took me a long time to make friends here. I like to get to know people first. At hope springs it's like a springboard - you can get involved at a level you feel comfortable with and then you start to feel accepted.* ([redacted] *hope springs*)

*There are lots of activities at* [redacted] *but it's a very different environment. And there is no puppy dog there. You are treated like a client there; here you are a friend of the church. At the* [redacted] *you have to stand and wait at a reception desk, and I might not always feel comfortable about that. You don't know what the receptionist is thinking. They might be looking down at me. At hope springs you can just drop in and make yourself a coffee like it's your own home.* ([redacted] *hope springs*)

Creating the environment and culture that enables people to connect and make friends is a key element of the communities. This is done through managing the space effectively so that all people feel safe and secure. It is also achieved by providing activities where people can engage with others who share their interests (including volunteers). These activities include – the choir, art activities and lunches etc at BCO and the art, women's and music group at *hope springs*.

*We have fun too; a lot of interaction and a lot of fun.* ([redacted] Volunteer, *hope springs*)

Fun of course is another key ingredient for building community. The sense of fun, light heartedness and enjoyment that people get from participation helps to inspire their commitment to the program.

## *Support for exploring spirituality*

Both *hope springs* and BCO have developed a very flexible approach to supporting people to explore their spirituality. Both provide structured Bible Study sessions offered weekly at BCO and each fortnight at *hope springs*. Participants who choose to opt into these discussions mentioned that they were very engaging and personally meaningful.

*'Here we have the best Bible Study because we are free to say what we like'.* ([redacted] *BCO)*

*'On a Thursday we sit in a circle and certainly when I lead it it's very relaxed. People take turns to read; they go in and out for coffee all the time; there is a sermon and we have a reading and people talk about the reading and what it means to them. And people love to light candles and we pray, we don't sing - I have music on a CD or on an iPhone, very quiet and contemplative music. It's not high liturgy'.* (Rev [redacted] Cross Gen)

*'I go to Thursday Worship and Bible Study on a Wednesday night. I like Thursday worship because it is a smaller group and that's where I feel comfortable. The other services on a Sunday are too long and I lose concentration. On Thursdays the minister runs it. The service goes for about 30 minutes and there is a sheet we can read off. We chat beforehand and we can light a candle as part of our prayers .....we can think about who we want to pray for and send good wishes to them. It's quite peaceful without a lot of noise'. ([redacted] hope springs)*

In addition to the small group Bible Study discussion groups, there are different opportunities for people to attend a church service. The Sunday service at the Cross Gen church in Heidelberg (on the same site as the *hope springs*) is a 'relaxed format' service designed to cater for young people, and a broad cross section of people. A number of participants from *hope springs* attend the Sunday service regularly. One participant described the Sunday service as window to the world and a way to locate their faith in a broader social context:

*'I sometimes go on a Sunday. Some of the sermons are really interesting. We hear about people doing missionary work and also about aboriginal issues. It enables you to keep abreast about what is going on in the community'. ([redacted] hope springs)*

The congregation at Heidelberg has been welcoming people who live with mental health issues into their congregation for many years, and have developed a level of flexibility to support this 'welcome':

*When we first started back at Rosanna and had some people from the secure extended care unit coming along, the first thing you had to get used to was people going in and out and in and out. We had one classic time, I'll never forget, when one of the ladies from the congregation was giving a talk. It was the first or second time she would have given a talk so she was really nervous and this guy came from the back right up to the front and gave her a peck on the cheek and said "look, I agree with every word you say love, but I just gotta go out and have a smoke". And she coped really well. You've gotta cope with the lady who wants to come up to the front and sing the song, and the lady who says I don't believe in God; I can't believe in God today. ([redacted] Volunteer, hope springs)*

Some however, as noted above, prefer the more contained and structured small group Bible Study discussion over the more fluid approach to the liturgy and service.

At BCO, in addition to the fortnightly discussion group, there is a special Sunday service every month which has been developed to specifically cater for people who are part of the BCO community, and others who prefer a 'relaxed' form of service.

## *Reciprocity – a place to 'give and receive'*

*'It has enriched my life coming here. What you see in this community is what you get. People here are very genuine – they are what they are....if you meet them with a loving heart you will get so much back. It is an important part of understanding the need of this community. Relationships are the core – it is about belonging. We all need to belong. Its about the dignity of going to a place where you feel you belong'.* ([redacted] Volunteer BCO)

*'I have been coming every week for the last 12 years. I am now 87. It's rewarding and I wouldn't give it up for anything. It's just a wonderful thing to do. I am sorry that more don't take part in volunteering. As I said I am 87 and I tell my wife you have to keep giving....I love it. You establish great relationships with the people here and the other volunteers. It's a great privilege to come along each week. And I truly think that the volunteers get more out of it than the users/clients who are using the service. And we also have got great relationships with a range of other people – Tom at Trinity College who is a ball of fire as is [redacted] We are all getting older, but it is just a wonderful thing to do'.* ([redacted] Volunteer BCO)

There is a strong sense of reciprocity and mutual respect in the communities. These are places where you receive support but they are also places where you are able to give and show love and kindness towards others. This sense of reciprocity goes for participants, volunteers and paid staff.

*You can't be kind to just anyone out on the street but in a place like hope springs you can be kind to people which is really important for people here who are vulnerable and lonely. And I can be kind to people here but then I don't have to take that responsibility home with me. ([redacted] hope springs)*

Giving also extends to opportunities provided to the participants to volunteer and do odd jobs to support the programs or behind the scenes work to support the community.

*'[redacted] has given me a voluntary job recently meeting and greeting the new people'. ([redacted] hope springs)*

*'For 6 years after my accident I didn't have a job. A friend introduced me to [redacted] and then I decided to come along here. It gave me something to do and a chance to get out of home and meet people with mental health issues. I now volunteer 3 days a week. I like coming here because I am involved with people and I can help out'. ([redacted] hope springs)*

*'I like getting involved behind the scenes too – helping with the planning and organising. [redacted] gives me jobs to do like doing the shopping. It's great that [redacted] is happy to use my skills'. ([redacted] hope springs)*

*'And [redacted] makes us lovely food especially her sandwiches. [redacted] is awesome'! ([redacted] hope springs)*

Having responsibility for running the communities and activities helps to boost people's sense of self-worth and ownership of the programs and increases investment in the Drop In and broader church community.

*At BCO in all activities there is an expectation to help when able. But this is the expectation because participants see the place and group as 'theirs' , and not necessarily something put on for them by volunteers. We all get in and do it together.* (Rev[redacted])

## Key Service Components of *the hope springs* and BCO approach

### *Open Door Communities including structured activities*

In addition to the open door community, both *hope springs* and BCO offer some more targeted and structured activities, including weekly art groups, music groups and womens groups. *hope springs* also supports outings to places of interest on a fortnightly basis. All of these activities are on an 'opt in' basis, and enable people to follow or develop their interests. Some people attend only to participate in one or more of these activities.

Both initiatives would offer a wider range of activities if additional resources were available.

### *Links and Referral with Formal Supports*

Both BCO and "*Hope springs*" Coordinators are well connected to a range of local service providers are proactive in linking people to various services. The relationships of trust which are cultivated in the communities are enablers, in the sense that some people who would not usually engage with services are prepared to do so on the recommendation of the BCO or *hope springs* Coordinator, because they have confidence in the advice given.

## Advocacy

Churches and their ministers are key stakeholders in a local community. [redacted] work at Boroondara shows the potential for the church to influence and shape the local community. BCO is part of a network of services (what might be understood as constellation of resources) that can be mobilised to respond more effectively to people living with mental health issues. The description by Laurel (from CROP) shows a potential for BCO to work within a place based context and to engage in community development work. The power of [redacted] advocacy is increased by the knowledge of local responses and the gaps in planning and service delivery for people with mental health issues. This knowledge also includes an awareness of the broader context and reforms in mental health and disability such as the NDIS which are impacting on local responses.

Being open to collaboration and co-productive responses across denominations and between the church or churches, and a range of other stakeholders including mental health services the local council and other community organisations, has the potential to see BCO leading planning and change in the local community. The knowledge and experience of living and working in a local community, and a willingness to share that knowledge and experience, positions BCO as a key local leader that is respected by other key players in the community.

## Networking and Partnerships

The BCO and *hope springs* ministries are linked to local networks made up of key local mental health services. They attend these regular meetings and are active players in developing coordinated and co-productive responses to local issues and advising on innovative support and project development opportunities. Having a presence in these networks is critical to being able to influence thinking about the nature of support for people living with mental health issues in local communities.

*'The idea was for clinical workers and community workers to understand that the clients come first and we don't segregate people's plans. It's their plan and we need to work together to deliver it. [redacted] got some money from the Commonwealth and that's kept the network going. It also acts as an interface between the local drug and alcohol services and the Northeast dual diagnosis group. The idea is we try to develop the work of the network and improve the interface between services. hope springs was invited into that group and [redacted] been an active member'.* ([redacted])

*'..... networking is important – harnessing the strengths of all of these places in a wider regional network is really important'. ([redacted] BCO)*

One such response is the drop-in program at the Hawthorn Community House which is staffed by a roster of people from local mental health services who are able to work together to share resources, expertise and knowledge to support activities at the community house. [redacted] is a key player in this network along with the manager of the Hawthorn Community House and the coordinator of the YMCA Community Recreation Outreach Program known as CROP.

*There is the Boroondara Mental Health Alliance – where the managers and workers meet to talk about changes to the services and supports and their impact in the local area. And it was here that Nat and Kate and I realised that all of the resources were now going to individualised support. Through the Alliance we identified the need for peer groups and peer support work. In the new mental health and NDIS context there was no place for this anymore; there was no funding for group programs. So the 3 of us identified where the gaps are in the area and then worked out how we could set up a Drop In at Hawthorn Community House and get funding to run it. Drop In was definitely identified as one of the needs in the area because there is no place for people to go. There was no place for people to go where they felt accepted as a group.* ([redacted] Boroondara, CROP)

Not being funded through state or Commonwealth government mental health programs puts the ministries in a unique position to stand outside the service system with capacity to challenge orthodoxies and lead creative mental health responses.

*It depends on what the challenge is. In the last 12 months we were dealing with a lot of males who had been banned from other mental health services and neighbourhood houses. Some of their behaviour was probably borderline illegal and their social engagement was extremely poor. But because the drop-in is staffed with people with different and specific skills and because the drop-in involved different agencies how you engage these people with complex behaviours is different. Between [redacted] and I we can work out a way that they can be here. But if it was with a sole organisation, I think these people would be banned from entering. We broke down that barrier by working together as a group. We made it work. And especially with Nat, because you don't need a diagnosis to access her programs. With the difficult people there is much better support here and better skills and experience to deal with complex situations. ([redacted] CROP)*

## Outreach

*'There is a lot of sadness in rooming houses and SRSs – people living there need more support. If you haven't got a safe place to live, that's the start of all your problems'. ([redacted] BCO)*

*'If it wasn't for [redacted] these guys would have zero hope of moving on or of moving forward in many aspects of their lives. [redacted] gives hope and she always comes through. [redacted] actually works with people and she gets things done....she just does it. I like to think that between us we have made some people's lives better. She is a massive help'. ([redacted] Manager, [redacted])*

A key element of [redacted] work in BCO and [redacted] work at ***hope springs*** is the provision of outreach to local rooming houses, SRS's and community housing. This reflects a long tradition associated with the work of the ministries.

*'My involvement with Kew goes right back to the beginning when [redacted] was the first person in that role. She started it off. At that time I was running Mosaic which was a drop-in next to Summerlea Rooming House in Hawthorn. That started shortly before the Boroondara Ministry started. Mosaic took off really well because it was a huge population at Summerlea and there wasn't anything being offered. It was a day program, a bit of a structured program. At the start we used to get 50 to 60 participants coming along. [redacted] used to come along too and one of the things that stands out was that there were people who would come along who you would say hello to and they wouldn't have much interaction but being there was significant to them. There were several people like that who [redacted] who was a very quiet woman, would just sit down with and before long by working on a one-to-one basis they would be chatting away and talking. And that led eventually to involvement with the services. I've known and still know several people to this day who would say that the church service on a second Sunday of the month - that that's my church and that's largely people who would not be welcome or who would stand out in conventional congregations. And really that was [redacted] outreach work that enabled that to happen. '* ([redacted]l, Volunteer BCO)

In many ways outreach is central to responding to the mission espoused in the Gospel and the work of Jesus. It is highly valued by people living with mental health issues who are homeless, at risk of homelessness, or living in desperate situations in rooming houses or in their own homes where they feel extremely isolated and alone.

*It's a known fact you can die from loneliness. ([redacted] BCO)*

*'I have been living at [redacted] for about 4 years. At first it was very rough. There was at least one serious violent assault a week. But now with the new Manager, [redacted] and [redacted] and [redacted] (RDNS Nurse) it feels much more structured here. I have gone from feeling terrified to making friends'.* ([redacted] Resident, [redacted]e)

*'[redacted] is great, absolutely great. I had problems with gambling and severe depression. [redacted] got me out of my room and organised things for me – Doctors and Centrelink - until I got myself on my feet again. She never gives up on you and she's got a fantastic memory'.* ([redacted] Resident [redacted]e)

*'[redacted] brings food down here. It helps us to get out of our room and to meet people. It also helps to know that someone cares. Not once has she let me down. I had no ID to get Centrelink but [redacted] paid for my Photo ID and she brought me food before I got Centrelink'.* ([redacted] Resident, [redacted]e)

*'I always say to the residents if you have any problems talk to [redacted] [redacted] is our outreach worker. If you don't know where you are at but you need something [redacted] will know the direction to point you in. You will always gain something when you connect with [redacted] I say to the residents - have a chat with [redacted] because you will always gain something. Her energy and generosity towards people is unbelievably good'.* (G[redacted] Manager, [redacted]e)

Outreach is a powerful strategy for connecting the work of the ministries to people who are isolated and socially disconnected. It enables the ministries to engage people and to get a sense of where they are at and what their most critical needs might be. It provides a basis for bringing support and essential services to people and for making referrals to a range of allied health and other important services such as counselling, financial planning and housing services.

Outreach also enables the ministries to promote the range of opportunities available at the church and other related mental health programs. Many people initially contacted through outreach have been made aware of the range of programs on offer and are now connected and embedded in the church and other community recreation or arts activities.

*'I've known [redacted] for a couple of years. I met her from her visits to [redacted]e. I also go to the church for a feed once a week on a Tuesday. It helps to break up the week; I go up with a couple of friends from here'.* (Resident, [redacted])

*'I also go to CROP (Community Recreation Outreach Project) where I got involved in the band playing the bass - I look forward to practice every week at the Church. It provides everything we need - much more than I get through a psychologist....its so much more hands on. And I would like to think I have got better as a musician'.* ([redacted] Resident, [redacted])

*There have been a number of occasions where we have called upon [redacted] programs to assist doing some of that direct outreach. That direct outreach type of work is also important because we really don't have the case management for that type of homelessness other than from [redacted] has some connections with our known primary homeless people and she comes from a different perspective like offering a meal and linking them into the CROP programs or the programs or the community house.* ([redacted])

## Key success factors: *hope springs* and BCO

### *Program Leadership*

The leadership of the co-ordinators and experienced volunteers at BCO and *hope springs* is a key success factor. It is their vision and guidance that ensure that the Open Door Communities provide the welcoming, safe and supportive space which enables the sense of community to develop.

Paulo Reid who currently co-ordinates the Engagement Hub in St.Kilda (formerly St Kilda Drop-In) draws on her experience, highlighting the importance of experienced leadership:

*'There are opportunities for Yarra Yarra Presbytery to express all the qualities of a faith based community.....but any response has to be practical.....there must be experienced staff to guide voluntary effort, and to develop a place of welcome and a place where you are remembered'.* [redacted]

[redacted] a long-time volunteer at *hope springs* describes the importance of inspiring confidence:

*'[redacted] and [redacted] - they're both laid-back, they are very open and happy to talk to anybody; welcome anybody; and they don't get fazed by much. They are both very experienced - very experienced in talking to people who have different mindsets and they are great at dealing with conflict..... And this extends to the volunteers - people have confidence and trust in you but [redacted] and [redacted] are important as the program leaders'.* ([redacted] *hope springs*)

*He ([redacted] is there to help people with their mental health problems. He does a good job and works very hard like me. He has a nice kind heart.* ([redacted] *hope springs*)

*The coordinator is very present very and provides hands-on leadership. He really has the confidence of all the people who come here. And I think as volunteers we follow that leadership. ([redacted] hope springs)*

*I just say [redacted] is like a conductor. He is instructive but is not explicit; it's very subtle he just has to say a few words or demonstrate a gesture and, you know [redacted] he is all arms, and then we know what we are doing next. That's what gets everybody up and off we go. ([redacted] hope springs)*

This leadership is also critical to inspiring confidence and mobilising the skills and knowledge of volunteers and other congregation members.

*People need to be equipped to handle what is being asked of them. With appropriate levels of support and supervision the congregation can grow with the role and responsibility framed by mission. ([redacted])*

This comment, by [redacted] was made in the context of reflections on a local school mentors program supported by the Montrose Uniting Church. The connection between local students and Uniting Church mentors enabled the congregation members to discover and realise untapped talents that they did not know they possessed. Effective leadership has the potential to unlock these talents and resources on a number of 'missional' fronts.

## Responsiveness and Flexibility

The flexible approach to providing support opens the ministries up to a greater capacity to respond to gaps in current program approaches and to impact on the levels and types of support available in local communities. [redacted] for example is lauded for her willingness to step up and do her best to fill some of the gaps in relation to case management across Boroondara communities and to collaborate to develop a new drop-in at Hawthorn Community House.

Within the communities, the 'can do' attitude of the Coordinators creates a certain optimism and confidence, which contributes to a positive culture. This is a key element which motivates people to attend regularly and to actively engage with the other participants, and with the various opportunities on offer.

## Volunteers

The volunteers are critical to the communities – without their contribution to creating the atmosphere of active welcome and acceptance these communities could not function. There are a number of practical roles through which volunteers contribute, including cooking and serving food, driving, setting up the venues, etc.

Both *hope springs* and BCO support participants to take on volunteer roles where they show interest in doing so. Orientation and training is provided to volunteers, and this is supported with induction manuals and policies and procedures to provide guidance. There is a high level of peer support between volunteers, and co-ordinators are readily available to provide additional support and advice if required.

The volunteers reported high levels of satisfaction with their roles, and a strong sense of purpose and satisfaction. There is a strong sense of mutual respect between volunteers and between the volunteers and the co-ordinators.

*'We developed a code of ethics for volunteers and that sets guidelines for involvement. In particular this involves not sharing personal information, only giving mobile phone numbers and not home phone numbers, and being free to say no. And also, there is encouragement to talk about any difficulties. It's part of the ongoing training of volunteers. And the supervision of volunteers is a way of keeping a check on involvements of people have and whether they need any more skills in a particular area. Regular training sessions with the volunteers was always part of the work of hope springs'.* (Rev [redacted])

### *Congregational support*

The ongoing support provided to BCO and *hope springs* through the local congregations is a key to their success. Members of local congregations serve on their reference groups and committees; a number having maintained their commitment to the vision and 'mission' over many years. As long term members in their local communities and congregations, their enduring association with the Open Door Communities is a key factor in the stability and sustainability of the initiatives. These people also play a key role in advocating for the continuing support of the initiatives through the congregations and the Presbytery, in an environment where there are at times pressures to divert resources to other 'missions'.

Approximately one third of volunteers who support BCO and *hope springs* are from the congregations, and many of these have been involved over a long period. They bring with them energy and commitment which is a key contribution to the atmosphere of welcome that is cultivated. Some bring particular skills and experience to contribute to specific activities including the BCO community choir, music and art activities. Others assist by proving transport for people who would not otherwise be able to attend.

In addition to these practical contributions, many members of congregations across the Presbytery assist by donating regularly – these contributions are a significant element in the funding available to support activities.

## Findings – Outer East Mental Health Ministry

There are some particular challenges for the Ministry in the Outer East resulting from the changes in the way community mental health support is now delivered. The pastoral care ministry (Chaplaincy) with EACH (Eastern Access Community Health) is currently operating as a specialist form of support within hospital and community based mental health services. Connections are built with these services and clients. To gain access to clients, the ministry has to build trust with staff, or as Rev Pam White put it 'you have to earn your stripes' in the context of a partnership approach, in order for chaplaincy and spiritual support and counselling to become valued.

*'The challenge is rubbing shoulders with people, with participants, getting access to them. This is the biggest challenge I have. Once I am in the room with them its fine, but because I'm not in that space it is dependent on workers giving me access'.* (Rev [redacted])

In the past, as well as the chaplaincy role within services in the hospital, the ministry has run book groups (at Halcyon), Bible studies, a women's group and provided some one-on-one support for people interested in spiritual support and well-being.

*With [redacted] and [redacted] work ..... well, you've got something tangible. You can touch it and feel it.* [redacted])

When first established, the Outer East outreach ministry worked with local congregations, raising their awareness about the needs of people living with mental health issues. This included carers support work resulting in the establishment of support groups in local congregations, for example at St John's in Mount Waverley; establishment of carer support activities; formal training programs in partnership with Schizophrenia Fellowship; and a range of activities that challenged negative attitudes and helped people develop their understanding about how best to support and include people living with mental health issues. Congregation members were also encouraged to talk about their experiences of mental health issues through a number of formal information sessions and discussion. Awareness raising work was incorporated into the congregations' spiritual practice and teachings – eg.it was worked into Bible studies and Bible readings to enable people to ground their experience of mental health issues in the teachings of Christ and the Gospels.

Rev. John Tansey has been in the position now for a little over a year and has come from the ministry at St Kilda Uniting Church which hosted a long established and relatively well-funded drop-in program. John observes that the absence of similar social group programs in the Outer East poses some difficulties for the outreach ministry, as there are few opportunities to engage with people living with mental health issues in a more informal setting. He is also concerned that the more formal and individualised way in which mental health support services are delivered disadvantages people with more severe mental health issues, as they are less likely to engage with these services.

*'There are not these social spaces now that people can access. There is a small group that meets in Ringwood and also something at Boronia but they only meet for a few hours. It's a start, but it's not what I think of when I imagine an informal social group program. I'm involved in a men's group which has continued since the closure of Lifeworks but instead of it being five days a week it's now only two hours a week so they attend for those 2 hours and then they go. It's no longer OK to just to hang around in more informal ways. The funding doesn't work like that anymore. You can't just 'be' in a space, there has to be structured activities with a defined 'recovery' focus. You have to be working towards something, learning something. It's not enough just to be able to chill out with friends or with peers and others who are 'ill'. The government doesn't want to fund that. It's seen as not valuable, whereas I say that's how people begin to feel a sense of community and that's what's missing from this model'.* (Rev. John Tansey)

The original 'outreach' ministry approach is somewhat compromised in this context as contact with people is made on a referral basis from mental health workers, who may or may not value the spiritual aspects of their client's wellbeing. In effect the outreach minister must win over gatekeepers and convince them of the value of spiritual health and well-being to people living with mental health issues. In this context the ministry occupies a far more formal position within the service system where its role is reduced to that of the 'spiritual specialist.' A response to this constraint has been to provide training sessions with support staff on *"Spirituality in Mental Health Recovery - towards a holistic approach to recovery"* as an introduction to the connections between spirituality and wellbeing.

Without a focal point like a drop-in there is also less opportunity for people to voluntarily choose to engage with the ministry and seek support within the context of a local congregation. The far more formalised relationship with the service system reduces the opportunity for spiritual dialogue and pushes the outreach ministry into a more transactional arrangement. The relationship with clients or patients is constrained by the more structured and prescribed approaches and measured outcomes within the formal and/or clinical based practice.

A number of specific groups are run by EACH including gym groups, carers groups, art groups, and a men's group. However, these are structured activities that do not provide the kind of opportunities to engage which are available in less structured social group contexts. More recently, training in mindfulness and a meditation group has also been established as part of the Outer East Ministry.

While there is continuing value in the outreach ministry, there are very few informal settings where people can freely choose to attend and where they can feel the embrace of a community and have much greater control about the way they engage and negotiate access to support, connection and community membership.

This presents a challenge for the work of the mental health mission in the outer east, where congregations may be more comfortable with the traditional chaplaincy role which distances them from actual contact and connection with people living with a mental health issues.

*'What challenges people is their willingness to get eyeball to eyeball with someone with a mental health issues'.* [redacted]

A broader role for the mission, similar to BCO and Hope Springs, where congregation members can 'touch and feel' ([redacted] people's distress and transform it through the gift of service, is something that needs to be considered in future planning across the region.

**The ministry from the perspective of EACH**

The pastoral care/chaplaincy role is valued by EACH, with the organisation continuing to make a financial contribution towards the position, and providing the office base for the position within the EACH team. There is an appreciation of the challenges posed by the loss of informal engagement opportunities in less structured activities, which has resulted from the recommissioning of community mental health services. The management of EACH is keen to retain the capacity to provide a pastoral care aspect to the support offered to people using the EACH services, and the availability of pastoral care for staff is also seen as an important benefit of the partnership arrangement with the Presbytery. The recent work in developing and delivering workshops on spirituality – provided for service users and also EACH staff– is seen as a valuable way of raising awareness about the role of spirituality in well-being.

## Findings – Building capacity within congregations

Congregations have been pivotal in the establishment and development of the Yarra Yarra mental health ministries. It is important that congregations are encouraged to exercise leadership in defining and enlivening their faith in a commitment to mission. This role of the congregations is described by Rev Andy Calder:

*'Congregations have a capacity for re-visioning the internal and external life of the church'.*

With the Mental Health Ministries in place for more than 20 years, there is considerable expertise within the Presbytery, which should be considered a resource for further capacity building with congregations:

*"One of my things is that we really should have a consultancy across the Presbytery just to encourage other congregations and denominations who want to set up something and help them to do it. We have got this large body of expertise and information which we could share".* (Rev [redacted])

(See Notes from the workshop at the Presbytery meeting November 2017 for an overview of capacity building issues identified by Congregations - Attachment 7).

### Responding to the 'whole person'

The Mental Health Ministries are congregational responses to people in need in their local communities. Inspired by the spirit of the Gospel they embody the flexibility and full and open heartedness of creative responses to emergent issues and challenges. The ministries support and reach out to people where they are, as an unencumbered expression of care for others. From the beginning members of congregations have also extended a welcome to join in worship for those interested in exploring the spiritual dimensions of their lives.

*There is a depth of spirituality in the connection with people with mental health issues. Some of the most insightful Bible studies we ever had were with the group from Halcyon..... This spiritual depth that people bring, well, in a sense, I feel that many people with mental health issues are very spiritual people - they have insights into vulnerability and humanity which we can learn from. We need to hear their stories. We need to listen to them.* (Rev. Deacon [redacted])

All church communities and congregations are challenged to find a balance between more formal and traditional forms of worship (liturgy) and more flexible approaches to appeal to newcomers and people who are seeking a more accessible and contemporary experience.

*'I have been moving away from the church because I find the liturgy and the patriarchal words oppressive. It sometimes feels like we are in the dark ages. We need to bring in more inclusiveness in relation to gender and diversity. We also need an inter-generational church because the older generation can't keep going. The church*

*has to modernise its way of presenting the liturgy. This has to change and the church has to make a statement about this.' (*[redacted] BCO)

Increasing flexibility and responsiveness in the liturgy is seen as one way for the church to open up to new 'audiences'. Within the Yarra Yarra congregations various approaches to more deliberately open and welcoming forms of worship have been developed.

*'One interesting thing, Marie was intent on making the service quite informal but there was the insistence from people that she always wear her Minister's robes - that was important to them. But if you look at what the (adapted liturgy) does - its informal, people can talk out loud.* [redacted] *will take questions. People can be themselves there. For a long time there were quite a lot of people that were coming from Kew cottages. They might sing out or make involuntary noises but that was okay. Particularly with* [redacted]*, it's a service where people are actively involved. She has people singing solos and reciting their poetry. In practical terms it's also the food - a meal is for some people a real drawcard and that of course is meeting a need. But I would say there's a real community experience there'.* [redacted])

In many ways this adaptation of liturgy and church service parallels trends in disability sport, recreation and arts programs where mainstream sport and recreation clubs and associations have changed their structures and sporting programs to better enable participation by people with disability in their activities. These changes reflect a growing realisation that people bring 'additional' needs to sport, recreation and church service and liturgy contexts. For these contexts to become inclusive, they often need to change and adapt and respond to these 'additional' needs and in doing this they will become more relevant and meaningful to a more diverse cross-section of our community.

The development of what might be called 'relaxed' church services does not preclude people from participating in the usual Sunday services. Many congregations actively welcome people living with mental health issues, with the CrossGen congregation in Heidelberg including several people who are members of the *hope springs* community.

## Building awareness and knowledge about mental health issues in congregations

Consultation with members of congregations highlighted some key needs and opportunities within congregations. These can be summarised as:

a. A desire to be active in supporting church members, and others who are living with mental health issues, but a lack of confidence in knowing how best to be supportive.
b. A desire to make church services more welcoming to people living with mental health issues and others, including considerations around the formality of the liturgy.
c. A long term commitment by some members and congregations to support the mental health ministry by:
    - A program of regular donations and fundraising
    - Volunteering in the BCO or "Hope Springs" communities
    - Serving in the governance of the BCO or "Hope Springs"
d. A desire for training and development on mental health issues and how to help

*There should be regular worships to raise awareness of the seriousness of the issue and also to help people understand what they can do. This is not something to feel ashamed about. We need to enable people to share their stories so they can be supported along the way.* ([redacted]

Capacity building within congregations could involve a number of activities, including formal training for members of congregations interested in supporting the mental health ministries. There were a number of examples where the missions had developed links with mental health services which provided training to congregations across the Presbytery. This included mental health first aid training and Wellways training (formerly Schizophrenia Fellowship).

## Training for ministers

Although ministers have a key leadership role in congregations, they have varying levels of experience and confidence in dealing with people who live with mental health issues. In addition to community education sessions with congregations, ministers would benefit from more specific training about providing support and pastoral care for both people experiencing mental health issues and their carers.
Within the Yarra Yarra Presbytery there is a high level of experience and expertise, and experienced ministers and others could contribute to training sessions for other ministers. Consideration could also be given to encouraging participation in the course offered through the Synod, including contributing input to the course design on the response to people living with mental health issues:

*'Every 2 years we run a 12 week course for Ministers and lay people. The course – incudes: Theology, Inclusive Anthropology; community engagement strategies; perspectives on friendship; reinterpretation of miracles; and charting the move from medical to social models of disability. The aim of the course is to promote responsiveness and receptiveness of people with disabilities as a church community'.* (Rev Andy Calder, Synod VicTas, Inclusion and Disability)

## Developing the capacity to advocate

Over many years there have been very proactive members of congregations who have persisted in their commitment to maintain the ministries, at time in the face of apparently insurmountable difficulties, including resource constraints. This capacity to advocate for initiatives and approaches which support those who are most in need is an important contribution of congregations and Presbytery.

The importance of having a vision, and the ability to advocate and bring that vision to fulfilment, is captured by Rev Andy Calder: *There is a symbolic and material contribution of the church – advocacy could help to play a defining role for congregations if we knew what we wanted to do – we could develop a vision and we could state it to ourselves and others who might support us .....the vision could help us to respond to the question..... Why is the church involved in mental health support'?* (Rev Andy Calder, Synod VicTas, Inclusion and Disability)

# THE MENTAL HEALTH MINISTRY
## creating community

The three ministries have developed a sophisticated approach that responds to people living with mental health issues and others in the community who experience social isolation. Guided by the Gospel's ethos and sprit of service, these initiatives provide a powerful way of connecting people who are marginalised to caring and empowering communities.

Our research on how participants, volunteers, co-ordinators, ministers and referring agencies see the opportunities provided by *hope springs* and BCO reveals a rich narrative describing a dynamic and responsive approach which can best be described as open door communities. .

BCO and *hope springs* have developed a robust and cost effective response to the loneliness, isolation, and poverty that many people experience in our communities.

In summary, the elements which are highly valued by those who attend are:

- A high level of informality which allows people to attend on their own terms – this may be regularly or infrequently - and they can determine their level of participation 'on the day'
- Being amongst people who 'understand' difficulties because they have similar experiences results in peer support, and the freedom in not having to explain or hide particular issues or experiences
- The provision of lunch is a drawcard, and fosters the sense of community and conviviality, as many of those who attend live alone and seldom have the pleasure of sharing meals with others
- Being a place of safety and' sanctuary', especially for those who live in insecure accommodation or other settings where there are limits on personal space
- A sense of being part of a caring community rather than 'attending a support service'
- A place where people can 'be themselves', which for some people includes exploring spirituality and existential questions, including access to a more 'relaxed' and accessible liturgy
- Opportunities to participate in more structured activities with others who share common interests
- Respect for people's strengths and what they bring to the open door communities – there are opportunities to share particular skills and/or contribute to various tasks, including opportunities to demonstrate and develop leadership
- A sense of respect and reciprocity, resulting in a strong sense of a 'safe place', as people respect boundaries
- Responsiveness – there is a high level of flexibility in the way workers and volunteers interact with people who attend, enabling a responsiveness to 'where people are at' at any given time. This includes more informal boundaries, so that people attending can take on volunteer roles if they wish
- Opportunities to experience and express Christian mission
- Long term connection with volunteers
- A place to find and make friends

A number of complementary strategies associated with the open door communities contribute to developing a unique and effective model of community support and development for people who are socially isolated, including those who experience severe and enduring mental health issues and associated difficulties.

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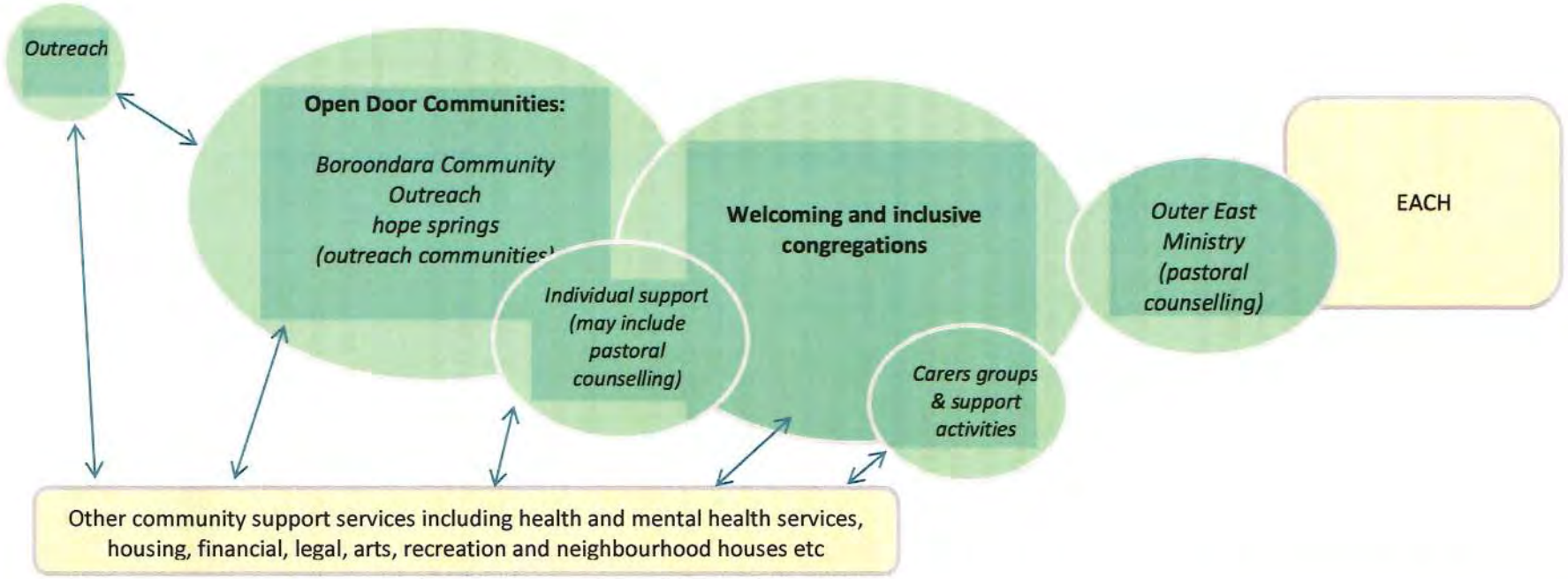
## The Yarra Yarra Mental Health Ministry




**Capacity building to support more welcoming and empowering communities**

Community education and awareness raising within congregations

Volunteer training and support

Skills development and peer leadership within the outreach communities

Developing more inclusive liturgy and flexibility in worship services

Networking and partnering with local services and groups (neighbourhood houses, service clubs, schools etc) to create a wider range of community participation and support options

# Creating Community – Developing a conceptual framework for the Mental Health Ministries

The Mental Health Ministries have a strong commitment to engage with people living with mental health issues who are socially isolated, to promote their inclusion in the life of the local community, and to extend a welcome into the church congregations. This vision of 'being with' [37]people who are most in need of support, care, connection and friendship is inspired by the Gospel.

The ministries understand and acknowledge the key issues and challenges experienced by people living with mental health issues, including those with serious mental health issues, as:

- Reduced self-confidence resulting from the experience of depression, anxiety and/or psychosis
- Social isolation due to difficulties in maintaining social and family networks
- Reduced participation in the workforce and restricted life choices associated with low income
- Homelessness and/or insecure housing
- Stigma – the community response of 'othering' which has a profound impact on people's lives, and results in an enduring sense of 'not belonging' in the community

The work of the ministries demonstrates the unique role the church can play in reaching out and creating spaces for friendship and companionship, based on unconditional love and concern for people who are struggling, for whatever reason, and are unable to find a valued place within traditional family and work contexts and the wider community. The ministries seek to restore hope and meaning in people's lives by developing communities where people can come together to find practical support, share their experiences, tell their stories, engage in activities and common interests, and find friends and companions in an environment of mutual respect and care and concern for people's well-being.

From the beginning, the Mental Health Ministries have responded to gaps in the formal supports for people with mental health issues living in the community. The Ministries were initiated in the context of deinstitutionalisation, and as a response to the lack of support within communities for people moving from the large institutions into the community. More recently, the former Victorian Government's recommissioning of community mental health services in 2014, and the move towards highly individualised approaches to mental health support, including the transition to the NDIS, has reduced the range of formal supports available in the community, and highlighted the need for community creating approaches. There is concern that many people currently supported by mental health services will lose access to support services as the NDIS is rolled out. The Mental Health Ministries are already seeing increasing demands for the support they offer, as people begin to 'fall through the cracks'.

While this reduction of formal supports is a real concern, it is important to also recognise the limits of formal support. In *Closing the Asylum*, Barham highlights the inherent limitations of mental health support services when he reflects the observations of mental health service users:

*'the kind of service provided by the mental health professionals is not the only or necessarily even the main issue that determines the quality of people's lives in the community'.* [38]

This is due to the inherent focus of formal mental health services on the specific impacts of mental illness, rather than on the 'whole person' who aspires to a meaningful life in community.

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[37] Swinton, J. (2000), *Resurrecting the Person,* p 22

[38] Peter Barham, Closing the Asylum, 1992, p42

Barham expands further on this idea, describing the potential impact of traditional psychiatry as diminishing personhood:

*'Traditionally psychiatric knowledge has provided thick descriptions of the patient and thin descriptions of the person in which the patient is represented as a notional person but never fully described as such. ..... Inevitably, there are those who want to maintain the rhetoric of distance and shore up established positions. But this is profoundly unsatisfactory, for what increasingly the era of community care is bringing about is a new intermingling of voices in which the authority of this or that brand of professional knowledge cannot be taken for granted.'* [39]

This theme emerged in focus groups discussions with participants in the BCO and *hope springs* open door communities. Formal services on their own tend to lock people into a sense of themselves only as 'patients' or 'consumers' with little opportunity for them to assert themselves and find meaning as members of community alongside others who might share their interests and aspirations.

Mental health services in Victoria have adopted a limited focus on social change and community development strategies to address the disablement and oppression of people living with mental health issues. Given the current trend towards further focussing service provision on the individual, it is clear that creating communities that engage, affirm and include people living with serious mental health issues is a very high priority.

In this context we can see the importance of the community creating work of the mental health ministries, which is specifically focussed on addressing issues of social isolation, disablement and marginalisation.

Community and a sense of belonging is not a given. Community is a contested space. To be sure that your needs and aspirations are reflected in the way communities are planned and designed there is a need for people living with mental health issues, and their carers and advocates, to engage in community planning conversations to ensure that your voice is at the planning table.[40]

The idea of a community creating dimension[41] draws attention to the need for multiple strategic starting points and a focus on social justice as key tactical elements in community building. We see this reflected in the work of the ministries, particularly the community development focus of BCO where coordination

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[39] Barham,P. 1992, p41

[40] For a good example of centring consumer voice in planning and decision making see the *Voice at The Table* initiative (VATT) a project of the Self Advocacy Resource Unit - http://www.saru.net.au/

[41] The idea of a community creating dimension is captured by Adelaide academic, Lorna Hallahan, in the notion of ***communio***. Building on the work of John Reader (1994), Hallahan proposes the concept of communio as 'meaningful valued togetherness which can open up new pathways towards the goal of building community'. Hallahan is writing in a disability context about the potential for community/ies to embrace those deemed 'other.' Here community is not constructed as a 'substantive reality' but more as a process that binds people in friendship and comradeship. Hallahan emphasises that this implies a 'shift away from concentrating solely on developing organisations and structures to a process which allows people to come to know each other personally' (p.38). Communio provides a framework for emergent strategies based on association and encounters between people, including strangers, meeting and connecting from diverse backgrounds. This has the potential to avoid prescription and to open up communities as a basis for exploration and possibility. The mental health missions are well-placed to engage in this exploration.
Hallahan, L. (2004) *Believing that a Farther Shore is Reachable from Here. Mapping Community as Moral Loving Journeying* in Newell, C. & Calder, A. (eds) *Voices in Spirituality from the Land Down Under.* Outback to Outfront. London, Routledge.
Reader, J. (1994) *Local Theology: Church and Community in Dialogue*, London, Abingdon Press,

of effort targets a range of key players and engages them in a more planned response to people living with mental health issues. For people to live meaningful lives, multiple stakeholders in community need to be engaged. This includes Boroondara Council, local rooming houses, the YMCA, community houses, Centrelink, mental health services, the RDNS homeless Persons service, local schools, to name just a few of the organisations that BCO engages with and impacts. Community creating also requires understanding and use of a range of strategies to effect change - this can include, individualised support and case management, art and recreation programs, meals programs, camps, music groups, women's groups, congregation capacity building work, community awareness and education, active involvement in community planning networks etc. The idea of multiple starting points, and having at your disposal a ranges of strategies to engage individuals and build communities, reflects the complex reality of people's lives where their sense of well-being and access to resources to facilitate manageable and meaningful lives is impacted by their daily encounters and struggles as members of a community.

Working within a place based framework there is enormous potential for the work of the mental health ministries to add value and contribute to a more coordinated community response to people living with mental health issues. They are positioned alongside formal services and approaches as informal, mainstream, community creating initiatives which have the flexibility to be responsive and creative because of their volunteer and participant driven focus.

The power of the Mental Health Ministries derives from a moral and ethical framework premised on the belief that *'all human beings are eminently worth helping or treating with justice'* [42] and that they deserve first and foremost to be engaged with dignity. The belief that all people are of value and deserving of respect, care and love is a powerful motivation and affirming spirit with which the ministries and their congregations encounter and engage people living with mental health issues. The ministries and congregations *'bring people back onto the map' and develop 'new channels of communication' which go beyond their status as patients and starts to ground their experience, no matter how difficult that may be, in a community that is respectful and affirming.'* [43]

That the work of the Mental Health Ministries sits alongside the formal support system is its strength. While this work complements the formal mental health system it is much more than a complementary 'service'. The open door communities have value in and of themselves, and are unique, precisely because they are not captured by the formal constraints of the funded service sector.

At their core is a set of values which celebrates the restorative power of community, mutual respect, kindness, relationship and service inspired by the Gospel and the teachings of Jesus. This is a vision of an 'empowering church' [44] where congregations 'stand beside' people who for whatever reason are struggling to find a valued place in their local community.

[42] Barham, 1992 p.155
[43] Barham 1992, p.41
[44] Crabtree, D. (1996) *The Empowering Church. How one congregation supports lay people's ministries in the world*, New York, An Alban Institute Publication.

# Philosophy and foundational conceptual frameworks

A 'model' which includes three underpinning conceptual frameworks and a community development practice approach to guide and frame the work of the Mental Health Ministries is proposed.
The three key conceptual frameworks provide the foundation for the Mental Health Ministries model: Christian Friendship/Relational Spirituality, Social Model of Disability and Health; and Citizenship.

## Christian Friendship and Relational Spirituality

Swinton, in his work on friendship and the care of people with mental health issues,[45] identifies the potential for the church and Christian faith to respond with 'radical edge' to the needs of people living with mental health issues. For Swinton 'caring for the needs of people living with mental health problems is not an option for the church, rather, it is a primary source of its identity and faithfulness'.[46]

The model of 'Christian friendship' developed by Swinton has an understanding of the needs of people living with mental health issues and the marginalisation, stigma, poverty, loneliness and exclusion they typically experience. For Swinton, friendship is a resource of hope:

*'In times of crisis and amid the acute manifestations of the health issues, when David was unable to be a part of the worshipping community it was a symbolic knowledge that the friendship relationship was always there which was as important as the actual practice of it. Certainly that symbolic aspect of the friendship relationship was "made flesh" through the continuing ministry of the church community members who continued to visit David in times of crisis or hospitalisation, but it was a symbolic connection with the wider church community that moved beyond his health issues and helped sustain his sense of connection with others'.* [47]

Swinton's powerful work is based on his experience as a mental health nurse and chaplain, and centres the church as a key player in the local community. Alongside relational and participatory Christian theologies it represents an inspiring account of the church's capacity to realise it's better self through a deep sense of, and commitment to being with people with mental health problems, and through this relationship to transform individual, congregational and community life in the true spirit of the Gospel.

Swinton also draws on the work of Gutierrez and Liberation Theology to emphasise the church's capacity to mobilise gestures and ways of being with people as critical to *'liberating them from oppressive self and social identity'.* [48]

*'According to Gutiérrez true "liberation" has three main dimensions: First, it involves political and social liberation, the elimination of the immediate causes of poverty and injustice. Second, liberation involves the emancipation of the poor, the marginalised, the downtrodden and the oppressed from all "those things that limit their capacity to develop themselves freely and in dignity". Third, liberation theology involves liberation from selfishness and sin, a re-establishment of a relationship with God and with other people'.* [49]

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[45] Swinton, J (2000) Resurrecting the Person. Friendships and the Care of People With Mental Health Problems, Abingdon Press Nashville.
[46] Ibid p. 52
[47] Ibid p. p.160
[48] Ibid. p.160
[49] See Gustavo Gutierrez - https://liberationtheology.org/people-organizations/gustavo-gutierrez/

The power of Liberation Theology is its impetus for consciousness-raising both within congregations and the broader community by drawing attention to the exclusionary and marginalising practice of both formal mental health supports and mainstream community settings.

This liberating potential inspires hope, which Breznitz describes as *'a protected area'* a *'set of experiences that maintain positive features when everything else around it is threatening'*. [50]

The approach of the Mental Health Ministries is aligned with Swinton's work with its strong focus on creating communities in which Christian friendship is fostered. The focus on empathy, companionship and connection provides the basis for community development activity which strengthens capacity to support people living with mental health issues to enable their relationships and friendships to flourish.

The approach also challenges the more individualised response which has dominated pastoral care and chaplaincy. The power of locating the work of the ministry in grounded relationships with people who live with mental health issues is captured by the reflections of author, Barbara McClure on the limitations of a more therapeutic pastoral care practice which focused attention on her client Olive with little consideration of the social conditions that impacted on her:

*'I wonder what I might have learned if I had accompanied her, not just emotionally or interpersonally, but imaginatively, and even physically, on the bus, to her context, her system. I wonder what might have been different if I had experimented by using her anger and depression as diagnostic tools with which to analyse the socio-political (not just intra-or interpersonal) dynamics within which she was embedded. (What* ***in the world*** *made her depressed and why?) I wonder what might have been different if I'd had the creative thinking and practices in my toolkit? I imagine Olna would have taught me much about the requirements for human flourishing and the costs (developmental, emotional, physical, relational; spiritual) of being deprived of them'*.[51]

## Social Models of Disability and Health

The social model of health identifies social determinants as the cause of health inequities - the unfair and avoidable differences in health status. The social determinants of health are the social contexts in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. Social determinants consist of a range of social and institutional arrangements, and include access to economic opportunities and levels of social exclusion/inclusion. [52] While the development of a mental health issues is not usually attributed only to social determinants, the consequences of mental health issues are often compounded by the negative impacts of long term unemployment, and social exclusion.

The social model of disability has been a very powerful driver of change and mobilisation of the disability community in Australia, Great Britain and the United States. [53]

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[50] Breznitz cited in Swinton, J. (2000), p.160.

[51] McClure, B. (2010*) Moving Beyond Individualism in Pastoral Care and Counselling. Reflections on theory theology and practice*, Cascade Books, Eugene Oregon.

[52] http://www.who.int/social_determinants/sdh_definition/en/

[53] See for example the work of Michel Oliver in Great Britain – Oliver has written a larger range of material on the Social Model including his seminal book *The Politics of Disablement* published in 1990 by MacMillan. Irving Zola in the United States http://www.irvingzola.com/ For a full account of the history of the Social Model see Colin Barnes Article written in 2012 *The Social Model of Disability: Valuable or Irrelevant?* which can be downloaded from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.459.1606&rep=rep1&type=pdf

*'This new paradigm involves nothing more or less fundamental than a switch away from focusing on the physical limitations of particular individuals to the way the physical and social environment impose limitations upon certain categories of people'* [54](Oliver, 1981: 28).

The social model of disability draws attention to the way that societies and communities disable, primarily because they are not planned or organised in ways that respond to people who bring 'additional' needs to community life which are perceived to be outside of the dominant or normative order. [55]

In the mental health sector there is periodically a focus on gaps and chronic shortages in mental health services, however there is limited focus on the disabling impact of community structures and norms on people's capacity to fully participate in local communities. In contrast to the disability sector, there has been little commitment within the mental health sector to utilising community development strategies to build capacity within local communities to engage with, and support people living with mental health issues. It could be argued that the focus on the medical 'recovery' model in mental health, which assumes people living with mental health issues can recover and resume a 'normal' life course, has distracted policy makers and mental health workers from the realities of the lived experience of many people with severe and enduring mental health issues.

*'It was the casting out, the stigma, that felt most damaging..... Having been given, and accepted for lack of an alternative, a label of 'mentally ill', I did not feel that my opinions were valid. Many aspects of the treatment itself confirmed this view. Society's discrimination against people who've received psychiatric treatment, in not accepting us for proper jobs and proper housing, adds to this. Unlike criminals, society does not forgive our former diagnoses after a period of time..... It is difficult for a person who has been treated for years as a mental patient to realise that her or his thoughts and actions are valid and could make a difference. At this stage I had of vague awareness that I needed to join with others towards political action. The thought that I could play a part in bringing about change was alien to all that I had learned about my worthlessness during my upbringing and in the psychiatric system. One of the things that we service users have in common is this shared experience of total powerlessness. We learn to define ourselves by the roles and diagnoses given to us by psychiatrists, take them into ourselves and feel helpless to influence our own lives. With powerlessness goes poverty of an enduring and humiliating nature.'*[56]

Using the 'social model' framework to understand the challenges faced by people living with mental health issues would draw attention to the disabling features of social and community life which make it difficult for people to fully participate.[57] This perspective is based on a politics of mental health which

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[54] Oliver, M. 1981: A New Model of the Social Work Role in Relation to Disability. In J. Campling (ed.), *The Handicapped Person: A New Perspective for Social Workers.* London: RADAR, 19-32.

[55] Vanier, J. & Hauerwas, S. (2008) *Living Gently in a Violent World: The Prophetic Witness of Weakness,* London, IVP Press. In a theological context, the work of Jean Vanier and Stanley Hauerwas also alerts us to this potential for re-narrating disability by listening carefully to people who see and feel differently. John Swinton, in his introduction to their book, *Living Gently in a Violent World: The Prophetic Witness of Weakness*, alerts us to the theological and political dimensions of this careful listening and the potential for it to facilitate grace **and activism** which enables people to affirm and celebrate their differences *'in the eyes of God'* and the world we live in.

[56] A direct quote from a user of mental health services in a report by Lindow, V (1990) 'Participation and Power', Open Mind 44, April/May In *Closing the Asylum* (1992) by Peter Braham , p.116.

[57] This has implications for the way our cities and communities are planned. There are a number of writers who draw attention to the normative assumptions and power invested in city and urban planning. Sandercock, (1998) Fincher & Jacobs (1998) and Solnit (2007) expose the vested interests in city and community planning and propose a

demonstrates the impact of social and economic factors on the experience of mental health issues. Warner[58], Barham[59], and Pattison[60] are a few of the people who have articulated this perspective.

The social model identifies an 'enabling potential' in communities which can be activated to build capacity to respond to people living with mental health issues. In simple terms, this refers to changes which can be made within, and by communities, so that people who are currently marginalised or excluded can more fully participate. The social model of disability underpins access and equity agendas, and anti-discrimination initiatives. For example, changes in the built environment – now mandated for public buildings – are making significant inroads in changing inaccessible buildings and spaces, a key 'disabling' feature of communities for people with physical disabilities.

The social model identifies a number of 'disabling' features of community life for people living with mental health issues – these include discrimination, prejudice and stigma which result in reduced social and economic participation opportunities, financial disadvantage, insecure housing etc. Strategies to address these issues are critical to working with the wider community to build opportunities for people living with mental health issues to more fully participate in the community.

Clearly the 'social model' resonates with citizenship perspectives, and is aligned with the imperatives articulated by Barham (quoted above) – the need to open up opportunities for participation in the community on a more equal footing for people living with mental health issues.

## Citizenship

The concept of citizenship aligns well with the social models of disability and health.

Central to the Mental Health Ministries is a commitment to promoting people as valued citizens and understanding the way social structures and systems impact on people's citizenship and compromise their community membership status.[61]

In his book, ***Closing the Asylum***, Peter Barham draws attention to the disabling impact of social issues and conditions on both the citizenship status of people living with mental health issues and their potential to live a good and meaningful life. Barham also points to the limitations of narrowly focussed individualised

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'model' for planning that responds to the diverse needs and aspirations of the community. They favour heterogeneity over homogeneity – and city spaces which embrace a contingency that facilitates respectful encounters between strangers. This is a form of cosmopolitanism that sits well with the Christian commitment to welcoming the stranger. It aligns with a Christian cosmopolitanism that embraces diversity and is charged with a responsibility to advocate for social justice, inclusion and universal access to all aspects of community life.

[58] Warner, R. *Recovery from Schizophrenia. Psychiatry and Political Economy*. Third edition. (2004) London, Routledge

[59] Barham, P. & Hayward, R. (1991) *From the Mental Patient to the Person*, London, Routledge.

[60] Pattison, S. (1994) *Pastoral Care and Liberation Theology*, Cambridge, Cambridge University Press.

[61] The *Victorian Government 10 year Mental Health Plan (State of Victoria, Department of Health and Human Services November, 2015)* promotes a vision of service system and community that provides opportunities for people living with mental illness to live valued lives as equal citizens. Improved citizenship status, in this context, relates to inclusion in all aspects of Australian life; services and communities drawing on the lived experience leadership of people with mental illness; effective strategies for mental health promotion; a more integrated approach to mental health service development, planning and delivery; and improved engagement and performance from mainstream organisations in delivery of services and support. https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorias-10-year-mental-health-plan

mental health services in terms of supporting the citizenship claims of people living with mental health issues. For Barham, the challenge is to 'reclaim (people) for citizenship':

*'The destiny of people who are assigned the role of mental patient depends on the degree to which those around them recognise and respect how normal they are, rather than how ill they are. If you've learned that psychiatric disabilities persist even after the patient has left the Asylum, we have surely also learned that the problems of disability and demoralisation cannot simply be dealt with in narrow technical terms. The real dispute is not between those who think chronic mental health issues has been left behind in the asylum and those who recognise it for what it is, but between those who want to improve the social prospects of people with long-term mental health issues, to reclaim them not for mental patienthood but for citizenship, and those who settle for a highly restrictive vision of the 'place' of people with mental health issues in social life in which they must be 'content to be on the sick and cope and manage' as best they can'.* [62]

Simon Duffy at the Centre for Welfare Reform has developed a framework for understanding and guiding what we might call 'citizenship work'. For Duffy, *'Citizenship is important because it reminds us that we can each live a good life, in our own way, while also being able to live together with mutual respect. Citizenship means rejecting the idea that people's worth can be measured by money, power, fame, intelligence or any of the other ways that make people different and, which some people imagine, define 'what is important.'* [63]

Duffy's Seven Keys to Citizenship are – Freedom, Money, Home, Help, Life, Love and Purpose. Citizenship provides an important focus for talking about the factors that constrain and expand the terms of community membership available to people. It recognises the potential for all people to contribute, give and actively shape the communities in which they live. For people living with mental health issues, this potential is often largely unrealised, because there are not the social spaces in which they can actively participate with confidence and a sense of safety and security.

In Duffy's framework, the focus on citizenship suggests that we need to raise expectations of ourselves, people living with mental health issues and 'others' in the community to consider more thoughtfully the sources of personal and community meaning available to us.

The work of the ministries resonates with Duffy's citizenship framework, with their focus on creating safe and welcoming community 'spaces' in which people can freely participate to find support, affirmation, acceptance, love, dignity and friendship, and develop the skills and confidence to enact their citizenship by being active contributors to congregational and community life.

The ministries provide informal mainstream settings which mobilise volunteers and a range of other supports to enable people to feel this sense of belonging and to be a part of the life in their local community as valued citizens. They provide a platform to explore the seven keys to citizenship and to provide and receive the mutual respect which enables one to imagine and work towards 'a good life.'

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[62] Barham 1992, p.151

[63] Duffy, cited at http://www.centreforwelfarereform.org/library/by-az/keys-to-citizenship2.html

## Community Development – a mobilising practice approach

Community development provides one of the key strategies for challenging the 'disabling' and 'marginalising' tendencies within our community. With community building, as one of the key goals of the mental health missions, the ministries can draw on a range of resources to inspire their community development planning and practice. [64]

While the ministries currently use some community development approaches in their practice, a more sophisticated understanding and systematic application of community development strategies would strengthen their work.

The church is well placed to lead **community building activities** in partnership with a range of community stakeholders. At this point, this 'co-productive potential' is not fully realised, or well defined and articulated in the mental health ministries.

There are a number of organisations and resources that could assist the Ministries to develop and strengthen their community development practice. One of these is the Borderlands Community Development Cooperative located at Habitat at the Augustine Centre in Hawthorn. With over 20 years' experience in community development training, research and publishing and led by Dr Jacques Boulet , Borderlands draws on a range of academic and activist perspectives to inform its community development practice. With national and international connections, Borderlands continues to publish New Community, the last remaining journal dedicated to community development in Australia.

A key community development framework that is well aligned with the work of the ministries is Asset Based Community Development (ABCD). ABCD is a community led approach originally developed in the United States by John McKnight and John Kretzmann through their work at the Asset Based Community Development Institute in Chicago. [65]

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[64] See for example:
Born, P. (2014) *Deepening Community*. Building Communities that Sustain Us.
http://www.deepeningcommunity.org/
Born, P. (Editor) (2008) - *Creating Vibrant Communities: How Individuals and Organizations from Diverse Sectors of Society Are Coming Together to Reduce Poverty in Canada*, Toronto, BSP Books.
John McKnight & Peter Block (2012) *The Abundant Community,* San Francisco, Berrett-Koehler.
http://www.abundantcommunity.com/ (A great website with years of John McKnight's and associates work on the value of community building as a transformative tool).
Schwartz, D. (1997) *Who Cares? Rediscovering Community,* Avalon Publishing,
Vogl, C. (2016) *The Art of Community – Seven Principles for Belonging*, Berrett-Koehler, San Francisco.
Lane, M. (2017) *People, Power, Participation: Living Community Development: A memoir and reflections on community development,* Hawthorn, Institute of Community Development.
*Asset Based Community Development (ABCD) in Action – When People Care Enough to Act*, Mike Green with Henry Moore and John McKnight (2006) Inclusion Press, Toronto. (See: http://abcdinaction.org/ & http://www.inclusion.com/)
Kenny, S. & Connors, P. (2017) *Developing Communities for the Future,* South Melbourne, Victoria Cengage Learning.
[65] https://resources.depaul.edu/abcd-institute/about/Pages/default.aspx

ABCD has four key foundational elements[66] (Kretzmann, 2010[67]; Kretzmann & McKnight, 1993):

- It focuses on community assets and strengths rather than problems and needs (strength based rather than deficit approach):
- It identifies and mobilises individual and community assets, skills and passions:
- It is community driven – 'building communities from the inside out'[68]
- It is relationship driven and recognises that the relationships and social networks in communities are assets in their own right.

The ABCD framework aligns strongly with the ethos of the ministries which seeks to validate the inherent value of all people by virtue of their membership of community and their fellowship in the eyes of God. There is real resonance for the ministries with ABCD with its emphasis on identifying the individual and collective strengths and assets that can be mobilised to create more supportive, resilient and inclusive communities.

In Australia, the Bank of Ideas led by Peter Kenyon[69] and based in Western Australia provides a comprehensive set of ABCD resources, information, consultancy and advice about ABCD activities across the country and internationally. The Bank of Ideas has a free monthly e-newsletter which is well worth subscribing to for up-to-date information about research, publications, training and other resources that the missions and congregation members can access.

Organisations like the Tamarack Institute[70] also provide a range of resources that the missions can draw on to support an understanding of new approaches to community capacity building. As well as ABCD, the Tamarack Institute provides information, resources and articles on co-design strategies and collective social impact as further examples of collective approaches to social and community change.

In summary community development approaches generally use the following strategies as part of the 'CD toolkit'. They are described below with some indication about how they might be used in the context of the mental health ministries:

- ***Information sharing*** - activities and resources which increase knowledge of social issues and promote awareness of services, programs and opportunities available in the local community.

- ***Community education and awareness*** - refers to a range of activities targeting local communities to increase their awareness of the needs and aspirations of people living with mental health issues. A key focus of community education strategies is community capacity building so that local community organisations are better able to understand and include people living with mental health issues.

- ***Training and development*** - refers to a range of activities which build individual organisational and community capacity to support people living with mental health issues. This can include volunteer

[66] https://communitydoor.org.au/asset-based-community-development-abcd
[67] Kretzmann, J. P. (2010). ***Asset-based strategies for building resilient communities***. In J. W. Reich, A. Zautra & J. S. Hall (Eds.), ***Handbook of adult resilience***. New York: Guilford Press.
[68] John P. Kretzmann and John L. McKnight, pp. 1-11, from *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*, Evanston, IL: Institute for Policy Research (1993).
[69] https://bankofideas.com.au/
[70] http://www.tamarackcommunity.ca/

training for congregations as well as leadership training for participants with mental health issues so that they can refine and draw on their existing leadership skills to advocate for change and influence organisational and community planning.

- ***Community mapping/planning*** - refers to a range of activities used to gather information about the full range of resources and assets available in a local community which can be mobilised to support people living with mental health issues.

- ***Networking and partnership development*** - refers to initiatives and projects based on collaboration and partnership between key stakeholders in a local community. This can include the development of new networks which are formed around a particular issue or need, or the infiltration of existing networks by people and organisations interested in mental health issues or otherwise charged with the responsibility of advocating on behalf of people with mental health issues.

- ***Project design and development*** - refers to initiatives and activities that emerge from community consultations and deliberations and usually respond to key issues identified by project partners. Projects designed within a community development context are based on principles of collaboration and co-production and centre people living with mental health issues as key collaborators and project designers.

- ***Advocacy*** - refers to activities by an individual or group which aims to influence decisions and planning within communities, government policy and programs to ensure that the needs and aspirations of people living with mental health issues are understood and asserted. Advocacy can include media campaigns, public presentations, lobbying, research and positioning and support for people with mental health issues to have their 'voice at the table'[71] in key organisational, community and government planning and policy decisions.

Together these strategies enable community workers to focus efforts on multiple starting points to effect change and to draw on a diverse set of skills, expertise and knowledge to facilitate flexible and innovative responses to complex and challenging social issues.

There are a range of benefits for Uniting Church congregations, more broadly, to be gained from adopting and utilising, at least some elements, of community development to strengthen their commitment to mission. In particular Asset Based Community Development, by focusing on the strengths of a congregation and the resources that it potentially brings to a community to enable complex social problems to be addressed, can contribute to a re-energising of a local church community. An example of this was the work associated with *Stable One* led by Jenny Willetts and the Lilydale Baptist Church. [72] *Stable One* is a night shelter program for people who are homeless, initiated in the Shire of Yarra Ranges in 2017. It is based on a similar night shelter model that has been developed by churches in the UK.

[71] Voice at the Table(VATT) is a pilot project managed by the Victorian Self Advocacy Resource Unit which aims to increase the number of people with cognitive disabilities sitting on boards, committees and advisory groups within government, service providers community and mainstream organisations at a local, state and national level, in order to inform and actively participate in planning, advocacy, policymaking, service development, delivery and evaluation.

[72] https://stableone.org/

In many ways *Stable One* exemplifies the power of Asset Based Community Development in action. Jenny's powerful leadership and commitment to providing shelter for 13 weeks during the winter of 2017 saw 165 volunteers and 30 church communities provide support for the program. Even small and dwindling congregations were able to get involved with the program - they may not have had the person power to do much, but they were able to provide their church facility as a shelter. Their capacity to get involved with the program was enhanced by their ability to coproduce with volunteers from churches with stronger membership and/or community volunteers who had been engaged in the project.

In our interview with Scotty Maxwell we told him about Stable One. His response was simple but affirming, ***'good things happen when churches work together'***. Community development practice provides a framework for mobilising across Uniting and in partnership with other denominations in response to a collective sense of Christian mission. *Stable One* is one example of this but there are undoubtedly a number of other issues that could be addressed through a similar commitment to local networking, partnership and coproduction. The potential for reinvigoration of church communities through projects like this is something worthy of further reflection.

The frameworks outlined above provide a basis for understanding and analysing the issues that impact on people with mental health issues from the vantage point of a commitment to social justice within the spirit of the teachings of Jesus and the Gospels. Central to each of them is a realisation that something needs to change in the way communities are organised so that they are more responsive to the aspirations of people living with mental health issues. Together these frameworks provide the philosophical foundation (Christian and secular) for the Mental Health Ministries as they draw on the inspiration and mobilising potential of the Gospel to challenge injustice and pain wherever it is found and to lead the developments of more inclusive communities.

# CHALLENGES, OPPORTUNITIES & RECOMMENDATIONS

In this section of the report a number of key issues are briefly described, and strategies for strengthening the ministries are recommended for consideration. Key community development approaches underpin the suggested strategies, including information sharing, community awareness raising and community education, skills development, community mapping and collaborative planning, networking and partnership development and advocacy.

## 1. Articulating the approach, value and impact of the Mental Health Ministries

The Mental Health Ministries which have been developed in the Yarra Yarra Presbytery over the last 25 years are a strategic community response to the issues of loneliness and disengagement experienced by many people living with severe mental health issues. The Open Door Communities deliver highly valued community connections and personal support which is embedded in local and congregational communities, and inspired by Christian altruism. This imbues the communities with qualities which cannot be delivered through the more regulated formal service system. The value of the approach is demonstrated by the level of referral by mental health services, and the number of participants who attend regularly, many travelling considerable distances to participate in the activities.

It is important that congregations, other stakeholders, and current and potential supporters understand the important work which is supported through the Presbytery. The work of the ministries needs to be articulated in terms of creating community, and as an expression of compassion and common humanity inspired by the Gospels and grounded in theological understandings.

The framework outlined in this report provides a basis to the narrative about the role and intent of ministries. An extension of the narrative would include a description of the impacts in terms of personal development and well-being, friendship, kindness and altruism, spirituality, and belonging to and contributing to a community. The findings from the focus group discussions with people who attend *hope springs* and BCO describe various aspects of their experience and the value they derive from participation in the open door communities and related activities. Any further work on impact and outcomes should include volunteers and others associated with the open door communities, the participating congregations and also those who are engaged through the various activities of the Outer East outreach pastoral ministry.

The narrow framework for measuring outcomes in the more individualised, and 'marketised' (NDIS terminology) approaches are not adequate in the context of the mental health ministries.

There is an opportunity to build a rich set of measures based on the community creating objectives and imbued with the theological context of the work, in order to get a full sense of the comprehensive impact that the ministries have on people living with mental health issues, their carers, friends and family, volunteers and others engaged in the congregations.

An approach to 'measuring' the impacts of the ministries would need to include indicators relating to self-confidence friendship, resilience, the impact of kindness and altruism, and indicators of community participation and 'belonging'. The measures would not only focus on people who live with mental health issues, but all those involved the open door communities including volunteers, paid staff, congregation members, and key partners such as mental health services, supported residential services, rooming houses, and local councils.

Articulating the model and describing the unique benefits of the approach is a priority. The ability to clearly describe the impact of the ministries is critical to maintaining the strong connection between the ministries and the congregations, to maintain the current level of resourcing, and to attract new sources of support.

**Recommendation 1a:** Articulate and describe the approach and develop information resources, and a communication strategy to engage in a more systematic way with current and potential supporters

Suggested strategies:

- Developing resources which articulate the 'model' including reports, videos, regular updates on highlights from the perspective of participants and volunteers. Include the story of how the various ministries were initiated and developed by congregations and Presbytery.
- Develop the capacity of participants and volunteers to 'share the story' about what the ministries mean to them

**Recommendation 1b:** Work with others across the Synod who are developing congregational community outreach initiatives to develop the theological framework underpinning community creating initiatives.

**Recommendation 1c:** In the future consider developing an approach to capture the impact of the ministries for individuals, congregations and networked organisations.

## Finding the balance between informality and more a formal approach

As community initiatives instigated by members of the congregations and as local responses to local issues and people, the ministries are firmly grounded in the community. However, as the demands on the ministries have increased and the extent of activities has grown, there is a tension between organising and formalising and not losing the immediacy, flexibility and 'personal' approach of a less formal approach.

The connection between flexibility and responsiveness is well understood by people in the congregations:

*"The mental health ministry, as with so many other aspects of church life, is caught in this tension between managerialism, and being able to respond urgently to cries for help without first seeking permission ."* [redacted]

*'The church should be about finding ways to be receptive to difference – we need to redefine the margins where we are prepared to go where the rest of the community won't go.....that's the potential strength of the church. But this is particularly complex when you dovetail with bureaucratic requirements – how can you not be thrown off the central game? That's the challenge.'* ( Rev Andy Calder Disability Inclusion for the VicTas Synod)

There is considerable flexibility in the way the BCO outreach role works – with a key focus on responding to needs as they emerge. This 'can do' approach contrasts with many services which have parameters about what services they can offer. The limited nature of some case management and the lack of responsiveness and flexibility frequently mean these services do not 'hold' people who have low stress tolerance, and low levels of trust in services generally. As the coordinator of BCO explains:

*"It's also about the fact that people have left the formal supports of having a case manager because they were not getting the help they needed. Too slow, too infrequent, not set up to help with crisis intense times, not skilled, didn't refer to the right places etc etc. so people prefer to come to me because as they say "you get it done". Often even when people have a support worker I still do a lot of things as the worker does not have the 'time' or the issue is not within their parameters of focusing on the person's mental health and it might be a housing matter. Because we don't have criteria I can help with anything people need support with."* ([redacted] BCO*)*

While paradoxical, it is clear that in some cases the less formal service can be more suited to people with more complex needs. This places considerable pressure on the BCO, as the resources for individual work are limited.

For the mental health ministries, particularly BCO and *hope springs*, where the open door community is complemented by a response to individual needs involving referral and advocacy to get access to services, a role that at times loosely approximates case management, there are sometimes questions about whether the informal approach adequately supports this work. In the context of this informal service approach, a high level of 'professional' judgement is exercised about what can be offered through the ministry, and where formal services need to be engaged. The experience of the person making these judgements is a key to ensuring that people are provided with the formal supports they need, while also being supported through the ministry.

While it may seem that there are few formal 'risk management' processes in place, there is a constant awareness, monitoring and mitigation of risk by the co-ordinators and key volunteers at BCO and *hope springs*. Unlike the situation in other public places and many services, where the delineation of unacceptable behaviour is made clear and the imposition of sanctions is the main control mechanism, in the open door communities there are strong, shared social norms and peer expectations about respectful behaviour, and these function as effective control mechanisms. While some may doubt the efficacy of this 'cultural' approach to social control, its effectiveness has been demonstrated in both the *hope springs* and BCO open door communities, which routinely include some people with poorly developed social skills and behavioural issues, without any serious incidents. The power lies in having established relationships of trust and respect.

Both *hope springs* and BCO have been operating in this informal manner with mostly volunteers, many of whom bring significant life experience, expertise, compassion and wisdom for many years, and these 'communities' have thrived on the mutuality and reciprocity which is inherent in the informal approach .

It is instructive to note that both *hope springs* and BCO were auspiced by Uniting Care agencies for a period of time, but that both have reverted to being managed through the congregations and Presbytery.

There are various risks to congregational initiatives if their management is taken over by more formal agencies. The experience for *hope springs* was both sobering and clarifying:

*'At one stage we were told you have to be part of Kildonan (a Uniting Care agency) but Kildonan looked at our mission and said this is 'far too Christian, you won't get funding with this mission, with all the spirituality stuff in it'. But we said that there is a spiritual dimension to life in mental health and this is a core thing to us so perhaps we might miss out on some funding as a consequence - but so be it. So it was a bizarre relationship with the hierarchy of the church. What came from the ground up was this sense of calling; we felt this was the right thing to do at the right time because all sorts of people were in all sorts of trouble."* ([redacted] *hope springs*)

Undoubtedly it was true that government funding agencies would not fund the 'spirituality' component of the initiative, but for the members of the congregations who had worked hard to establish *hope springs* as an expression of their 'Christianity in action' it was unacceptable to jettison spirituality from the *hope springs* approach. While the consequence of this decision has been a limited resource base, *hope springs* retains its strong support from local congregations, and continues to be highly valued by a wide range of people who attend regularly, some of whom participate in Sunday worship services and other spirituality discussions, and many who do not.

It appears that the experience of BCO was somewhat different, although it is unclear why Uniting Community Care relinquished the auspice arrangements with BCO. The then coordinator, Pam While noted that as personnel changed at Uniting Care, so too did the level of interest and commitment to supporting BCO. Often more formal services find it difficult to see where the less formal services place on the spectrum of services and opportunities which are valuable to people in need off support.

As mentioned above, this more informal approach has served both BCO and *hope springs* well over more than two decades.

The Outer East the ministry is currently functioning as an outreach pastoral care role, and so the questions arising around informality are less relevant. However, key issue for the Outer East role the extent to which it is fulfilling the broader vision for the outreach ministry.

## Affirming the role of congregations in supporting the Mental Health Ministries

The sustained commitment to the Mental Health Ministries for more than 20 years by congregations in the Yarra Yarra Presbytery is impressive. However, during that time it has been necessary for those members committed to the ministries to actively advocate within the church networks to maintain the focus. Inevitably there are many other worthy causes and ideas for alternative ministries which compete for the limited resources within congregations and across the presbytery. Without this ongoing 'advocacy' for the ministries, it will be difficult to sustain the ministries.

A congregation member at *hope springs* described the difficulty of first establishing the commitment to supporting *hope springs* as a congregational initiative:

*"It was an interesting start when we were getting off the ground because the institutionalised church was closely aligned with the institutionalised mental health practice. The church had a chaplain based at the mental hospital, and when it was closed people were meant to be absorbed by the community. To get it recognised that we needed to fund someone to work in the community instead of as a mental health chaplain was 'like ploughing concrete'. .....with this I think we've been ground breakers, but there was this*

*sense in the church hierarchy that's it wasn't such a good idea. At hope springs it took a bit of pushing, and we are still pushing.* ([redacted] *hope springs*)

The vision, creativity, and tenacity, and voluntary and financial contribution of members of congregations have sustained the ministries over two decades, ensuring that the ministries continue to fulfil their mission as 'Christianity in action' in their communities.

In his article 'Outlining a framework for understanding congregational community services', Dr Ian Bedford[73] describes the importance of congregations maintaining 'strategic intent' to ensure a community ministry that expresses a congregation's quest to be a people of faith in their particular location can be retained. Bedford identifies key factors which help congregations to maintain congregational initiatives, including:

- maintaining the congregation's culture and commitment
- the importance of clergy as "active permission givers" or "encouragers" supporting and affirming the lay leadership involved
- networking with other local community services instead of operating in isolation;
- strategically and continuously promoting 'psychological ownership' of the community initiatives by the congregation
- recognising the unique blend of the voluntary and the professional modes of operating
- the importance of appointing people to strategic roles who are linked to, or are willing to become linked into the life of the congregation

Bedford suggests that without 'strategic intent', there is often a natural evolution which sees these ministries lost to congregational life, as they grow in size and complexity. His analysis of two congregational initiatives, one of which is absorbed into a formal agency, and 'lost' to the congregation, and the other which is deliberately maintained by the congregation, provides useful insights relevant to the Yarra Yarra mental health ministries.

**Recommendation 1d:** That the Yarra Yarra Mental Network consider ways to affirm and strengthen the role of congregation members and Presbytery representatives in the management and future planning for the mental health ministries.

## Negotiating the relationship with Uniting VicTas

The Synod is currently leading a process to explore a range of possible relationships between the newly formed Uniting and congregations. This will present opportunities to explore whether there are avenues through which Uniting could support the work of the mental health ministries.

Given the long history of the ministries and the current sense of ownership by the congregations and Presbytery, a key consideration will be the extent to which the Presbytery and congregations retain oversight and control of the ministries.

**Recommendation 1e:** That the Yarra Yarra Mental Network engage with Uniting to explore whether there are avenues through which Uniting could support the work of the mental health ministries.

[73] Dr Ian Bedford, 2014, https://www.urbanseed.org/publications/articles/2015/11/12/u9md70cm61esig18awanfoo12f633p

## 2. Strengthening the connection between the Mental Health Ministries and the congregations

The Mental Health Ministries were instigated by local congregations, and continue to be energised as an expression of mission by local congregations and the Presbytery. The outreach ministries 'belong' to the congregations, which continue to provide support to the ministries through financial contributions and volunteering activity, as they have done over many years. The ministries also have a focus within the congregations. Over the years there have been various initiatives within the congregations to foster welcoming and supportive congregations, including community education and awareness raising, more flexible liturgy and approaches to worship.

Some congregations in the Yarra Yarra Presbytery are more strongly connected to the ministries than others. It is vital that congregations are kept well informed about the work of the ministries, and have opportunities to connect with people who are members of the open door communities.

### Fostering welcoming congregations

The Mental Health Ministries have emerged as congregational responses to people in need in their local communities. Inspired by the spirit of the Gospel they embody the flexibility and full and open heartedness of creative responses to emergent issues and challenges. The ministries support and reach out to people where they are, as an unencumbered expression of care for others. From the beginning members of congregations have extended a welcome to join in worship for those interested in exploring the spiritual dimensions of their lives.

All church communities and congregations are challenged to find a balance between more formal and traditional forms of worship (liturgy) and more flexible approaches to appeal to newcomers and people who are seeking a more accessible and contemporary experience.

*"I have been moving away from the church because I find the liturgy and the patriarchal words oppressive. It sometimes feels like we are in the dark ages. We need to bring in more inclusiveness in relation to gender and diversity. We also need an inter-generational church because the older generation can't keep going. The church has to modernise its way of presenting the liturgy. This has to change and the church has to make a statement about this. "([redacted] BCO)*

Increasing flexibility and responsiveness in the liturgy is seen as one way for the church to open up to new 'audiences'. Within the Yarra Yarra congregations various approaches to more deliberately open and welcoming forms of worship have been developed.

**Recommendation 2a:** Convene a time-limited network across congregations in the Presbytery to consider innovations in the liturgy and other approaches to 'welcoming' people living with mental health issues into congregations. Ensure that the network include members of congregations who live with mental health issues. The network could consider whether specific content referencing mental health should be included, whether there is merit in special services during mental health week or at other times, and any other specific suggestions by members of congregations.

### Capacity building – building leadership capacity and awareness of mental health issues, knowledge about the mental health outreach ministries

At various times, the Mental Health Ministries have included initiatives to raise awareness about mental health, and to build the capacity of congregations to actively support members and carers of those who are living with mental health issues. Currently there is not a strong focus on this aspect of the mental health ministry.

While some congregations in the Yarra Yarra Presbytery have strong historical links to the Mental Health Ministries and individual members have continuing links as volunteers or committee members for the outreach ministries, or providing financial support, many congregations have little connection to the mental health ministry.

As congregations and individuals make decisions about the ministries they support, it would be desirable for all congregations to have access to information and resource material on mental health and congregational responses. Members of congregations involved in the research project expressed a desire to know more about mental health issues and strategies to support members of their congregations and others.

**Recommendation 2b**: That the Presbytery of Yarra Yarra Mental Health Network convene a sub-committee with members of congregations, and volunteers and participants of the open door communities to develop/source community information resources and community education opportunities for congregations, including:

- General information on mental health issues including information for carers
- Information sessions including personal stories and updates on highlights from the Open Door communities, and other initiatives across the Presbytery
- Offer Mental Health First Aid training regularly – to members of congregations and other community members - consider using this opportunity to also promote the Open door communities and inviting people to consider volunteering
- Partner with EACH and/or other services to develop and provide community education
- Explore options for Open Days hosted by volunteers and participants at the BCO and *hope springs* open door communities
- Invitations to congregations across the Presbytery to attend special events showcasing the music and art activities at BCO and *hope springs*.
- Organise forums and/or an annual 'showcase' or conference in the Yarra Yarra area, working in conjunction with participants, key partners and similar initiatives to profile and promote the approach – ensure significant input by participants

## Generating specific support for members of congregations including carers and people living with mental health issues.

Providing information and support for families and carers of people living with mental health issues was a key focus in the initial work of the mental health ministries. Since that time there has been a stronger focus on support for carers in the mainstream, and it is unknown whether this is currently an unmet need within congregations.

**Recommendation 2c**: That the Presbytery Mental Health Network undertake a process to explore the extent to which there is a need for additional support for carers within the congregations, or whether suitable options for carer support exist within the wider community.

## Training & orientation for ministers and other Presbytery leaders

Given their key leadership role within the congregation and also in the broader community, it is important that ministers are well informed and equipped to support people who live with mental health issues and their carers, in both practical ways - including referring to services and supports if necessary - and in providing spiritual care. Others with leadership roles in congregations and the Presbytery could also be invited to participate in the training.

There is considerable expertise across the three ministries and given adequate time key people associated with the ministries could play an important role in providing training and support to ministers and others in the Presbytery, and more broadly in the Synod. This training should also draw on the lived experience of participants with mental health issues who are engaged in the BCO and *hope springs* open door communities as well as volunteers and other key program supporters.

Formal training for ministers and others across the Presbytery should be considered. This would incorporate explorations on the theological foundations for the ministries as well as building knowledge about mental health and the experience of living with mental health issues. Discussions could be held with EACH and local mental health services to support this training. Building this into the partnership with EACH would strengthen the connection with EACH and provide a sounding board for ministers and build their knowledge of referral and support options.

**Recommendation 2d:** The Presbytery of Yarra Yarra Mental Health Network convene a working group with interested ministers from the Presbytery, and representatives from Synod and Spiritual Health Victoria to scope possibilities for mental health training and awareness-raising for ministers in the Presbytery, and within the Synod. The working group should include people with lived experience and carers, and the training should draw on the experience of congregations and the BCO and *hope springs* open door communities.

# 3. Developing the Outer East Outreach Ministry

## The changing focus of the Ministry

The Outer East Ministry has experienced significant change since it was established. Initially the ministry focussed on providing outreach pastoral care with the social group programs offered through Maroondah Hospital psychiatric ward and Halcyon, Lifeworks, and Riverdell, and also providing community education within congregations to increase their capacity to support people living with mental health issues and their carers.

With the closure of the three social group programs, and a reduced focus on work with the congregations, the role is now more individually focused and more reliant on referral by mental health workers or others. This limits the flexibility of the role, and there is a concern that the lack of social group programs in the Outer East is leaving many people with serious mental health issues increasingly socially isolated, with negative impacts on their mental health and wellbeing.

There is interest within Presbytery's Mental Health Network in exploring options for the development of one or more open door communities in the Outer East. However, with resource constraints, it is unclear at this point in time where the opportunities might be to establish a new open door community initiative.

A number of different possible approaches should be explored and scoped to identify potentials.

**Recommendation 3a**: It is recommended that the Presbytery undertake a feasibility study to explore opportunities to develop one or more open door communities in the Outer East area. This feasibility study should include:

- Mapping of the area to identify:
  - Uniting Church and other local congregations which may have an interest in supporting an open door community by providing facilities, volunteers and/or financial support
  - Existing drop-in or meals initiatives offered through Uniting Church congregations and other churches including Wesley Mission-Ringwood
  - Potentials for an ecumenical partnership to support the development of open door communities across the Outer East
  - Additional potential partner organisations with an interest in developing activities, including neighbourhood houses, Helping Hand, Stable One, service clubs, etc
  - Other strategic alliances including key mainstream services and local government
  - Potential locations and facilities including options for a single location or multiple locations operating on different days
- Identify resourcing requirements for various options
- Identify resourcing options including funding, in-kind contributions voluntary inputs and facilities
- Identify workable governance arrangements

### Refreshing the partnership between the Yarra Yarra Presbytery and EACH

The partnership between the presbytery and EACH remains strong with a commitment by both parties to continue the arrangement. However, given the changes which have occurred since the partnership was negotiated in 2006, it is timely to undertake a review of the interests and expectations of both EACH and the Presbytery, and to refresh the partnership.

**Recommendation 3b:** Review the jointly funded position with EACH to review the interests and expectations of both EACH and the Presbytery, and develop a clearer role description and action plan.

## 4. Build the capacity of the Mental Health Ministries across the Presbytery

### Building the resource base

While the unique qualities of the open door communities at BCO and *hope springs* and the Outer East outreach pastoral ministry are highly valued by all who are associated with them, maintaining the resource base is an ongoing challenge. The majority of funding is provided by Synod (through BOMAR) and by direct contributions by congregations in Yarra Yarra. The remainder of funding is provided through a range of sources including local government, philanthropic and service clubs and individual donors.

The Yarra Yarra Mental Health Ministries need to be positioned and promoted more strongly to attract a wider range of supporters.

The open door communities at *hope springs* and BCO operate on very slim resourcing, with a reliance on volunteers and the active contribution by people who attend. In the course of this research, many people

spoke of their concerns about the capacity of the work to be sustained and the toll it potentially takes on the co-ordinators.

*'It is really vital though that BCO gets more support. It is not tenable to work as a single chaplain. I want to make a very strong recommendation that this is on the record for Ministers working within a mental health context. The role requires enormous heart and emotional capacity. We need to support our people who provide care in these contexts'.* ([redacted] Volunteer BCO)

It is clear that people feel the initiatives are operating close to capacity and that any increase in numbers or activities would have to be supported with an increase in funding and resources. However, there is a widely shared view that attracting funding from government sources would lead to significant constraints on the flexibility, creativity and openness of the current approach at BCO and *hope springs*.

Possibilities for developing stronger links with other services were suggested in some discussions as a way of supporting additional opportunities. A number of partnering arrangements have been established by BCO to extend the range of activities that can be provided.

*'... there could be a lot more going on here if there is an expansion of the capacity to staff it. I do not know whether* [redacted] *is the only employee but that's not sustainable in my view and he's not full-time. If you could develop more time and support across the week you could have a different range of activities. You could have other interests for people to pursue and an opportunity for growth of personal interests. One of the things that this place could have if they had another full-time person is they could develop a lot more linkages. Services like Outdoors Inc could offer something here, something low-key, but with a bit more stimulus; activities that people might build on because of the trust that has been developed here, something that might encourage people to take that next step into community-based activities. Some people at hope springs will never do this but some would really get a lot out of it.* [redacted]

Recognising the importance of the work undertaken through BCO, the Boroondara City Council supports core activities with some funding and provides additional support for projects through their annual community grants program. Funding is also sourced through philanthropic and local service clubs etc. for one-off activities and short term projects.

## Maintaining support through the congregations and Presbytery

While there are various sources of funding for the mental health ministries, overall sustainability is closely related to the capacity to maintain funding from church funding sources. It was identified that there is not always consensus about prioritising the mental health ministries. This highlights the importance of strengthening the connections between the congregations and the ministries.

It is important that members of the congregations fully understand the potential of the ministries to enliven congregations by developing more creative and inclusive liturgies and welcoming church communities, and building on the congregational investment and 'ownership' of the open door communities and outreach ministries. Articulating model and approach will assist in 'sharing the story' of the ministries with congregations, and strengthening their connections with the ministries. See recommendations 1a –d, 2a, 2b, and 2c.

## Extending the capacity through strategic alliances and partnerships

While the BCO and *hope springs* are functioning well, both are at capacity, and continue to experience strong demand. Resourcing for both initiatives is an ongoing challenge. It is recommended that strengthening networks around both initiatives will assist in identifying and mobilising resources, and will garner new avenues of support and advocacy for the Yarra Yarra mental health ministries.

The value of partnership and collaborative approaches is significant. The potential to 'coproduce' by sharing resources and knowledge can help to expand and sustain the reach of the ministries and greatly enhance the experience of community life for people living with mental health issues.

Coproduction will also help to extend the influence of the ministry and could potentially position this work more strategically in the local community. For example, the co-ordinator at BCO was instrumental in leading a collaboration project with the Hawthorn Community House and the YMCA Community Recreation Outreach Program (CROP). The development of a jointly supported drop in program at Hawthorn community house exemplifies the potential to respond to what might appear as complex and intractable problem if tackled by a single organisation.

Participants, volunteers and workers all identified a number of activities and opportunities that they would like to see introduced at BCO and *hope springs*. See Attachment 8 for details. Co-productive work is the suggested approach to help expand the range of activities offered by the open door communities.

By drawing on the expertise of other community groups and organisations and entering into partnership with them, the open door communities can be enriched and a range of new opportunities developed, including further opportunities to assist participants to explore options and activities in the local community.

By developing partnerships with specific community groups and organisations the ministries could also play a critical role in ensuring that mainstream community organisations are engaged and more able to include people living with mental health issues in their regular activities.

Extending partnerships will also potentially broaden the circle of supporters for the open door communities and assist in attracting volunteers and other resources. A number of volunteers in the open door communities who are not members of Uniting Church congregations mentioned the inspiration they draw from the approach, and are highly motivated to contribute their energies and skills.

There may be additional opportunities for the Mental Health Ministries to attract funding support from local government. The City of Boroondara has been supporting the BCO over many years, with some core funding, and community grants. Especially in the current environment where there are fewer funded social support programs, local councils are likely to see the Mental Health Ministries as making an important contribution to the wellbeing of local residents who experience social isolation.

**Recommendation 4a:** BCO and *hope springs* coordinators and committees actively explore potential partnerships to support any extension of activities. Potential partners might include members of congregations (Uniting Church or other churches), neighbourhood houses, schools, community interest groups, sports and recreation clubs, service clubs, local government, etc

**Recommendation 4b:** That the Yarra Yarra Mental Network engage with Uniting Prahran to explore whether there is potential for a mutually beneficial collaboration with Uniting Prahran

**Recommendation 4c:** That the Mental Health Ministries seek to strengthen partnerships with local government contacts and seek community grants to support specific projects.

## Mapping and Networking across Yarra Yarra Presbytery

While there is a shortage of social support generally for people living with mental health issues, there are various meal programs and activity programs which are mostly supported by churches from various denominations across the Presbytery area. Mapping and networking with these groups would have the following benefits:

- Enhance referral and service options for people using BCO *and hope springs*
- Assist in identifying opportunities for service partnerships, and developing alliances
- Assist in a coordinated response to funding discussions or partnerships with other local churches to develop a more coordinated and co-productive response
- Potentially develop a stronger advocacy 'voice' on policy issues

There are some other smaller scale initiatives supported by local congregations within the Presbytery which may benefit from being linked to the mental health ministry. It is recommended that a survey of Uniting Church congregations in the Presbytery be undertaken to gather information about current (and past) initiatives. This survey could also gather information to inform a capacity building strategy with local congregations

**Recommendation 4c:** Undertake a survey of Uniting Church congregations and other church networks in the Presbytery, to identify relevant initiatives and other church based activities

## Network with similar Uniting Church ministries

Developing a network with similar initiatives within the Uniting Church across the VicTas Synod would benefit individual initiatives through sharing resources, experience and critical knowledge. In addition, this could assist in profiling the approach, and strengthen the capacity to advocate for these types of congregational initiatives.

The Yarra Yarra Presbytery could host an information sharing session with similar initiatives (and people who are interested or engaged in the issues) in partnership with the Uniting Church Synod. This would help to develop a dialogue about the way church congregations and ministries are working to include people living with mental health issues. It would help to identify the potential for peer support, profile the range of work that is being developed, and identify opportunities to develop the theological foundations for the ministries.

**Recommendation 4d**: Undertake a networking project to identify other Uniting Church led mental health initiatives in Victoria and elsewhere and develop a communications strategy to form an active network for the exchange of information, capacity building and strategy development to support the community responses of Uniting Church congregations and presbyteries.

## Develop a Presbytery wide capacity building role

The three ministries hold a significant level of expertise and experience, and are ideally positioned within sub regions of Yarra Yarra Presbytery. The capacity building work should draw on their expertise, and

develop ways through which their expertise can be shared to support congregations in their work to become more welcoming and supportive of people living with mental health issues. There is a potential to build alliances and partnerships with other congregations and key stakeholders in community; and to develop capacity building, networking and training within congregations and the broader mainstream community.

The expertise and leadership that has been developed within the ministries for over two decades is a vital resource that is currently under-recognized and underutilised by the Presbytery and Uniting, as the limited funding for the ministries allows very little time for partnership development and capacity building activities. To do this effectively the Presbytery would need to extend the funding base for the mental health ministry to support a new capacity building position.

**Recommendation 4e:** That the Presbyteries provide consultancy to congregations and other initiatives drawing on the expertise within the mental health ministries.

A dedicated position within the presbytery to support congregational initiatives would support the mental health ministries, and other initiatives. This position could also undertake networking across the presbytery, and work on identifying options for the further development of the mental health ministry in the Outer East.

It may be possible to secure funding from philanthropic bodies, and local council community grants. NDIS Information Linkages and Capacity Building (ILC) grants will become available in Victoria in 2019, which could present opportunities for a time-limited capacity building role with the Presbytery. The ILC project funding could offer the ministries an opportunity to undertake a discrete capacity building project to work across the Presbytery. This could be attractive to the NDIS, as it could demonstrate an approach that promotes the development of 'mainstream' participation opportunities for people with disabilities that could be replicated in other regions, across other denominations, at a statewide or national level.

**Recommendation 4f:** That Presbytery consider seeking funds to establish a capacity building role to work across the Presbytery to support the further development of the Mental Health Ministries and other congregational initiatives.

## 5. Developing a stronger advocacy role to improve community supports.

The considerable experience and expertise within the Yarra Yarra Mental Health Ministries could be used to advocate and influence key decision makers.

The Presbytery has the opportunity to be proactive and more influential in policy debates about the place of people living with mental health issues in community, and the design and resourcing of services to support community participation and inclusion.

**Recommendation 5:** Strengthen the advocacy role of the Presbytery on matters relevant to the work of the ministries by developing a deliberate approach to advocacy to influence:

- Decision-makers within the Synod, and Uniting – to explore avenues for funding for community development and capacity building roles within the Presbytery to strengthen the capacity of congregational community initiatives
- Interfaith/ecumenical networks in the Yarra Yarra area
- Local government – mayors and councillors in local government areas within the Presbytery

- Current policy discussions about the NDIS and support for people living with mental health issues, working in collaboration with VICSERV, VMIAC
- State Government contacts including the Minister for Mental Health, Martin Foley (who reversed a funding decision to continue support for the St Kilda Drop-in, St Mary's House of Welcome and other similar initiatives)
- Local Members of Parliament

Suggested strategies:

- Regularly report to Presbytery and Synod on the achievements of the ministries
- Build alliances with partners, key stakeholders and similar Uniting Church initiatives (and other denominations) to strengthen the advocacy 'voice'
- Working with the Social Justice Unit at Synod, participate in the policy discourse, and relevant sector forums across all levels of government
- Foster relationships with key stakeholders and 'influencers' within the Presbytery, Synod, Prahran Uniting and Uniting
- Foster relationships with local councils in the Yarra Yarra Presbytery
- Connect with the advocacy work led by the Synod on related social justice and policy issues

# ATTACHMENTS

Attachment 1 When Margaret Thatcher said there is no such thing as society - by Sandy Jeffs

Attachment 2 Project Brief

Attachment 3 Transition Concepts (Paul Dunn and Marie Hapke)

Attachment 4 Information provided to research participants at about the Project

Attachment 5 Detail of the consultations and research participants

Attachment 6 Focus Group Questions

Attachment 7 Ideas for expanding BCO and *hope springs*

Attachment 8 Notes from workshop at Presbytery meeting - November 2017

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# Attachment 1 Presentation by Sandy Jeffs at the Project launch

## A 4am Rant: How Neoliberalism has Highjacked the Recovery Model

In 1987 Margaret Thatcher famously said: *there is no such thing as society. There are individual men and women and there are families. And no government can do anything except through people, and people must look after themselves first. It is our duty to look after ourselves and then, also, to look after our neighbours.* She was giving voice to the new emerging 1980s philosophy of politics and economics where the individual is the sole arbiter of their lives. Ultimately, they self-actualise through the act of consuming. Each person's contribution to the well-being of society is through their continual consumption, to do their bit by buying products. Without consumers, there is no economy.

Anne Manne in *The Life I: The New Culture of Narcissism* writes of the emergence of Neo liberalism in the 1980s *as a new ideology that placed at the centre a vision of Economic Man where the greatest good for the greatest number was based on a vision of the sovereign self, freely competing against others in the market place, pursuing rational self-interest...in this new capitalism was freedom and faith in the beneficent power of the market to deliver well-being.*

The worth of a person is measured not by how creative they are, or by how much support they give to their family and friends, or how resilient they are, or how diligent they are at work, or how much time they give to volunteering. The worth of a person is measured by how much they consume. And if a person is not fulfilling their obligation to consume and contribute through work, if they happen to be receiving a pension like many of us with mental illness do, then we are denounced as *leaners*. The blind faith in this thing called The Market is a form of madness. The Market and how it performs is used by politicians and economists to measure how well a society is doing, and this is misplaced and dangerous. Everything and everyone has been reduced to a commodity. For example. students have become *consumers* buying a product called *knowledge*, households are measured by their consumption of products; art, dance, writing, poetry and music have become part of the creative *industry,* objects and artefacts are called products, the end result of a project is called a product. People with a lived experience of mental illness are called consumers. The language of the economy is everywhere and the Market dominates our lives to the extent that we have hourly updates on its activity with every TV news bulletin. We have become obsessed with the stock market because we have been turned into a society of investors since so many of us have superannuation invested in shares. The Market is even touted as a moral agent that will bring about social change through the agency of people's choices in what they consume. It is the Market, not social policy, that is the supposed game changer.

This neo liberal capitalism is highly suspicious of things such as *social justice* because it raises the spectre of radical Marxist ideas. And it valorises the individual over the collective. I feel this emphasis on the individual has infiltrated the individualised recovery model now in vogue in mental health. The idea that we are going to make you, the individual, recover by throwing all our resources at you, sounds fine. What will this recovery look like? How will it be validated? Will the person be accepted into the social fabric in the process of their recovery? What if they are still affected by stigma? What if they cannot breach the social barriers? What if the person can't engage with an individualised model, or the worker can't work with them on their recovery? Where can they go to get support if this happens? Will their recovery end with a fulltime job? Who will determine that a person has recovered? Will a recovery box be ticked?

My beef is that there is nowhere for people with a mental illness to go and be with their mad comrades. Nowhere to share their war stories. Funding has been withdrawn from day programmes and

drop in centres to fund the new individualised recovery model. One good example of how short sighted some of the funding cuts have been is the Splash Art Studio formerly run by NEAMI where people with a lived experience of mental illness went to pursue their art with the support of established artists. They were practising artists with exhibitions and sales of their art. Splash Art lost funding because it didn't fit the individualised the recovery model. Another example of cuts to funding for a collective programme is in Seymour where WellWays closed their house where they ran programmes for people with a lived experience and carers. Instead, they opened an office where you made an appointment to see a worker. I asked a mother what her son was now doing since the closure of the house and she responded with, *my son is sitting in his room alone smoking himself to death*. I know drop in centres had their problems and were seen as mini institutions where people went and smoked and did little else. And where women sometimes felt threatened and excluded by the men. But some worked well. The Clubhouse model where people engaged with the running of the Clubhouse and learnt skills with each other as support, worked well. I ran writing classes at Terra Firma where participants came along to learn the craft of writing which ended up with a small publication. And of course, we have the NDIS to negotiate with its individualised packages, and we all know it has problems with how to assess mentally ill people, recovery and the episodic nature of mental illness. This is a new can of worms.

Margaret Thatcher might have said*: There is no such thing as society, only individual men and women*, but she forgot *celebrities*. Celebrities are a strange manifestation of the valorisation of the individual. Our obsession with them is out of control. Why we worship someone who appears in a reality TV show or makes a movie is bewildering. And why do we hang off every word they say? As such, why do we appoint them to be our spokespeople for various causes? I am conscious that *beyond*blue has a done a fabulous job in normalising depression and anxiety but they have also celebritised it. Suddenly we find ourselves being more concerned about Ian Thorpe's depression than the person down the road who can't get out of bed to feed themselves or drag themselves to work because they are paralysed by their depression. And with Ian Thorpe's disclosure he doesn't lose his status or adulation, rather it seems to be enhanced because he has had the courage to reveal his mental illness. And *beyond*blue's campaign to normalise depression and anxiety has worked so well that in the public's consciousness the only mental illnesses they are aware of are depression and anxiety. And because celebrities get them, they have almost become the mental illnesses of choice. Even Bipolar has its pin up boy with Stephen Fry. My question is: where are the celebrities with schizophrenia?

The culture of the individual in a neo liberal world has highjacked our sense of belonging. And as a way of feeling like we belong we attach ourselves to the cult of celebrity by worshipping and living through these distant figures we see on the screen or on TV, or read about in mags, or see on-line. Through them we assuage our loneliness.

Individualising recovery can only work if the individual is embraced in a social setting. We *do* live in a society and we feel its pressures all the time. How do we negotiate the tensions between the emphasis on the individual and the loss of the collective? If *there is no such as society, only individuals* then everyone of us is an atomised, unconnected, lonely entity. But recovery doesn't happen in a vacuum. We do live within the realm of others. How your neighbours relate to you, how the check-out person talks to you, how your work colleagues treat you, how the taxi driver talks to you, how you relate to your case worker, how you relate to the people around you and how they relate to you, can impact on recovery from a mental illness. So, while it is your individual recovery at stake, the wider world can heal or harm the process. But to expect recovery to be an individual's responsibility in a vacuum sets people up to fail. Sometimes we need to hear the stories of others who struggle like we do. We need to share our stories from the trenches so we can know we are not alone. We need to feel part of that something which is bigger than ourselves that has the power to embrace us. Sadly, it also has the power to shun us.

And we need to feel accepted for who we are regardless of our economic participation or economic value.

The neo liberal world is tearing us apart and turning us into commodities who worship people we will never personally know or meet, living virtual lives in a virtual world. The notion of *lifters* and *leaners* has seeped into our consciousness. A decent society shouldn't/wouldn't make such a distinction. Recovery must not be looked at only through the prism of how economically valuable a person can be, or how quickly we can get then off the books. Nor do we need to measure ourselves against the plethora of celebrities who parade in front of us with their seemingly fabulous lives, who have highjacked our understanding of what success is. My heroes are those people who everyday live within the darkness of their profound mental distress and still get out of bed and may even manage to go to work or simply walk to the letterbox; ordinary people, unsung for their tenacity who face extraordinary demons and live the best lives they can.

# Attachment 2 Research Brief

PROJECT SPONSOR
Yarra Yarra Presbytery is one of eight presbyteries in the synod of Victoria/Tasmania.

PROJECT TITLE
Mental Health Ministries Research Project – Trends in service needs of marginalised people with mental health issues.

BACKGROUND
The Presbytery has identified ministry to those whose lives are impacted by mental illness as a high order priority.

Three key Mental Health Ministries operate under the auspices of the Presbytery, and others may operate under the aegis of member congregations. Each ministry offers practical responses to the needs of marginalised individuals.

The ministries find expression in:

- Providing ecumenical pastoral ministry in partnership, wherever feasible and appropriate
- Delivering practical emergency assistance to those with unmet needs
- Monitoring trends in delivery of mental health services, identifying emerging needs and advocating for better provision based upon sound evidence
- Highlighting adjustments to government policy and provision
- Identification of volunteer needs and equipping volunteers to support mental health chaplains
- Integrating mental health service provision by Presbytery members and ministers
- Raising community awareness through information gathering, seminars and other distribution of information

MANAGEMENT AND ACCOUNTABILITY
Oversight and direction will be exercised by the Mental Health Working Group of Yarra Presbytery.

FUNDING AND RESOURCING
The project has received a one off grant of $25,000 from the Uniting Church's Board of Mission and Resourcing.

RESEARCH PROJECT OUTLINE

- Identification of key policy parameters impaction upon provision/non-provision of mental health services
- Discussion and meeting with key players in delivery of mental health services
- Meetings with focus groups comprising individuals with mental health needs
- Formal survey of representative sample of those with mental health needs
- Identification of opportunities for Uniting Church engagement in responding to shortfalls in meeting mental health needs
- Recommendation of select strategies for Uniting Church engagement at community and other appropriate levels

TIMESCALE
The project should be undertaken and completed in 2017.

# Attachment 3 Researchers - Transition Concepts

Paul Dunn and Marie Hapke (Transition Concepts) trconcepts@netspace.net.au

**Paul Dunn** has 30 years' experience working in a range of Community and Human Services settings including State and Local Government, large and small NGOs, and academic settings.

A key focus of Paul's work has been the development of new and innovative approaches to service development to improve community access and inclusion for people with disabilities and people living with mental illness.

Paul has held a number of roles working at a local level working actively to promote community inclusion opportunities and has extensive experience working within State and Local Government. He has a comprehensive understanding of current trends and policy developments across state, national and international contexts.

Paul led a major change process within the Department of Human Services through the introduction of a community building framework in Disability Services. This included the development of the RuralAccess and MetroAccess programs in conjunction with Local Government, and support for new community building teams in regional DHS offices.

Paul has a Bachelor of Arts Degree from Monash University and has worked in a number of academic and post graduate teaching contexts. This includes positions at TAFE and at Deakin University in Disability Studies and RMIT in Social Policy.

**Marie Hapke** has 30 years' experience in various settings including community health, mental health, disability services, neighborhood houses, local government, and more recently state government.

Qualified as a social worker, Marie has substantial experience working with individuals and groups, networking, and community development. Much of Marie's work has been in innovative service development with an emphasis on building more inclusive communities through partnership arrangements.

Marie co-ordinated the City of Port Phillip's Special Needs Arts & Recreation Service, developing a range of community participation with people living with mental health issues and homelessness. Initiatives included the Bipolar Bears Band, RAG Theatre Troupe, Rawcus (theatre), Roomers Magazine and a range of community based social and recreation activities.

Marie has also worked with Aboriginal Victoria, and currently works in service development in family violence services.

# Attachment 4 Information for Participants

Uniting Church in Australia
SYNOD OF VICTORIA AND TASMANIA

Yarra Yarra Presbytery Research Project
**Innovations in Community Mental Health Support**

## INFORMATION FOR PARTICIPANTS

The Uniting Church (Presbytery of Yarra Yarra) is undertaking a research project to

- explore issues and opportunities for people living with mental illness
- explore future opportunities for the Church and community to develop support in creative ways.

Background work on the project has commenced including work on the Literature Review and some initial interviews. It is anticipated that the project will be completed by December 2017.

**What will the project do?**

1. A review of relevant research and publications will provide background and a conceptual basis for the project. This will include an outline of the current policy context and exploration of creative approaches of fostering community involvement and connections.
2. The views of a range of people will be sought. There will be opportunities to participate in the project through:
    - Focus groups
    - A limited number of interviews will be conducted
    - A written survey
3. A draft report will be presented for discussion.
4. The final project report will be made available to those who participate in the project.

**Who will be involved?**

The project will seek the views of various people including:

- people living with mental health issues
- church members, ministers and staff and volunteers in the current Yarra Yarra programs
- mental health workers
- other community workers including people working in neighbourhood houses and other key local community organisations
- local government contacts

Participation in the project is entirely voluntary, and participants may withdraw from the project at any time if they wish. Individual participants will not be identified in the project report, unless this is formally agreed with the researchers and documented on the consent form.

If you would like to be involved in the project contact one of the members of the Project Steering Group by 10 September 2017. See contact details below.

The project will be conducted in a responsible and ethical way, and in accordance with privacy legislation and principles.

The research will be guided by the National Statement on Ethical Conduct in Human Research 2007 (Updated May 2015).
https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e72_national_statement_may_2015_150514_a.pdf

This means that the project has been designed and will be conducted in line with the following values:

| | |
|---|---|
| Respect | The autonomy and individuality of participants will be valued in the research project.<br>The researchers will respect the privacy, confidentiality and cultural sensitivities of participants.<br>The researchers will respect the rights of participants, including their right to withdraw from the project at any time. |
| Integrity and Merit | The research will further develop knowledge and understanding about effective community support for people living with mental health issues. It will inform the work of the Yarra Yarra Presbytery, and will also have more general application.<br>The research project will be supervised and undertaken by experienced people who understand the particular context and relevant issues for people involved in the research. |
| Justice | Participation in the project will be open to all those who wish to be involved.<br>The research will be just in the sense that expectations on participants will be reasonable, and the project report will be provided to participants in a timely manner. |
| Beneficence | The research will be conducted with the well-being of participants as a primary concern.<br>The research will be conducted so as to minimise the risk of harm or discomfort to participants |

**Project Steering Group members:**

Lionel Parrott – Yarra Yarra Presbytery lionel.parrott@y7mail.com

John Tansey - Chaplain, Transition Team EACH John.Tansey@each.com.au 9871 1887

Natalie Dixon-Monu - Boroondara Community Outreach natdixon@ozemail.com.au 0409 019 269

Jon Rumble rumble.jon@gmail.com - *hope springs* 9459 8859

**About the researchers:**

Paul Dunn and Marie Hapke (Transition Concepts) trconcepts@netspace.net.au

**Paul Dunn** has 30 years' experience working in a range of Community and Human Services settings including State and Local Government, large and small NGOs, and academic settings.

A key focus of Paul's work has been the development of new and innovative approaches to service development to improve community access and inclusion for people with disabilities and people living with mental illness.

Paul has held a number of roles working at a local level working actively to promote community inclusion opportunities and has extensive experience working within State and Local Government. He has a comprehensive understanding of current trends and policy developments across state, national and international contexts.

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Marie co-ordinated the City of Port Phillip's Special Needs Arts & Recreation Service, developing a range of community participation with people living with mental health issues and homelessness. Initiatives included the BiPolar Bears Band, RAG Theatre Troupe, Rawcus (theatre), Roomers Magazine and a range of community based social and recreation activities.

Marie has also worked with Aboriginal Victoria, and currently works in service development in family violence services.

# Attachment 5 Detail of consultation and research participants

**Interviews:**

Gavin Blakemore and Sieu-Kim (Mission and Ethos Partner Eastern Division, Uniting)
Jenny Willetts, Stable One
Lionel Parrott - (member of Yarra Yarra Presbytery Mental Health Network)
Paulo Reid – Coordinator, 101 Engagement Hub formerly St Kilda Uniting Care Drop In
Peter Ruzyla – CEO, EACH
Rev Peter Sanders - founder, former Coordinator and now volunteer at *hope springs*
Rev. Deacon Andy Calder, Disability Inclusion for the VicTas Synod
Rev. Deacon Pam White – Maroondah Presbytery Mental Health Ministry (Outer East) and former Coordinator at BCO
Scotty Maxwell – formerly Co-ordinator, Halcyon, and volunteer at BCO
Stav Stathanopoulos (General Manager Services) and Janet Charalambakis– Prahran Uniting

**Focus Groups**

Rev Deacon John Tansey, Rev. Deacon Natalie Dixon-Monu and Jon Rumble

**Members of the *hope springs* open door community** (2 Focus Groups)

Anonymous (6)

[redacted]

**Volunteers – *hope springs***

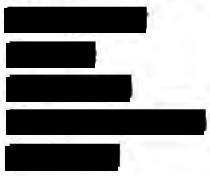
[redacted]

**Members of the Banyule Network of Uniting Churches**

**Workers who refer people to *hope springs***

**Members of the Boroondara Community Outreach (2 Focus Groups)**

**Volunteers – Boroondara Community Outreach**



**Workers who refer people Boroondara Community Outreach**

**Members of Uniting Church congregations in the Ringwood, Montrose and Lilydale areas**

**Workshop at Yarra Yarra Presbytery meeting – November 2017**
Presbytery meeting attended by approximately 80 members of congregations and ministers

**Responded to survey**

[redacted]

# Attachment 6 Focus Group Questions

**PEOPLE LIVING WITH MENTAL HEALTH ISSUES**

**Key topics for exploration:**

- Key challenges for people living with mental health issues
- Views on the types of supports and opportunities currently available
    - what is valued
    - what is in short supply
    - what is missing altogether
- What should be the priorities for support services - What types of opportunities would people like to have
- What are the features of 'good' support
- The role of the church and support services in promoting community membership/citizenship
- Perceptions about the role of the church in the continuum of support
- Possible improvements to existing services (church and other??)

**Questions for focus group or interviews (and surveys):**

**Kew and *hope springs***

1. What do you think are the key challenges for people living with mental illness ?
2. What are the best things about (*hope springs*/Kew drop-in)? (encourage brainstorming)
3. What makes it good? How do these things make a difference ?
4. What if anything would make it even better?
5. Is there anything you don't like about what happens here?
6. Are there activities or opportunities which you would like to see offered, which are not available now?
7. What (if anything) is different about your experience *here* compared to groups or other activities you attend (or have attended in the past)?
8. This centre is run by a church group – are you aware of this? Do you think this makes a difference? if so, what is the difference?
9. Thinking about the support you get from different services – what would you like more of / less of?
10. Are some support services more important to you than others ?
11. Are there issues you have to deal with which you would like more support with? If so, what kind of support would be helpful?
12. To what extent to you feel part of your local community? What would make it possible for you to feel more connected?
13. Do you have any other comments or suggestions?

**EACH clients (if we not get access)**

1. What do you think are the key challenges for people living with mental illness?
2. Think about the different support services, activities or groups you attend - what makes it a good experience for you?
3. What is helpful? What would you like more of / less of?
4. Is there anything you don't like about the services you receive and the opportunities which they provide?
5. What if any changes would make your experience better?

6. Are some support services more important to you than others?
7. Are there issues you have to deal with which you would like more support with? If so, what kind of support would be helpful?
8. Are there activities or opportunities which you would like to see offered, which are not available now? What would these be?
9. To what extent to you feel part of your local community? What would make it possible for you to feel more connected?
10. What do you understand John's role to be? Do you think this is an important role? if so, why ? If not, why not?
11. Do you have any other comment or suggestions?

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**MENTAL HEALTH AND OTHER RELEVANT SERVICE PROVIDERS**

**Key topics for exploration:**

- Key challenges for people living with mental health issues
- Views on the types of supports and opportunities currently available
    - what is most important
    - what is in short supply
    - what is missing altogether
- What should be the priorities for support services
- What are the features of 'good' support
- The role of support in prompting community membership/citizenship
- Types of opportunities people with living with mental health issues should have?
- How could existing services be improved? (formal mental health services & community based services)
- Interaction with and views about the services provided by YYP. How is the role of the church perceived?
- Anticipated impact of the NDIS on the provision of support services
- Vision for the future – potential for further engagement with YYP in supporting people living with mental health issues

**Questions:**

1. What do you think are the most difficult issues facing people living with mental illness?
2. Thinking about the range of support services and opportunities generally available to people living with mental health issues in this area, which services do you think are:
    a. Most important
    b. In short supply
    c. Missing altogether
3. What do you think makes for the most effective 'social support' for people living with mental health issues.
4. What if any additional supports or services do you think would assist people living with mental health issues to have a stronger sense of belonging in their local communities?
5. What role if any do you see for community groups including local churches in supporting people living with mental health issues ( if there are examples which illustrate your point, please mention these)
6. Do you have any particular views about the role of local churches generally in supporting people living with mental health issues?

7. Are you aware of the activities/support program provided by (Kew drop-in/hope springs)/ if so, can you comment on:
    a. The range of support offered
    b. The effectiveness of support
    c. Any opportunities for improvement ( in your view ), including new or different activities/approaches
8. *(EACH) Replace Q6 with What is your understanding of John Tansey's role? What is your view about this role? What if any benefits or issues do you think are associated with the role?*
9. Do you have a view about the likely impact of the NDIS on the provision of social and community support and activities for people living with mental health issues?
10. Do you have any further comments?

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**CHURCH NETWORKS AND VOLUNTEERS**

**Key topics for exploration:**

- Views about the role of the church in supporting people living with mental health issues
- The role of the church in promoting community membership
- Views about the success of the current approach
- Views about any challenges/ drawbacks of the current approach
- Vision for the future

**Questions:**

1. What role if any do you see for local churches/congregations to support people living with mental health issues?
2. What do you think are the most difficult issues facing people living with mental illness?
3. What do you think local churches should be doing to support people living with mental illness?
4. What if anything do you think local churches can offer which is unique, and not offered through the more formal services?
5. What would support local congregations to be more active in providing this kind of support?
6. What if anything do you think local churches should not be involved (in relation to support for people with mental health issues)
7. Considering the work of the Kew drop-in/hope springs:
    a. What do you think are the most successful aspects of their work?
    b. Are there aspects of the approach which you think does not work well?
    c. What if any connection does you see between spirituality and supporting for people living with mental illness?
    d. What would you like to see more of and less of in the future?
8. What do you understand to be the role of the Outer East Mental Health Ministry ?

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**NEIGHBOURHOOD HOUSES, COMMUNITY CENTRES, RECREATION & ARTS PROVIDERS**

**Key topics for exploration:**

1. Involvement in supporting people living with mental health issues
2. Views about the NDIS and impact on their capacity to support people living with mental health issues
3. Views about the role of the church in providing support for people living with mental health issues
4. Ideas for promoting community membership of people living with mental health issues

5. Vision for the future – potential for further engagement with YYP in supporting people living with mental health issues

**Questions:**

1. What do you think are the most difficult issues facing people living with mental illness?
2. Thinking about the range of support services and opportunities generally available to people living with mental health issues in this area, which services do you think are:
    a. Most important
    b. In short supply
    c. Missing altogether
3. What do you think makes for the most effective 'social support' for people living with mental health issues.
4. What if any additional supports or services do you think would assist people living with mental health issues to be more connected to their local communities?
5. Are you aware of activities in neighbourhood houses which support people living with mental health issues – either in this area or elsewhere – please give examples.
    a. What makes for a successful approach in a neighbourhood house?
    b. What if any issues or challenges are there?
    c. What if anything would you like to see happening in neighbourhood house to support people living with mental illness in this area?
6. What role if any do you see for other community groups including local churches to support people living with mental health issues ( if there are examples which illustrate your point, please mention these)
7. Do you have experience of successful partnerships or other initiatives in community houses which have been successful in supporting people living with mental illness?
8. Do you have any particular views about the role of local churches generally in supporting people living with mental health issues?
9. Do you have a view about the likely impact of the NDIS on the provision of social and community support and activities for people living with mental health issues?
10. Do you have any further comments?

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**LOCAL GOVERNMENT SERVICES / CONTACTS**

**Key topics for exploration:**

1. Involvement in supporting people living with mental health issues
2. Views about the NDIS and impact on their capacity to support people living with mental health issues
3. Views about the role of the church in providing for people living with mental health issues
4. Ideas for promoting community membership/citizenship of people living with mental health issues
5. Vision for the future – potential for further engagement with YYP in supporting people living with mental health issues

**Questions:**

1. What do you think are the most difficult issues facing people living with mental illness?
2. Thinking about the range of support services and opportunities generally available to people living with mental health issues in this area, which services do you think are:

   a. Most important
   b. In short supply
   c. Missing altogether
3. What do you think makes for the most effective 'social support'for people living with mental health issues.
4. What if any additional supports or services do you think would assist people living with mental health issues to be more connected to their local communities?
5. Are you aware of services, activities or opportunities offered through the Council to support people living with mental health issues – either in this area or elsewhere – please give examples.
   a. What makes for a successful approach?
   b. What if any issues or challenges are there?
   c. What if anything would you think Council could be doing to support people living with mental illness in this area?
6. What role if any do you see for other community groups including local churches to support people living with mental health issues ( if there are examples which illustrate your point, please mention these)
7. Do you have any particular views about the role of local churches generally in supporting people living with mental health issues?
8. Do you have a view about the likely impact of the NDIS on the provision of social and community support and activities for people living with mental health issues?
9. Do you have any further comments?

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**OTHER STAKEHOLDERS**
**Questions:**

To be tailored, drawing on any relevant questions above, plus specific to area of interest/expertise

# Attachment 7 Notes: Workshop at Presbytery Meeting Nov 2017

**Workshop Qn 1a.** What is needed to provide better support to people **within congregations** who are experiencing mental health issues, and their families and friends?

**Workshop Qn 1b.** What could be done within congregations to better support people within congregations who are experiencing mental health issues, and their families and friends?

**Empower the congregation to share with all and not leave mental health issues to professionals alone.**

Empower congregation – we can all care and notice – mutual care

- Leadership team need to be aware –of asking too much
- People need permission to say no
- Congregation members as 'apprentices' to professionals
- Use the various skills and expertise of church members
- "we can love freely – we can tell the story"
- Theological understanding of the inclusive God leading to a welcoming environment
- Understanding our role
- Balance between being tolerant and being welcoming

Find ways to raise awareness about mental health issues:

- Speak about the issue – as many keep silent
- Open a space for sharing of wisdom on both sides without judgement
- Cross cultural, multicultural awareness
- Congregation meetings re mental illness – to name it, and discuss
- Depression is a real issue in many/most congregations – look out for over commitment by our people/ministers (can be linked to depression)
- We all encounter mental health issues ("we all have mental health issues – some of us haven't been diagnosed yet")

Education about mental health issues:

- First Aid for mental health – how to respond
- Being educated about the different forms of mental illness
- Suicide support/ prevention
- Understanding dementia - Dementia Australia
- Understanding backgrounds and causes leading to mental illness
- Mental illness doesn't always have cures
- Communities don't always need to 'make allowances' for bad behaviour
- People tend to hide their conditions
- Be aware of cycles and episodes
- Recognising need

- Regular routines
- Respecting boundaries, including our own for self-care
- Culture of safety initiatives
- Dispel myths
- Notice change in behaviour eg withdrawal

**What support can the church offer?**

- Welcome people as they are
    - Every person is unique
    - Acceptance of behaviour – eg come late, say strange things
    - Openness to the issues
    - We can all notice and care
    - Do not take things personally
    - Give people space
    - Listen, support, without making judgements
    - Listen to the stories without making assumptions
    - Meeting people where they are – tailor approach to individual
    - Respect for diverse experiences and needs
    - Inclusion – avoid isolation
    - Contact via internet
    - Finding roles for people to participate
    - Avoid segregating into group made up only of people with issues
    - Welcome reduces stigma – treat people as people – not clients
    - Do not shun families who are impacted by mental illness/mental health issues
    - the church as a supporting and caring community
    - Church people making the church a friendly place
    - welcoming DNA, where all people feel safe
    - Walk the talk
- Mental Health Support Group - Heathmont Uniting Church
    - Meets monthly – discuss stories and issues for sharing and peer support
- Spiritual care
    - Role of pastoral care network is very important
    - Creating a space for spiritual care
    - Pray for them
    - Include family/pastoral care
    - Help with theology: especially when a person's choice is compromised and classic counselling and spirituality is inappropriate
- Skills based response (rather than typical pastoral care)
- Practical support ( there are many ways to express care and love)
    - Physical support – food, a place to go, sense of community (loving and patient)

- Ability to refer, and follow up seek expert advice – know community resources – eg housing support, professionals
- Use the various skills and expertise of church members
- Meals
- Assistance with mowing etc

- Ensuring safety
  - Dealing with issues – eg homeless people setting up camp in church property – how to respond, role of police, safety issues etc
  - Keep everyone safe – inclusion in safe church policy – embrace safe church code of conduct
  - Recognising skilled people to manage particular behaviours – involve professionals as they have expertise and experience

**Workshop Question 2a.** What role do you think the church should play in **providing outreach support** to people who are socially isolated due to long term and chronic mental illness?

**Workshop Question 2b.** In what ways can congregations support outreach initiatives which provide support to people who are socially isolated due to long term and chronic mental illness – and what support should be provided to members of congregations to be more involved?

1. **Welcome into worship**
   - Our worship styles may be alienating
   - Theological understanding is important

2. **Supporting outside of worship**
   - Need to increase awareness in congregations
   - Support individuals and families (in the church) living with mental illness
   - Volunteering in outreach programs and initiatives (volunteering is a two-way street)
   - Financial support (VIF)
   - Link with Uniting (VIF) eg Connections with Harrison uniting – low cost housing – shared and built resources
   - Mental health ministry can be a bridge for changing community attitudes and increasing acceptance of people with mental illness
   - Does outreach mean going out and visiting? if so, how can that be done responsibility ?
   - Perhaps a willingness to invite/engage within our own homes? (depending on circumstances – safe church etc)
   - Build relationships between congregations and established programs (*hope springs* and BOC)
   - Annual service with personal story/testament
   - Monthly lunch for cares

- CAVE
- Practical support – eg driving

**3. Examples of responses**

St Stevens Community Living Centre – outreach programs offered to the community
Heathmont UC welfare office
FTG (?Ferntree Gully ?) Girl Guides Hall – free meal – feeling of community
Gippsland UCs – community meals
Croydon – community meals
Hope Springs
Boroondara Community Outreach
East Ringwood congregation started EACH
Visiting shut-ins
Some congregations run weekly drop-ins

- Helpful to have professionals to support **or** to speak with congregation members to equip them with increased awareness.

**4. Issues and Potential Opportunities**

- Long term plan involving Wonga Road property
- Ongoing funding is an issue, but government money may be a poisoned chalice
- Struggling with 'shoulding' in the church
- Church is ideally placed to support (outreach) but some smaller congregations may struggle – critical mass
- Being proactive rather than reactive
- Need to determine skills and capabilities within congregations to deal with mental illness
- Recognising those in the community with mental illness and how they desire to be helped.
- Many members feel unprepared to deal with mental illness. Need for training to skill and reduce stigma.
- Pastoral care for visitors and volunteers – build confidence
- Gathering – debrief lunches for peer support and mentioning to build confidence
- WWCC

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Key reflections post the workshop

- Leadership role of ministers a key to building capacity within congregations.
- Existing volunteers in BOC and HS could be a resource in education and inspiring others
- Need for awareness raising and education within congregations

# Attachment 8 Participants and volunteers at BCO and hope springs were asked for their views on new or additional opportunities (if resources were available):

## Kew participants

**Suggestions for other activities**

- Table Tennis
- Portable housing for women
- Reading and Writing Groups
- Scrabble
- Men's Group
- Bring U3A here.
- Basic psychology classes
- Personal Development classes
- Exercise Classes eg Tai Chi
- Computer Training / Training on the internet and smart phones etc
- People from within the groups running more things – eg social things, Movie Nights
- Education Groups – like current affairs groups – things to keep your brains going
- Gentle exercise groups (Exercise at the Salvos on a Monday is magnificent – you can do a full push up or a half push up. The instructor take in people's ability and needs....he is great. Can we get Bill to come here? )
- Camps in partnership with rural congregations

**Strengthening the program**

- Expand with the same model but don't go too big.
- More days for open invitation meals - not just Tuesdays
- Space could be better eg an Arts Specific studio – and we could get a bit more tech savvy with our exhibitions.
- Another room for other activities
- Draw on a roster of volunteers of participants
- How do you balance drop in with more structured programs
- It would be great to be able to improve kitchen
- How can we raise $ for more activities
- There is no website or promotional pamphlet - there should be a pamphlet that can be left around – and there could be a section on the website for donations
- It's really important that we get more support for Natalie

**Additional services**

- Laundry Services
- Service on a Sunday in a regular basis (currently only monthly)
- Centrelink visits to BCO
- Doctor to visit BCO

- Access to companion cards – 2 for 1 movies
- Visiting legal service at BCO

## *hope springs*

Note: less time was spent discussing this question in the *hope springs* focus groups

**Strengthening the program**

- It would be great to have more scope to try and encourage people to do more to follow their individual interests and realise their potential
- there is space for another day a fifth weekday - there is room for growth but not under the current staffing structure
- more outside people coming in to join the group not just as formal volunteers
- people learning from each other
- Stronger links with the men's shed (but more support is needed to make this happen successfully)
- Support for people to do things beyond *hope springs*
- A mini bus and driver, to help people to get to *hope springs*