Social Work Focus

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SOCIAL WORK PRACTICE AND MENTAL HEALTH

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NEXT EDITION

Contributions for the Autumn 2018 issue will be accepted until 28 February. The theme for articles will be **The first Australians: Aboriginal and Torres Strait Islander peoples**.

AASW members whose articles are published in *Social Work Focus* can claim time spent to research and prepare them towards CPD requirements, specifically Category 3. We accept up to 10 articles in line with each issue's social work theme.

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CHANGING OF THE GUARD

CHRISTINE CRAIK
AASW National President

I begin my first National President's report for *Social Work Focus* with heartfelt thanks to our past President Karen Healy. Together with an amazing team of dedicated Board members, Karen has steered the Association into a sound position, both in terms of increasing membership and financial stability.

I would also like to express sincere appreciation to our CEO, Cindy Smith, and her committed team, for the incredible amount of work they have done to ensure that the Association is better placed to meet the challenges ahead, and to ensure that members receive the best value possible from their professional association.

Last financial year was the fifth year in a row that the AASW recorded a budget surplus. We are now in a sound financial position and have reached our equity target that we were advised to achieve back in 2011–2012. Having reached this target, we are now investing in government-backed ethical investments (as members have asked us to do). The AASW will continue to invest in initiatives for members that promote the social work profession and achieve greater social justice for the people we work with.

However, we are not here to make a profit. We are committed to remaining financially sustainable and solid, but this year the Board has made a firm decision to spend time, energy and money reinvesting back into the Association and its members. We will reinvest in our IT systems and social media presence, in our staff and staff management teams, and in our CPD and advocacy strategies. This is long overdue, is necessary to meet the challenges of the larger professional association we are, and is in line with our new strategic plan.

The new strategic plan will take us through to 2020 and will help us to navigate through this next stage of growth and innovation as we aim for 20,000 members by 2020. The plan is built upon seven pillars aiming to achieve our vision of 'Working together for professional excellence and social justice'. This will be achieved by promoting and advocating for the profession of social work and AASW members; continuing to be a strong voice for social justice; building the professional capacity of members; upholding our responsibilities for the regulation of the profession; advancing Aboriginal and Torres Strait Islander social work; collaborating with our international colleagues; and providing responsible governance and management.

There are so many opportunities in this new strategic plan that will take us forward and into projects and actions that previously we have not been able to invest as much energy in as we may have wanted to. It is difficult to single out any one objective that is more exciting and necessary than another, however the implementation of our reconciliation action plan, working with Aboriginal and Torres Strait Islander social workers to make a difference and reaching out to our social work neighbours in the Pacific region are particularly exciting.

Upholding the standards and responsibilities around regulation of the profession will also continue as important work this year. Not only will we continue with our registration campaign, but we will be working closely with educators and other stakeholders to ensure we have sound processes of consultation and ways forward for our education standards, accreditation procedures and work towards a national conversation on field education.

The important work of good governance will continue with further review of the governance of the Association. When we made changes to the constitution in 2015, we flagged that these were the first actions in a process towards best governance practice for our association.

This coming year will be as exciting as it will be challenging. The communities, families and individuals we work with deserve social work and social workers to be the best we can be. We owe it to them and we owe it to ourselves. So this is my call to arms. I encourage all members to be involved and to contribute when your knowledge, time and expertise is called for in our state and national bulletins.

We are nothing without member participation. I encourage you all to be the inspiration that makes your colleagues want to join the Association and be part of this terrific project. The AASW is only as good as those who contribute and it is up to all of us to make this the Association we want it to be.

Enjoy this issue of *Social Work Focus*. Mental health is a challenging field and along with our understanding of the impact of systemic disadvantages on the mental health of those we work with, our ability to be skilled and generous listeners and to show respect for those we work with, places social workers in a unique and vital position in the understanding of, research into, and delivery of, mental health services.

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AASW AND MENTAL HEALTH ADVOCACY

CINDY SMITH
Chief Executive Officer

The AASW National Symposium 2017, 'Advocacy and social work: Creating individual and social change', held in Hobart, was a great success. It was a wonderful experience to hear from so many social workers across Australia who came together to share new research, experiences and ideas.

We had more than 60 presentations from social workers. We were also very fortunate to hear from our guest speakers the Hon. Michael Kirby AC CMG and Julian Burnside AO QC, who provided the audience with many stories from both their personal and professional lives detailing advocacy in action. More than 280 social workers attended the symposium and of these 120 social workers were first-time attendees of an AASW symposium. It was just fantastic to see so many social workers together sharing ideas and networking, which we know is a great foundation for advocacy.

I would like to thank the staff and volunteers who worked hard to ensure the AASW National Symposium 2017 was a success and I am looking forward to seeing how we can make the AASW National Conference in South Australia 2019 even better.

The AASW continues to advocate on key mental health issues and the important role of the profession in this field. In the past year, we have completed numerous submissions, engaged in government consultations and met with ministers and key stakeholders. Submissions have focused on a range of issues including suicide, adoption, family violence, child abuse and elder abuse, to name a few. We advocate for a more inclusive and holistic approach to mental health that considers both individual and contextual factors.

We have also worked with government on range of consultations including: The Fifth National Mental Health and Suicide Prevention Plan, the implementation of the Review of Mental Health Programs and Services and the Medicare Benefits Schedule Review. The Medicare Benefits Schedule Review is currently considering how the more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The AASW has so far been involved in all the relevant forums and made a submission based on member consultation in relation to pay equity and better utilisation of social work supports. This inquiry is ongoing and we will continue to provide updates through our communication channels.

In the past few months we have focused on improving access to mental health support for aged care residents. Currently there are more than 170,000 older Australians living in residential aged care who are ineligible to access much needed mental health services, from Accredited Mental Health Social Workers for example. Representatives from the AASW met with Federal Minister for Aged Care and Minister for Indigenous Health, Ken Wyatt AM, MP to discuss the issue and while the policy hasn't changed, there are some promising indicators. Furthermore, after several years of advocacy the government has finally allowed telehealth sessions for mental health services to be covered under Medicare. This is a major milestone with significant impacts on the ability to provide supports for people in rural and remote communities.

This is an overview of some of the work we are undertaking, if you would like to learn more or are interested in contributing you can visit our webpage: https://www.aasw.asn.au/social-policy-advocacy/submissions-advocacy

We have developed a new strategic plan to take us through the next two years. Key internal stakeholders have contributed to the development and future direction of the AASW. A framework of seven pillars has been developed, underpinned by key areas of focus. Looking forward to 2018, the AASW will be busy working towards our mission to promote the profession of social work, advance social justice, uphold standards and build capacity of members.

AASW CEO Cindy Smith meets with Federal Minister for Aged Care and Minister for Indigenous Health, Ken Wyatt AM, MP

A MESSAGE FROM THE PAST PRESIDENT

Karen Healy, who completed her term as president of the AASW in October last year, looks back at the highlights of her six-year term.

KAREN HEALY AM

During my six years in the role of President of the AASW, I had the privilege of leading an effective Board and Association that delivered many positive outcomes to members.

These include: achieving financial viability for the Association; strong membership growth, today reaching well over 10,000 members; much needed governance reforms realised through a review of our Constitution in 2015; improved opportunities for members to learn and connect with others, including through the re-introduction of regular national symposia; and building the AASW's profile as a strong voice for our profession, for social justice and for reconciliation.

These achievements have only been possible because of the hard work of the Board, the branches, the national committees, practice groups and the dedicated AASW staff. Thank you to you all.

For me the key highlights of my time as National President include meeting members and hearing of your inspiring work to create change. Another was having the opportunity to represent the AASW in major national forums and international events, particularly as part of the steering committee of the World Congress for Social Work and Social Development held in Melbourne in 2014.

Other highlights were developing the national presence of the profession in the media, in public policy debate and in advocacy for professional registration, and increasing the use of online technologies such as online streaming of AASW events, webinars and our SWOT online platform for training and national practice networks.

The achievement of our first reconciliation action plan and the launch of our second are also excellent achievements and were enabled by the outstanding leadership of Jo Lee (Director from 2013 to 2017) and Linda Ford, who joined the Board in 2017 and who was later elected unopposed to the position of National Director (Aboriginal and Torres Strait Islander representative). Thank you Jo and Linda.

There is, of course, much work to do in the next stage of the AASW's evolution and I wish the Board all the best in leading our growing and diverse Association.

Karen Healy AM
AASW Immediate Past President

MENTAL HEALTH AND TELEHEALTH

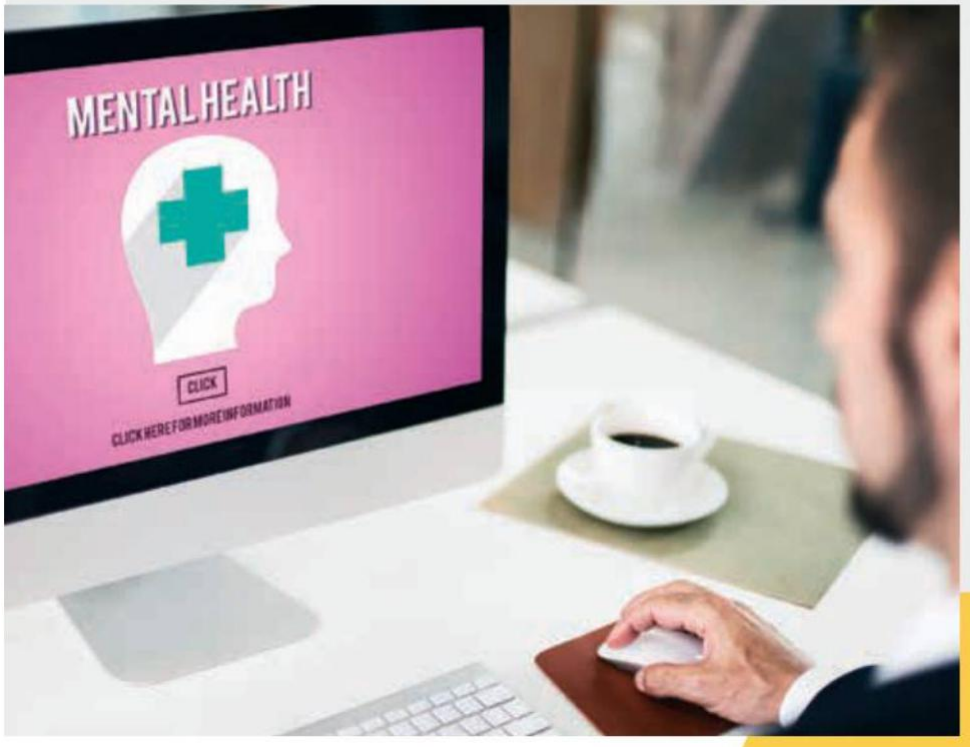
A new Medicare rebate for mental health services via telehealth for people living in rural and remote regions became available in November last year. Telehealth refers to the provision of a health service using telecommunications technology where an audio and video link can be established.

After several years of direct advocacy efforts by the AASW, this is a significant shift in policy and an important step towards making mental health services more accessible for all Australians. The online services are available as part of the Medicare Better Access to Mental Health Care initiative, through which Accredited Mental Health Social Workers can now provide focused psychology strategies through video conferencing.

The guidelines for the new scheme are available on the Department of Health website and we recommend members who are interested to have a look. According to the guidelines, up to seven of the 10 sessions currently offered under Medicare rebatable mental health plans will be available via telehealth. One of the first four sessions is required to be delivered through a face-to-face consultation to facilitate a personal connection with the mental health professional. We are currently working with government and advocating a greater expansion of the scheme to improve access for individuals for whom face-to-face consultations may prove difficult.

The service is available for people living in rural and remote areas or in the Modified Monash Model regions four to seven, which cover smaller country towns and remote and very remote locations. This will ensure that the services go to areas with the biggest access challenges, not to larger regional centres that are more likely to have mental health professionals.

The AASW is continuing to work with other stakeholders to develop additional information and resources to support the safe and effective implementation of this initiative. We will continue to keep you informed of the development of resources.



Key information

New MBS Numbers:

80151 – 20–50 minutes

80161 – 50+ minutes

80171 – 60 minutes (6–10 people)

For further information, you can visit:

- the AASW's telehealth page on our website, which provides further information about the roll out, including maps detailing which regions are covered, and new Item Numbers;
- the Department of Health's Medicare Benefits Schedule (MBS) Online web page for further detail about the new Telehealth Item Numbers,
- for questions about the interpretation MBS, Medicare can be contacted by phone: **132 150** or email: askmbs@humanservices.gov.au

STARLIGHT SUPPORTING ADOLESCENTS IN MENTAL HEALTH UNITS

The Starlight Children's Foundation, established in 1988, works closely with social workers and other health professionals to develop programs that have a positive impact on sick children, adolescents, and their families. Starlight's programs focus on supporting and caring for the whole family unit and have evolved to meet identified needs, including the increase in mental health issues.

Adolescence is a time of change. For young people with a serious mental health condition, normal changes and development stages can be delayed or compromised. Repeated hospitalisation, long lengths of stay, the restrictive nature of mental health units and the effects of an illness can compromise a young person's development.

The Starlight Livewire In-Hospital program provides a space for young people to interact with each other, while helping to transform the hospital experience for them through ward-based activities and empowering workshops.

A recent evaluation of the program at the Royal Children's Hospital's Banksia Unit in Melbourne highlighted the value of this service. It showed that the Livewire program assists in fostering social connection, and building self-esteem and self-efficacy. Findings indicated that the program and its facilitators helped support hospital staff in their roles.

A related outcome was that the Livewire program is highly valued among both health professionals and the young people involved. Hospital staff reported that Livewire sessions alleviated boredom among the young people, enhanced their mood and reduced overall stress and anxiety, leaving the adolescents feeling more relaxed.

Starlight currently delivers the Livewire program to young people being treated in mental health units at six paediatric centres across Australia.

For additional information, email impact@starlight.org.au.

LINDA MONDY: A GREAT ADVOCATE FOR SOCIAL WORK

KAREN HEALY*

Linda Mondy, esteemed AASW member and Foundation Fellow of the Australian College of Social Work, has passed away on 19 August last year.

Linda was known to many of us as a social worker who was passionate about quality service, evidence-informed practice, and social justice for vulnerable children and their families. She was the very embodiment of the qualities to which we aspire: calm, warm, compassionate, smart and dedicated.

Linda's career spanned more than 50 years. Her first foray into the social welfare field occurred in 1965 when she started work as an administrative clerk in the Unmarried Mothers Department in the London Borough of Haringey. Her duties included transporting newborn babies from Irish Catholic girls who had come to London to have their babies adopted. She started her formal education in social work in 1972 sponsored by the London Borough of Haringey at the University of East London.

From 1974 to 1983, she worked as a qualified general local authority social worker in the London Borough of Haringey. After a total of 18 years' service, Linda left Haringey and between 1983 and 1985 was a Senior Social Worker in the London Borough of Hackney. Following the birth of her daughter, Joanna, Linda returned to social work in London in 1986.

In 1987, Linda migrated to Australia with her husband Stephen and daughter. Shortly afterwards, her son Luke was born.

From 1988 to 1993 she was the senior social worker at St Vincent's Boys Home in Parramatta. The service focused on the restoration of young men to their families.

In 1993, Linda joined Burnside as a senior manager and held executive positions for more than twenty years until her retirement in 2015. During her time at Burnside she was able to pursue her passion for evidence-based services to vulnerable children and their families.

In 1997, Linda was awarded a Churchill Fellowship to study Newpin (New Parent Infant Network), an evidence-based intensive family support model originally developed in the UK. Linda was instrumental in developing the Newpin model in Australia. In 2008, Linda and Stephen Mondy published an edited practice collection on the Newpin model.

Recent longitudinal research has demonstrated the success of UnitingCare Burnside's Newpin program in substantially improving the safety and wellbeing of vulnerable children and their families. New South Wales Premier Gladys Berejiklian recently stated, 'Under the program, vulnerable families have received life-changing support.'

Linda's other great passion was out-of-home care. She worked tirelessly to promote positive outcomes for children and young people who were unable to live with the families into which they were born. Her colleagues note that Linda was a fierce supporter of best practice in out-of-home care and always fought hard to ensure that children and young people received the best possible care and opportunities.

Linda had a strong professional identity and was a great advocate for social work. She encouraged professional development of her staff, and her colleagues observe that 'Linda would stand up for good practice over office politics'. Linda was appointed a Foundation Fellow in the Australian College of Social Work in recognition of her considerable achievements in social work.

Vale Linda Mondy, a treasured colleague who will be missed.

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**By Karen Healy with support from Linda's family and friends.*

VIV MAHER: A PASSION FOR SOCIAL JUSTICE

MARY HOOD

Viv Maher, who passed away on 16 August last year, was made a Life Member of the AASW in 2015, acknowledging her 40-year social work career working for social justice.

Viv first worked in Papua New Guinea, establishing a Film Unit at Papua New Guinea University with a Myer Foundation Grant, and tutoring there. She also became the sole social worker in PNG Department of Health doing casework, supervision and community development.

Coming to South Australia in 1980, Viv worked at the South-East Community Shelter becoming Director in 1989. She used the role to establish a highly professional and sustained model of support for women and children fleeing domestic violence. This role involved cementing relationships with the local Aboriginal community (Buandig Country) and employing Aboriginal women as support workers, which at the time was groundbreaking. Later in her career, Viv found and acknowledged her own Aboriginal heritage though a male forebear of hers married to an Aboriginal Tasmanian woman. The name of 'that wonderful woman' was unrecorded Viv said.

During the AIDS epidemic in the 1980s, Viv supported members of the local gay community as well as raising awareness of the issues associated with the disease – in a time of great fear, little understanding and much stereotyping across the world.

Viv was a strong advocate of young people. She worked in child and adolescent mental health (CAMHS) and education, and was a successful promoter of the child's voice in family law and mediation in her time at Centacare.

As a tutor at University of South Australia's Mount Gambier campus, Viv paved the way for student placements to occur in non-traditional settings, such as in the Forestry Union, establishing projects to educate around domestic violence, and research projects in a special education school. Her legacy includes the tributes paid by many of the social work graduates who were guided by her great wisdom, intelligence and compassion.

Viv's passion for social justice and equality prompted her to run twice as a Labor candidate for the South Australian state parliament. Despite standing in a conservative seat, Viv's left wing views were well known and respected. Political activism remained an element of her social work career, and one of her proudest moments was to attend Government House to see her eldest son Kyam Maher sworn in as Minister for Aboriginal Affairs and Industry in the current SA Government.

Viv retired from formal employment in 2015 but continued to work with Pangula Mannamurna Inc., an Aboriginal community-controlled health service in Mount Gambier, and writing a book with husband Jim.

With the passing of Viv Maher, the whole South Australian social work community felt the loss of a wonderful social work leader and advocate. Viv's passing was rightly acknowledged in regional and state media with a funeral held in her honour attended by the state premier Jay Wetherill, and with council flags posted at half-mast to mark her passing. We pay tribute to her wonderful example to us all.

DISTINGUISHED SPEAKERS HEAD UP AASW'S 2017 SYMPOSIUM

The 2017 AASW National Symposium, held 1–2 December last year in Hobart, was a success by any measure. The event was well attended, with a higher number of delegates than expected having registered, and feedback was universally positive. Guest speakers Michael Kirby and Julian Burnside were well received.

The symposium was preceded by the Annual General Meeting of the AASW on Thursday, 30 November, which was followed by a cocktail party in the evening to welcome delegates. AASW National President Christine Craik gave the Opening Address on Friday morning to get events underway.

The theme of the symposium was 'Advocacy and social work: Creating individual and social change'. Sixty presenters, who presented more than 80 sessions over the two days, spoke on a broad variety of topics related to the theme, according to their own areas of experience.

The Keynote Address was given on Friday by the Hon. Michael Kirby, a former Justice of the High Court who has served on a large number of national and international bodies, such as the United Nations. This address on advocacy, the law and social change received coverage in Tasmania's *Mercury* newspaper. Later, at the Symposium Dinner, Melbourne QC Julian Burnside was the guest speaker, having stepped in to replace Gillian Triggs, who unable to attend due to illness.

Burnside, a well-known human rights and refugee advocate, was a suitable replacement, who engaged his audience despite having been given short notice to prepare a speech and having braved the Friday's wild weather to arrive by plane from Victoria. He reflected on his experiences as an advocate for individuals and on broader human rights and refugee causes.

Organisers were pleased with the attendance at the symposium, reporting that more than 280 delegates attended, of whom 122 attended the symposium for the first time. All sessions, including the early morning sessions at 8.15 am, were well attended, as were the cocktail function and pre-dinner networking session, which provided a social aspect for delegates.

The venue, the Hotel Grand Chancellor, was also deemed a success as having the sessions, networking events and dinner at the one location worked well and having participants all in the one place promoted networking opportunities and created a positive, upbeat and inclusive atmosphere.

Next it will be Adelaide's turn to host, with the AASW National Conference planned for South Australia 2019.

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National Symposium
Keynote Address
The Honorable Michael Kirby AC CMG


National Symposium 2017

VISION FOR PEACE AND RESPECT THROUGH EXCHANGE

Ten days in country Victoria doing the rounds with a rural social worker is quite a step away from life as a social worker in Moscow, but that was Marina Alaricheva's experience in September 2016. Marina was one of five international human services professionals who took part in a professional exchange program with the Council of International Fellowship (CIF) Australian branch.

Marina, together with social workers from Austria, Finland, Kyrgyzstan and Turkey, spent three weeks in Australia, initially in Adelaide for orientation and then 10 days on individual field placements in various parts of Australia. She then returned to Adelaide for evaluation and assessment of the experience with the group.

Having grown up in rural Siberia, in the Soviet Union, Marina was keen to find out about human services in a country area and so was hosted by AASW member Martin Butler, a rural social worker and farmer from the small town of Teesdale, near Geelong in Victoria. Often, to the extent that it is possible, host organisations provide placements for participants in their area of interest or expertise.

Martin was asked to consider hosting by Denise Grieshaber, one of CIF Australia's 'members-at-large' and a former president of the Australian branch of the organisation. The experience of learning through intercultural exchange works both ways between participants and hosts. Like all hosts Martin volunteered his time, taking 10 days off work to ensure that Marina had a great learning experience. He said it was 'full on' but that it was 'very rewarding hosting the exchange'.

Martin gave Marina the opportunity to visit various agencies in and around the local area, such as CatholicCare and Hope Bereavement Care, and introduced her to the Ripple Effect, a rural-based suicide prevention project with which he is personally involved. Having worked with Rusfond, the largest fundraising association in Russia, which works to help seriously ill children, Marina found it 'eye-opening' to visit small non-government organisations. She gained quite an insight into rural social work during her exchange, learning not only about the problem of suicide but about the prevalence of ice and other drugs, the lack of financial sustainability, and managing disability.

Writing for the AASW Victorian Branch newsletter, Marina commented, 'One of the advantages of the program is that you get not only the professional experience but cultural as well.'

The Australian branch of CIF has been operating since 2006, however the organisation was set up in 1960 based on the work of Dr Henry Ollendorff. Ollendorff was a labour lawyer who arrived in the United States in 1938 having fled Nazi Germany. Unable to practise law in the US, he retrained as a social worker.

In the wake of the devastation of the Second World War, his vision was to create a fellowship of youth workers and social workers with the aim of bringing people of different nationalities, races and religions together to create international understanding, peace and respect for one another. The Cleveland International Program of 1956 and ultimately the international fellowship group grew from that vision.

CIF Australia's stated aim is to 'promote international understanding and world peace' through the exchange program and to provide professional development through intercultural exchange for social workers and human services professionals.

If, like Marina, you are interested in learning about social work practice in other countries and you are keen to share your own experience, then the Council of International Fellowship (CIF) exchange program is something you might consider. CIF is 'a private, voluntary, non-profit, politically and religiously independent organisation' that provides social workers and human services professionals with the opportunity for short-term international exchanges.

There are 31 National Branches of the Fellowship throughout the world and many of these also run exchange programs. The 2017–2018 CIF program has a list of some 25 different exchange opportunities, ranging in length from 10 days to 4 weeks. Costs are reasonably low; there is a program fee, which averages 300 euros (roughly AUD$450) although for some there is no fee at all, and participants pay for their own airfares. The program fee is to cover costs only as administrators and hosts are all volunteers, and participants are provided with meals and transportation costs are covered while on exchange.

CIF Australia *is a branch of the Council of International Fellowship (CIF).*

Marina Alaricheva

Martin Butler

WORLD SOCIAL WORK DAY
20TH MARCH 2018

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CHILDREN, PARENTS, AND FAMILIES: LIVING WITH MENTAL ILLNESS

VICKI COWLING

Over past decades, there has been increasing awareness of impact on families when caring for loved ones with a mental illness. Vicki Cowling explains the diverse lived experiences of people caring for a family member with a mental illness in eight different situations.

In research conducted toward my PhD thesis, I made a study of support available to children and families living with a family member with mental illness, describing the experiences of eight different perspectives within a family context. Some of those living with and caring for a family member with mental illness may also have a mental illness, such as a parent with mental illness caring for a child who also has a mental illness.

The eight different situations are: parent with a mental illness; partner of a parent with a mental illness; children who have a parent with a mental illness; caring for a child with a mental illness; grandparents who are primary carers; foster parents; Aboriginal and Torres Strait Islander families.

There is little information about the number in each of these groups, with research concerning children and families in the past two decades focusing on parents with a mental illness who have dependent children, and children and young people who live with a parent with mental illness. Estimates based on mental health and Australian Bureau of Statistics (ABS) data show that there are close to 600,000 sole- and two-parent families in Australia with at least one parent experiencing a mental illness, with more than one million children in Australia being estimated to have at least one parent with a mental illness; this represents 23.3% of the population of children aged 0–17 years. A snapshot of the eight families follows.

A parent with a mental illness

Parents with a mental illness caring for dependent children are more likely to be on a low income, a sole parent, and socially isolated, with some of their children also having a mental illness. Motherhood and fatherhood are important roles, being central to a sense of self-worth, and having children helps to focus parents' lives. Parents may be fearful their children will develop mental illness, and that they will experience the stigma associated with mental illness. One parent has described the many losses parents may experience due to mental illness, including loss of income, loss of rights, loss of hope, and loss of their children. She also described the triumphs and complexities of life with children being pushed to extremes when a parent has a mental illness.

The partner of the person with a mental illness

Partners worry about the impact of mental illness symptoms on the unwell parent, and on their children, and may consider taking the children from the family home to protect them. Partners may feel hopeless and helpless. One father realised that he needed to accept his wife's depression was not his fault, and that he needed to be honest about his feelings, rather than try to be strong. Partners have described the impact on families of unpredictability, absence of the unwell parent, poverty, and disappointments when family outings are cancelled.

About the author

Dr Vicki Cowling, OAM, has worked for recognition of children of parents with mental illness (COPMI) and their families for 25 years through research, professional development projects and publications, and contribution to the work of the national COPMI initiative. In 2016 she completed a PhD in social work at the University of Newcastle. Vicki works with children and families as an Accredited Mental Health Social Worker in private practice in Melbourne.

Children who have a parent with a mental illness

Children and young people of parents with mental illness need to know what is happening for their parent, in an age appropriate way, and to understand how their parent's mental illness symptoms may affect them. They want to be included in discussions about their parent's treatment, sometimes they are expected to manage their parent's medication. School may be a refuge from home life, but bullying may occur at school, and academic progress may be affected if the young person has responsibilities for their parent. Children are aware of the stigma and negative beliefs others have about mental illness, and may not talk about their parent's mental illness as they do not want to lose friendships. Children and young people have also reported their strengths such as maturity, independence, and being able to effectively problem solve, and be responsible for family finances and housekeeping.

Caring for a child with a mental illness

Parents who care for a child or children with mental illness have reported feeling worried, depressed, and tired. Some take medication to alleviate these symptoms. Online interventions parents have used include education about symptoms and treatment, development of behaviour management skills, problem-solving skills and stress management skills.

Siblings of children with a mental illness

The experiences and needs of siblings of children with mental illness are virtually unknown as information is not systematically collected about how many there are, and how they may be helped. For some children, being a sibling may lead to a higher susceptibility to emotional or behavioural problems, although a cohesive family environment and supportive networks can act as a buffer. Siblings may experience teasing at school, and feel ambivalence towards their brother or sister, with home life disrupted, studies affected, and reluctance to bring friends home.

Grandparents who are primary caregivers of grandchildren

Grandparents parenting grandchildren may vary in number from 8,000 to 63,000 families in Australia, depending on how the family structure is defined and where age limits of children are set. An unknown number are 'hidden' as they may choose not to identify as the primary caregiver for their grandchildren due to cultural traditions, which include looking after family members and not seeking help. Grandparents providing primary care of children whose parents have mental illness are a further hidden group. Grandparents become the primary caregivers for their grandchildren for numerous reasons including physical illness or disability of the parent, substance abuse, mental illness, or child abuse and neglect.

The children may be infants when grandparents are called on, or volunteer, and they may resent the loss of freedom imposed by taking up the role of parent. Grandparents experience health, financial, and social impacts in caring for their grandchildren, such as stress, depression, and physical ill-health, and financial disadvantage. They may have to find housing where children are included, with this change affecting friendships, and social opportunities. Relationships with other family members may be disrupted. Grandparent groups are a source of social and psychological support where grandparents can find out about financial entitlements and legal rights.

Foster carers

Foster care is provided in a private household by carers who have undergone relevant screening and approval processes, and have been authorised by a relevant department or agency to provide care, and for whom there are varying degrees of reimbursement across Australia. The Australian Institute of Health and Welfare report, Child Protection in Australia 2015–2016, reports that there were 13,100 foster carers with one or more children in care at some point during that year. Children are generally placed in foster care following substantiations of abuse or neglect. Being a foster carer has financial costs, time costs, and emotional and psychological costs, including impacting on relationships with family. The foster carer's friends may not want to include children in social activities, and the behaviour of foster children may also lead to distancing from friends.

Aboriginal and Torres Strait Islander children and families

The experiences of Aboriginal and Torres Strait Islander children and families living with a family member with mental illness needs to be understood in the context of their history and culture. Family and kinship relationships influence Indigenous families and, alongside connections through ancestry, spirituality, song and story lines, and ceremony, are central to their holistic view of health. Children, young people and adult Aboriginal people are more likely than non-Aboriginal Australians to experience emotional or behavioural difficulties. Social and emotional wellbeing is negatively affected in many ways, with the forced removal of people from their lands, and children from their families, causing widespread grief and loss, and economic and social disadvantage. Health protecting factors include connection to land, culture, spirituality and ancestry, self-determination and cultural continuity.

It is important to understand the lived experience that is specific to each of these groups, and each individual who lives with a child or adult with mental illness. There is ample opportunity for further research related to each group where experiences specific to these individuals and their roles can to be studied, with findings adding to our understanding of their lived experiences.

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GETTING TO ONE OF THE ROOT CAUSES OF MALE SUICIDE AND DEPRESSION

TONY PHISKIE

Depression and suicide are gripping Australian males at alarming rates. The suicide rate is the highest it has been for at least ten years.

In 2015 alone, 3,027 people ended their own lives in Australia, 75 per cent were men. Suicide is now the leading cause of death for men under the age of 54, according to the Australian Bureau of Statistics. Although the numbers are shocking, those of us working in the sector are not surprised. It is part of the dialogue of many conferences and discussion papers as we grapple to find strategies to turn this around. However, what I see as missing from the dialogue is an in-depth discussion of the root-causes. Why are our Australian men suffering? What has happened in their lives to drive them to a point of no return?

I've been working with men for more than 25 years and, in my experience, men who have suffered childhood trauma, particularly abuse and specifically sexual abuse, suffer the effects into adulthood. The Australian Institute of Family Studies' paper on the long-term effects of child sexual abuse identified several studies that indicate that sexual victimisation, both in childhood and beyond, is a significant risk factor for suicide attempts and for (accidental) fatal overdoses, among both men and women. A study by the National Institute on Drug Abuse in the US found that as many as two-thirds of all people in treatment for drug abuse report that they were physically, sexually, or emotionally abused during childhood.

At Survivors & Mates Support Network (SAMSN), an organisation dedicated to providing support services to adult male survivors of child sexual abuse, we have also found these linkages. Our 200 plus members have told us that they suffer from depression, anxiety or mental health problems (93%); have suicidal thoughts or feelings (62%); have self-harmed (46%) or have displayed suicidal behaviour (37%). Almost all our members have poor self-esteem (89%); problems in their relationships (84%) and many have abused drugs and alcohol (76%).

The Royal Commission into Institutional Responses to Childhood Sexual Abuse has brought to light the wide-scale nature of child sexual abuse in an institutional context, estimating that 60,000 survivors may be eligible to seek redress and compensation. But the problem is bigger than institutional abuse, and research indicates that between one in 6 and one in 10 Australian men have been sexually abused before the age of 16 (Foster, Boyd, & O'Leary, Improving policy and practice responses for men sexually abused in childhood, *ACSSA*, 2012), and that the average time it takes for a man to disclose his abuse is 21 years. International research would suggest the first figure of one in 6 to 10 men is conservative and we know that the rates of intrafamilial child sexual abuse of females are even higher.

The co-founders of SAMSN themselves have lived experience. We know that recovery from child sexual abuse is possible and that survivors can live very full and rewarding lives, but the right help and support must be provided.

As social workers, we have a responsibility to adopt trauma-informed responses, as we work with clients who disclose or show signs of past trauma such as problems with substance use, gambling, suicidal tendencies or depression. In the right context, we should be asking our clients the question of whether they have experienced a childhood trauma such as sexual abuse. We should encourage them to seek support from services such as SAMSN, who provide a range of services including an 8-week group program for adult male survivors of child sexual assault, funded by the NSW Department of Justice, Victims Services.

If you want to find out more about trauma-informed care for men who have experienced sexual violence as children, SAMSN runs regular workshops for service providers that include the opportunity to ask questions of SAMSN's co-founders about their lived experience. We also run workshops for family and friends who are supporting adult male survivors. For more information visit samsn.org.au.

About the author

Tony Phiskie has more than 25 years' experience working with survivors of sexual assault, having worked at Eastern and Central Sexual Assault Service (ECSAS) at Royal Prince Alfred Hospital, Sydney. He is the Principal Social Worker at Survivors & Mates Support Network (SAMSN), a leading support organisation for adult male survivors of child sexual abuse in Australia.

CLOSING TIME: RECONSIDERING THE CONCEPT OF DISCHARGE IN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Fran Cheverton examines the current meaning of 'discharge' within child and adolescent mental health services, and the organisational factors that contribute to the increase in re-referrals. She then discusses how concepts from Attachment Narrative Therapy can lead to a re-thinking of the meaning of 'discharge'.

After nearly ten years of working as a child and adolescent mental health (CAMHS) clinician in Australia and the United Kingdom, I have witnessed service demand increase leading to extensive waiting periods. This is partly due to poor funding arrangements and a rapid rate of new referrals. But, there is another factor, a consistent increase in re-referrals of previously discharged clients.

Due to increased demand, once clinical goals have been reached, client's file is closed to CAMHS and they are discharged from the service. The client no longer has appointments and they are removed from the clinician's caseload. Closing a client's file is a time-consuming process. Upon completion, clinicians breathe a momentary sigh of relief before being allocated another case, with the aim being that clinicians always work to capacity.

However, discharge does not mean that the client can't return to CAMHS. It is common for CAMHS teams to have a policy whereby clients can be re-referred anywhere between one and six months after discharge. If re-referred, ideally the client is seen by the same clinician and their need prioritised. I reiterated to all the children, young people and families that I discharged that they could always re-contact me, or the service, in the future.

But simultaneously going through my mind was the small print, a bit like what you hear in an infomercial, 'Conditions apply: there is no guarantee that your child will meet our diagnostic thresholds in the future; if your child is accepted by our service, they may be waiting for an extended period of time even if they are prioritised; oh, and I may not be able to see them again as I will have a full case-load.'

In my experience, not only is this policy ineffective for families, it also places significant strain on clinicians. I remember my manager explaining that a discharged client had been re-referred and saying, 'I don't suppose you have space to see them?' The manager knew that I had no time, my case load was full, but that I would say yes, I would see them, because that's our policy. No consideration had been given to how caseloads could be managed to cater for re-referred clients.

I believe that CAMHS should maintain its re-referral policy, but what is contributing to a higher than average re-referral rate? And, could changing our approach to therapeutic endings, reduce re-referrals and make caseloads manageable?

Understandably, CAMHS is invested in implementing protocols that improve mental health, while also increasing the rate of clients' movement through the therapeutic process, to meet growing demands. Setting clear, attainable goals with clients, using best evidence-based interventions, and informing progress through routine outcome measures have all been features of my everyday practice. But, often something got in the way of me implementing them fully. It was this: complexity and the importance of relationship.

The children, young people and families who come to CAMHS have, as per government policy, complex and painful needs. Their needs go well beyond what the DSM-V would ever be able to describe.

However, the CAMHS protocols and policies put me in a double bind. I was to only work with the most complex of families and yet expected to do this in a timely manner with clear goals. Attachment expert Pat Crittenden describes this dichotomy, 'We strip a complex and painful situation of its complexity, reducing it to a simple, albeit unrealistic task. Why? Because it makes our job easier.'

About the author

Fran Cheverton is a registered social worker and family therapist. She specialises in working with children, young people and families who have experienced attachment injuries and traumatic experience. In addition to working privately, Fran is the lead consultant for the Trauma and Healing Team with the Berry Street Childhood Institute.

The more I attempted to strip complex family problems back to clear goals, I noticed my levels of frustration toward families increased, 'they're just not engaging in the process,' and I noticed families feeling misunderstood. Simultaneously, I was bombarded with re-referrals. And it wasn't just me, my colleagues were identifying the same concerns.

As I was hitting crisis point, 'Tammy'* and her family were referred for family therapy and I encountered the work of professors Rudi Dallos and Arlene Vetere and their Attachment Narrative Therapy (ANT) Framework.

ANT is a framework for practice combining attachment and systems theory and therapy with social constructivism – how we make meaning of our lives. ANT highlights the importance of the therapeutic relationship, working with complexity and engaging with the messiness of emotions. Dallos and Vetere remind us of the fundamental importance of building and maintaining therapeutic relationships at a time when moving clients through the system has become the central focus.

So how did this help me to work differently with Tammy? Tammy had had a year of cognitive behavioural therapy and the clinician thought that Tammy had made vast improvements. Discharge had been attempted, but the family kept coming back. With ANT in mind when I met with Tammy and her family, I heard important implicit messages for the first time. These messages families had been saying for years, such as, 'I've experienced a lot of loss in my life. I'm scared about therapy. I need to know that you won't leave me too soon.' And, 'I know all relationships have to end, but when the time comes, can it be slow?'

Is this why re-referrals were so high? Was it as simple as slowing the process down and maintaining a therapeutic relationship for a slightly longer period to ensure the consolidation of therapeutic insights? For Tammy's family and many more families I went on to work with, yes, this was the answer.

But how did I go about doing this when organisational pressure to move clients through the therapeutic process was so high? I used the family therapy concept of 'both/and'. I continued to use outcome measures and goal setting, *and*, I asked my manager and team if we could experiment with the meaning of discharge while working with Tammy's family. They agreed.

Dallos and Vetere stress that for the work of therapy to be consolidated, the therapeutic relationship needs to be maintained for a period of time following therapy. Instead of discharging Tammy the moment improvement occurred we increased intervals between sessions. The family could contact as required, but as Dallos suggests, 'The security we feel in knowing we can come back is often enough to avoid major relapse'. I made a monthly check-in phone call and this often sufficed. After 3 months of no sessions, the family contacted to say that things were great, and that they didn't need to come back. I invited them to a final session, we reflected on the family's progress and thanked them for changing the way we understood therapeutic endings – they had taught us a great deal.

Tammy was never re-referred to CAMHS. Providing families with time to consolidate and digest what they have gained from therapy, while knowing that their clinician remains available, leads to better outcomes for both families and the organisation. Clinicians don't have to balance a full case-load and re-referrals, but best of all, this approach to endings can lead to a long-term decrease in re-referral rates. Throughput helps in the short-term, consolidation in the long-term, using a 'both/and' approach is one way we could attempt to improve CAMHS for all.

**Not her real name.*

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COMPLEX ISSUES BEING ADDRESSED IN THE CHILD PROTECTION SECTOR

LISA J. GRIFFITHS

The approach to dealing with complex mental health issues within the child protection sector in Australia has been in a state of inertia, writes Lisa J. Griffiths. While there were few significant improvements in approaches or practice or renewed investment, the number of children and young people being taken into care continued to grow, rising to more than 46,500 in 2016. Lisa outlines a new strategy that promises to improve outcomes.

Last year, the NSW Government announced Their Futures Matter, the most significant child-protection and out-of-home care reform in a decade. Their Futures Matter is the government's coordinated approach and long-term strategy to improve life outcomes for vulnerable children and families. Their Futures Matter sets out a cohesive and accountable system where client outcomes, strong evidence and targeted services are delivered based on the needs of children and families. The reform is premised on an unprecedented level of collaboration across NSW Government agencies.

The changes will provide earlier support to families to address underlying issues, including mental health.

Mental health issues are linked with a range of adverse outcomes including family stress and breakdown, drug and alcohol abuse, unemployment and associated poverty and homelessness. These factors can have devastating impacts on the health and wellbeing of children and young people and increase the likelihood of abuse, neglect and the need to enter out-of-home care (OOHC). Further to this, once in OOHC these outcomes often get worse, so early and effective interventions that work are needed.

OzChild is one of the service providers delivering two new evidence-based family preservation and restoration models – Multisystemic Therapy for Child Abuse and Neglect (MST-CAN®) and Functional Family Therapy – Child Welfare (FFT-CW®) as part of the Their Futures Matter reform.

At OzChild, part of our strategic plan is to ensure everything we do is informed by evidence, so that we can make a conscious and measurable impact.

Let's face it, treating mental health issues can be complex and challenging. We need to take a more holistic approach and provide context-specific services that address this complexity to deliver gold-standard services and break the cycle of disadvantage and improve outcomes.

For families who are at risk of having their children removed from their care, evidence-based programs from leading international organisations such as the New York Foundling demonstrate context-specific and tailored services that provide families with the best hope for family preservation or restoration. In fact, the 2011 New York City Independent Budget Office Fiscal Brief showed that evidence-based interventions saw a 50 per cent reduction in the number of children in foster care over a 10-year period.

MST-CAN and FFT-CW are two models that have proven to be successful internationally and locally in targeting the causes of harm, including mental health issues, that put children at risk of entering the OOHC system. Both FFT-CW and MST-CAN models have built solid research bases over time, across different countries. The results from culturally diverse populations widely support the models' efficacy in working with children and families with multiple and complex needs, including family violence, mental health, and parental drug and alcohol misuse.

The NSW Government has committed significant funding to July 2020, as part of Their Futures Matter, to implement these new family preservation and restoration models that aim to reduce children entering and increase exits from OOHC. Each year, up to 900 places are available for vulnerable children and their families to receive the service, with half of the

About the author

Lisa J. Griffiths, Chief Executive Officer at OzChild, has worked in senior executive leadership roles for more than 30 years. She has delivered services to the community, focusing on children and families, people with disabilities, at-risk youth and the culturally diverse. Lisa has overseen systemic change involving primary prevention programs, evidence-based interventions and community awareness projects that address long-term strategic needs and objectives for the community.

places dedicated to Aboriginal children and their families.

OzChild has joined with Their Futures Matter and our sector partners to deliver these evidence-based programs and be part of this commitment for real change. Last November, we introduced the FFT-CW program in Victoria and have observed significant benefits for families, their children, our staff and the sector in general. The program's strength lies in its ability to address current issues within a family and understand underlying contextual issues.

FFT-CW operates on the basis that the onus is on the practitioners to engage with the family rather than on the family to engage with services. This means practitioners work relentlessly to engage families and provide tailored support that meets their specific needs. This is critical when there are underlying mental health issues as a 'one size fits all' model would not adequately meet the complex needs associated with mental health. In addition, strengthened engagement and strong clinical oversight has seen practitioners core skills flourish.

MST-CAN targets families where there are reports of physical abuse and neglect of children and young people aged from 6 to 17 years. The program targets trauma symptoms, mental health problems and substance misuse. It has been shown to be significantly more effective than outpatient treatment in reducing youth mental health symptoms, parental emotional distress, parenting behaviours associated with maltreatment, youth out-of-home placements, and reducing placement breakdowns.

Families with underlying mental health problems are more likely to have a higher degree of self-blame, shame and the presence of negativity. FFT-CW and MST-CAN work to reduce these issues, recognise individual strengths and build a relational understanding of the issues affecting families through targeted behavioural plans tailored that are catered to the individual family.

This shift in perspective has resulted in families being empowered to action positive change in their lives so that their children can remain safely in their care.

The NSW Government's rollout of FFT-CW and MST-CAN programs will provide the tools for practitioners to address the underlying issues faced by families helping ensure family units such as the Coopers (see case story) remain intact.

Rethinking the approach to practice has been necessary if we are to exit this state of inertia. By employing services that are proven through research and based on evidence, we can all make a conscious impact and reduce the number of children and young people entering OOHC, and keep children home with their family.

Case story: the Cooper* family

The Cooper family, who were early participants of Functional Family Therapy – Child Welfare in Australia, successfully completed the FFT-CW model in Victoria in 2017. They first came to the attention of OzChild after child protection services had been contacted following a report of physical abuse.

Their allocated family practitioner met with the family and during discussions she realised the parents had a strong relationship with their three children and they were open to following the FFT-CW model to ensure their family stayed together.

While not shying away from the referral reason during discussions, the practitioner was able to motivate the family to look at their difficulties not as a problem with the son, but as a family problem they could all help to resolve.

The practitioner identified with the family that the main skills they needed to learn were ones that would help regulate their emotions, such as deep breathing, mindfulness meditation, Progressive Muscle Relaxation and communication skills to express themselves in a non-violent way. By putting these skills into practise there is now a reduced risk of further physical abuse.

There was also the added benefit that all family members were able to use their new-found skills outside of the family home with many positive results. Dad felt comfortable enough to ask his boss for a pay rise, which relieved some of the financial pressure on the family.

Using the deep breathing exercises learnt during the practitioners visits, Mum was able to handle stressful situations better; the oldest boy is now better equipped to let his teacher know when he needs help; the daughter's tantrums have become less frequent as she practises her deep-breathing exercises when she gets frustrated; and the youngest is sleeping a lot better thanks to using his mindfulness app.

** Name has been changed*

YOUNG PEOPLE'S EXPERIENCES OF LOSS

TANYA GENITO

Creating music using the framework of meaning making is an extremely useful therapeutic technique as a way for young people to tell their story to assist them to move through their personal journey of grief. Tanya Genito outlines the theory and research related to this area for professionals who would like to incorporate music making into their repertoire when working with grieving young people.

About the author

Tanya Genito is a Mental Health Social Worker currently working in private practice. She has worked in the drug and alcohol, housing, community/youth and education sectors, specialising in working with young people and adults who have experienced trauma. Tanya was actively involved in establishing an independent high school for young people who have experienced trauma and are disengaged from mainstream models of education. She developed a unique model of practice called the Social Brain Education Model based on trauma-informed practice and neuroeducation.

Loss is a very personal experience and as such no one experience is the same. This is especially important to keep in mind when working with young people as their reactions can be even more unconventional than those of adults. Young people generally do not effectively process their emotions internally and verbally. As a result, they tend to demonstrate their grieving in external ways, such as aggression and risk-taking behaviours.

The grieving process requires a holistic view of the world. The process is shaped by the young person's experience, the nature of the loss, developmental stage, social supports, attachment patterns and individual coping skills.

Bowlby's idea of attachment is an important concept when working with young people in relation to how they experience loss. If a young person has an insecure attachment pattern they may have a more intense response to the grieving process, including maladaptive behaviours.

All humans have a basic need for attachment; it is rooted in our brain-body chemistry. When we have a strong attachment to someone or something, natural opioid-like chemicals in the brain and hormones in the body are released. These feelings motivate us to want to be with the object that creates those feelings. Even just thinking about the object has a neurological dimension. When we lose the object to which we are attached we experience a withdrawal from these positive feelings. This can cause anxiety levels to rise and increase stress hormones to be realised in our bodies causing a range of symptoms including, sleeplessness, nausea, depression, aggression.

These neurological responses can be reduced by being comforted, feeling safe and being in a calm environment. When working with adolescents who have experienced major loss it is imperative to create positive warm relationships to help build a healthy brain and improve mental health through contact and connection to caring people during their grieving process. Additionally, the chance to remember the person, and to talk about the loss, will be useful in terms of being able to make a healthy 'separation' and to move on.

Rando's 6 Rs describes a way to help young people free up the grief journey. Intervention can happen at any one of these points of the grief journey. Table 1 demonstrates the link between Rando's 6 Rs and music therapy's potential aims and outcomes when working with adolescents.

Once the therapist has understood where the young person is at in their grief, a useful method of intervention is meaning-making. Studies show that adolescents receive greater positive therapeutic outcomes than other groups when meaning-making is incorporated into the therapeutic intervention.

Table 1

To identify and safely express emotions (Recognise)	Music therapy can access and express emotions associated with the grief and loss in a very direct and immediate way.
To share the story of their bereavement (Reaction, Recollect, Re-experience)	Music experiences are adept at stimulating verbalisations.
To be supported by other teenagers (Readjust, Relinquish)	Music therapy groups work to relieve isolation through musical communications.

A meaning-centred therapeutic approach to managing grief and loss invites clients to turn their attention to various sources of meaning to help endure the pain of grief, through connecting with, for example, nature, music, art, writing.

Grief is the process of reframing a life narrative that accommodates a new world view. The new narrative must be grounded in meaning to be able to move into the new world. However, there have been studies that suggest that not all people experiencing grief search for meaning or, even if they find meaning, can put the meaning aside and move on, in fact they keep searching. In response to this an extensive review of studies conducted in this area found that meaning making was still a helpful intervention, however there are many concepts a counsellor needs to be aware of when using this framework:

1. The quest for meaning plays a prominent role in grieving. When a client is struggling for significance in the loss, the counsellor would be well advised to facilitate this process by utilising meaning-making activities, for example, music that has been specifically developed for this purpose.
2. Grief counsellors should be careful about instigating a search for meaning when clients are coping adaptively using pragmatic, rather than philosophic, strategies.
3. Meaning-making is an activity rather than an achievement. It is a process where new questions and new meanings are formed and reformed as the reality of living with the loss takes on different experiences.

One way to ground meaning-making is through music. Research shows that music therapy is one of the most effective treatment modalities when working with adolescents to relieve loss symptoms. Music therapy especially in a group context has been aligned very closely with successful outcomes for adolescent grief. It has been shown that it is important to provide a safe forum for emotional expression and emotional support through the powerful role of group cohesion for bereaved young people. Music therapy can be a tool to engage with a young person at any of Rando's 6 Rs intervention points to develop an understanding, attach language to emotions and create meaning.

There is a plethora of ways to use music in the context of working with young people experiencing loss. Below is a list of just a few possible activities that could be used. Many of these techniques use metaphors. Metaphors are a very powerful way to access the right brain but also to create containment around the feelings.

Song Sensitisation – group members each pick a song, which the whole group then listens to in a relaxed state with eyes closed. They then write lyrics to what comes to them from listening to the song. This is then shared and reflected upon with all members of the group. The new songs that develop out of this process can then be practised and recorded. This is a great technique to help young people focus on an issue and start to be able to put words to emotions.

Junkyard orchestra – Young people make their own instruments out of 'junk'. The worker facilitates the young people to work as a team to create a piece of music that holds their individual parts (solos of their feelings) but also their part of a bigger group (supporting each other).

Hip Hop Recording – This process is useful when working with adolescents as it taps into pop culture that they identify with but also it is an extremely accessible way for them to tell their story. With the use of technology clients do not have to have musical backgrounds to be able to create high quality recordings.

SILENCING SHAME: RECLAIMING LIVES FROM THE MYTHS OF SEXUAL VIOLENCE

TIM DONOVAN

Challenging myths about childhood sexual abuse, and helping survivors to identify their hard-won knowledges and values, enables survivors to contribute to others who have experienced abuse.

There are some pervasive myths about men's experience of childhood sexual violence: men and boys should be able to defend themselves; people can say no and fight back to stop sexual abuse from happening; men cannot and should not share their feelings openly. Social acceptance of these myths silences people who have experienced sexual violence and obscures the reality of abuse.

By confronting myths about childhood sexual violence, we can create openings for survivors to resist the silencing effects of shame, to gain distance from a problem-saturated life story, and to identify values and commitments that can provide the basis for a meaningful life that is no longer defined by the experience of abuse. Experiences of sexual violence necessitate the development of valuable skills and abilities. These can be identified and harnessed by survivors to contribute to others' lives.

John* had been sexually abused as a child by a prominent clergy member at his church and school. Before John shared his story with me, he had been silent for 40 years. I worked with John over a three-year period. In counselling John, and others with similar experiences, I have drawn on and developed ideas from narrative therapy, particularly the work of Michael White, Alan Jenkins and David Denborough. I believe that these ideas can be useful to others seeking respectful and non-pathologising ways of working with men who have experienced childhood sexual abuse.

My conversations with John initially focused on 'externalising' the problem and the effects of being silenced for 40 years. With my support, John identified shame as a contributing factor. Externalising conversations allowed John to gain distance from shame and self-blame, and to speak about his life in new ways. We spent many sessions exploring the ways in which John had responded to and resisted the effects of the abuse and of the shame it produced.

My concern at this stage was to avoid pathologising John by treating his distress as a mental health problem, but rather to define the problem in his own terms. Through our conversations, John identified the importance of integrity in his life and identity, and arrived at a stance that the abuse had not been his fault, but was evidence of the dishonourable behaviour of the abuser. These conclusions arose from John's analysis of his experience, rather than professional expertise or schemas. John was positioned as expert on his own life.

In the following sessions, we focused on John's values and beliefs, uncovering them beneath the oppressive thoughts shame and the abuser had encouraged. This made it possible for John to begin recognising a self that was not defined by his experiences of sexual violence. Questions about what was 'absent but implicit' in John's accounts helped to clarify his values: we came to see shame as a testimony to John's commitment to preferred values such as integrity, which had been affected by his experiences of sexual violence.

Continuing to explore the effects of shame, we investigated the relationship between John's individual experiences and their social context, including the ways in which myths about sexual abuse and dominant constructions of masculinity promote the silencing of abuse survivors. John was able to deconstruct these myths and to understand how they had influenced the ways he saw himself.

We began drawing connections between John's experiences and those of others,

About the author

Tim Donovan is a professional counsellor and an accredited mental health social worker. He serves as a consultant to children, young people and adults in individual and family contexts.

including reading and responding to accounts from other survivors. Having reconnected with his values and preferred ways of being, John wanted to contribute to others who had been silenced by their experiences of sexual violence.

Many of the people I work with have little opportunity to feel they are making a contribution. They may feel they have little to offer. However, the difficulties people face are not theirs alone. Experiences of responding to abuse can provide a basis for contributing to others in similar situations. Contributing to others can reduce the effects of abuse by providing a sense that the suffering has not been for nothing. This has the potential to ignite a sense of possibility, which can catalyse other changes in the person's life.

John decided to work towards preventing sexual abuse happening to others by speaking openly about his experiences. He accepted an invitation to share his story with the Royal Commission into Institutional Responses to Child Sexual Abuse. Before sharing his story with the Royal Commission, John reflected:

> To tell the truth is important, and, as painful as it is to [remember and share] what happened to me, the protection of others outweighs that pain … Not being silenced is an acceptance of who I am and the importance I now place on telling the truth, free from shame, and challenging society's myths around sexual violence. I can't change who I am and I don't want to.

Standing up for what he felt was right brought a renewed sense of purpose and freedom. In addition to contributing his experience to the Royal Commission, John recorded some of the knowledge he had developed through his experience to offer to other survivors of childhood sexual abuse. Part of his advice was to 'allow yourself to face your experiences of child sexual abuse head on':

> The longer you keep your experience a secret, the greater hold shame has over you. Shame is a liar. It is a lie that you are to blame, and if you think the shame is too great, that's a lie also. So please allow yourself to bring those experiences out. They can't hurt you anymore than they have, but they can continue to hurt you if you don't face the reality and truth of those significant traumatic experiences. This may take time. Write your experiences in a diary – that's a great start to facing your experiences. [Counselling] has also been instrumental in encouraging me to be truthful and honest with myself. This process continues to destroy shame and guilt, which allows me to see the truth about myself: that I was not evil or to blame and that I was innocent.

Through deconstructing the myths of sexual violence, and the power practices of his abuser, John was able to regain a sense of personal agency, and to take action to address broader social issues related to the effects of shame in his life. John began to see himself as part of a collective endeavour to address the social issues surrounding sexual violence, drawing on the knowledge he had developed through his experiences.

After around 50 sessions together, John had come to inhabit the preferred stories of his life. As his reclaimed stories of self and new identity conclusions were enacted and acknowledged, I became increasingly decentred in the therapeutic process. John no longer saw himself as someone defined by his experience of abuse.

Using narrative metaphors, he could now understand himself as a person who fights for justice with freedom.

This renewed sense of self and purpose, reinforced by the valued contributions he has made to the lives of others, has deprived the person who carried out the sexual violence from having the last say on John's identity.

My work with survivors of childhood sexual abuse involves a process of inviting separation from negative identity conclusions, reconnecting with preferred values and beliefs, making connections with others' stories, and supporting individual and collective acts that evoke a sense of purpose by using the knowledge gained through surviving abuse to contribute to others. This way of working to reclaim lives from sexual violence offers a non-pathologising pathway to support survivors to identify and access the skills, values and knowledge they have developed through their experience, and to use it as the basis for a life of integrity and possibility.

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**Not his real name*

'HAVING A SAY' ON THE SOUTH AUSTRALIAN MENTAL HEALTH STRATEGIC PLAN

AZMIRI MIAN

Building South Australians' mental capital and growing the State's mental wealth will have a significant impact on the mental health and wellbeing, social cohesions and inclusion of our people; it will also improve our State's economic competitiveness and prosperity. (SA Mental Health Commissioner Chris Burns, 2017)

The initial task of the South Australian Mental Health Commission (SAMHC) when it was established in October 2015, was to lead the development of the state's new Mental Health Strategic Plan. The five-year plan will provide strategic direction from 2017 to 2022, and be based on a 20-year vision and a 10-year outlook.

The commission is now taking a whole-of-person, life, community and government approach to developing the plan and the subsequent actions that arise from it. At the heart, are the people with lived experience of mental illness, their families, friends and carers and engagement of the mental health sector and community to promote the sharing of knowledge on mental health issues and to break down the stigma associated with them. This year, the Commission has appointed a Community Advisory Committee (CAC) to create a stronger connection with the voices of the community.

To ensure that South Australia has a strong voice, the commission, with the support of the CAC, ran the statewide 'Let's Talk' campaign to speak to people from all areas.

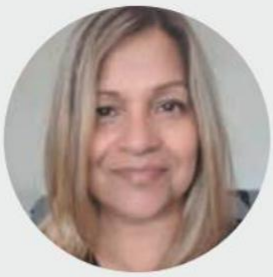
AASW South Australian (AASWSA) Branch members and their colleagues were a part of the commission's 'Conversations' in May last year and shared their views and experiences on mental health and wellbeing for the new SA Mental Health Strategic Plan. The Commissioner was present on the day to meet with practitioners, with a strong Aboriginal voice represented within it. Participants then discussed the following questions: what is working with respect to promotion of mental health and prevention or support for mental ill health; what is not working so well; and what key research is being undertaken, and what might the future look like?

During the commission's consultation, more than 2200 South Australians shared their stories and ideas about mental health and wellbeing which informed the seven top themes that can be found in the commission's Key Findings Discussion Paper:

- the importance of promotion, prevention and early-in-life intervention
- the need for community education to improve awareness and reduce stigma
- achieving integrated service delivery (services that work better together)
- access to the right care at the right time and the right place
- services that better meet people's needs
- targeted responses for some groups (care that is relevant to my situation)
- planning, funding and monitoring.

AASWSA participants, who had another opportunity in July last year to provide more feedback through the Mental Health Practice Group, agreed on the importance and relevance of all the themes in the social work context. These four key suggestions were added to the commission's conversation:

- education into nutrition to be included in prevention and wellbeing, as research indicates a link between nutrition and mental health and wellbeing
- people having a choice of 'generalised' mental health and wellbeing education, as appropriate and delivery of this education will



About the author

Azmiri (Azi) Mian is a Branch Committee Member of the AASW – SA Branch, Convenor of the Mental Health Practice Group, and represents the branch on the SAMHC Community Advisory Committee. She is also on the Board of Advocacy for Disability Access and Inclusion Inc.

Azmiri is a PhD candidate at the University of South Australia Business School and has a Bachelor and Master of Social Work. She is working in the tertiary education sector and has worked in the health and mental health sectors, among others, and still runs her own consultancy.

minimise harm in some communities or groups

- diversity needs to be highlighted to give it a stronger focus
- diagnostic measures need to have the diversity element as a focus

Being directly involved with the SAMHC CAC as a representative of AASWSA, has been positive and provided hope for the future objectives and future of the SA Mental Health Strategic Plan. Fueling this hope has been the involvement of the Commissioner and the staff of SAMHC, who have participated in extensive consultation to ensure the involvement of all the South Australian community.

The Commissioner and staff are keen to continue AASWSA representation on the Community Advisory Committee, particularly as the funding landscape changes there will be a place for social workers, for example though the NDIS. There is scope for the social work profession in South Australia to continue to be involved in shaping the actions emerging from the strategic plan. If its goal is to look at addressing mental health and wellbeing through 'the whole-of-person, whole-of-life, whole-of-community, whole-of-government perspective', social workers can have a significant impact on the plan as we are already working with people in this space. We just need to continue to advocate for our profession to ensure psychosocial support is embedded in a long-term care plan.

Follow the progress of the SA Strategic Mental Health Plan

THE UNSPOKEN IMPACT OF VOLUNTEERS IN THE HOMELESSNESS SECTOR

JEN RILEY

We should stop undervaluing our homelessness sector and those who work in it by over-reliance on volunteers.

When winter comes, homelessness shelters cry out for extra volunteers. In Canberra, as it is in many parts of Australia, winter can be a killer. Temperatures overnight can drop well into the negative, and sometimes not even reach a defrosting level during the day. If hypothermia does not get you, the inevitable viruses and bacterial infections will.

Overwhelmingly, those who are homeless are survivors of trauma. Escapees from family violence, sexual abuse, or their own internalised horrors. They are not the least complicated of clients. They can carry serious mental health issues, complex trauma, substance abuse issues, and subsequent health complications.

Too often volunteers are relied upon to maintain these shelters, despite their complexity. Promoting the use of volunteers in these specific roles carries the risk of undervaluing the importance of homelessness shelters in the public eye. Social workers should take a leadership role in this area and ensure that those "volunteers" are appropriately paid and trained professionals.

An untrained person working with trauma can make critical errors interpreting more complex presentations. The consequences can be devastating, not just in the missed opportunities to help a client engage, but the impacts on that client who may be invalidated and think that seeking shelter is worse than freezing on the street.

When we don't pay people appropriately, we minimise the importance of the role, and undervalue their training and support. When we are forced to go to the media to seek help and request volunteers, we give the impression that these roles are not complex, and that the amount of funding and resources given to them are appropriate.

Social workers should take a leadership role in this area and demand that those who work with our most vulnerable are not undervalued, that they are given the skills they need to carry out the role, and that they are paid appropriately for those skills.

About the author

Jen Riley graduated from her Masters of Social Work at the Australian Catholic University in 2011, and is currently an Advanced Accredited Social Worker with the AASW. Since graduating she has worked at the Canberra Rape Crisis Centre and with the Defence Abuse Response Taskforce.

WHEN THE DISASTER IS INDUSTRIAL: THE ROLE OF SOCIAL WORK DURING THE BEACONSFIELD MINE COLLAPSE

DEBORAH KLYE

The collapse of the Beaconsfield Mine in Tasmania occurred on 25 April 2006. Of the three men trapped in the mine, one was killed in the initial rockfall. The other two were rescued two weeks later on 9 May, during which time the event held the nation's attention. Deborah Klye writes of the role mental health social workers played in employee assistance provision and in the community during the rescue. She puts forward recommendations as a result of her experience.

The Beaconsfield mining disaster was both an industrial and community event. The Blue Door Employee Assistance Program managed much of the mental health response for site personnel and immediate families before, during and after the rockfall.

Our objective was to reduce negative mental health outcomes for personnel and families during and after the rescue. As ensuing events dictated that there was no clear end to the events, a need to attempt some analysis of intricate relationships became apparent. Our conceptual approach broadly emerging out of social work theory included systemic awareness. As more resources and people poured in from outside of this system, making a relatively closed system now an open system with the one major objective of rescue, the more complex the issue of attending to positive mental health outcomes became.

From our central location, we observed and deliberately mingled with workers. A barbeque was set up in the central court yard and it became our second office. Three questions we asked and asked again – How are you eating? How are you sleeping? What have you done today (with someone you care about) that is not related in any way to the mine? We believed immediate attention to two of the most important physiological requirements for normal functioning, sleep and food, were likely to be the two things that the miners could talk to us about and would be a clear indicator if psychological health was in crisis.

The 'doing something different' component was to remove miners from a sense of entrapment in a trauma zone and engage in constant cognitive reconstruction of their normal lives. Our rationale was to ensure normalisation of their lives with anchoring points of behaviour and relationship other than the mine and its personnel, ensuring clarity of thought and therefore judgment for shift work, and noticing changes that might reflect some sense of cognitive or affective struggle.

Despite a growing body of research suggesting that debriefings have limited positive outcome and can sometimes do more harm, briefings were the usual work pattern for mine personnel and the language of briefing was familiar to them, therefore we chose to use them but did so sparingly. We called group sessions briefings but made no attempt to do more than provide brief psychological education.

There were times when our social work practical approach was required, for example, in the case of the no-fly zone. The media aircraft hovered consistently over the office buildings meaning that all the planning and telephone discussions could not be heard. A no-fly zone was needed. The security guards had some contacts in Hobart but not in the Civil Aviation Safety Authority (CASA) and the criteria for obtaining a no-fly zone

are very specific. There had never been one approved in Tasmania. It took the dedication of social work tenacity to track down all the links for the security guards to proceed with the final call to ensure our no-fly zone was put in place.

The ambulance officers reported to us that rescuers were not eating well or regularly, and were not going home for the required breaks. A word with the office staff resulted in a fax from a dietician and regular deliveries of nutritious, fresh food. Office staff made rolls and soup, set up a fruit stall and cooked meals 24 hours a day between phone calls. Campervans were arranged for and placed in the car park. Some offices became dormitories with sleeping bags provided.

In conjunction with trapped miners Todd Russell and Brant Webb's medical and psychological team we worked on a recovery plan to provide psychological responses for the rescue team and families immediately after recovery. We also developed a planned response in the event that a more serious accident occurred during the rescue. This remained a constant working plan throughout as the situation at the mine and in the town were constantly changing. Confidentiality was difficult in this environment and could not always be expected. A lot of the work took place in the car park, the courtyard, multi-use offices, in the mine yard outside the shaft and in family homes where extended family and friends were gathered.

Every few hours one of the social work team would go with a management representative to family homes to report on progress and collect the next family notes to go to Todd and Brant. We regularly drove to multiple households containing large groups of distressed people, where current rescue team members had already been, to pass on information. Giving accurate information in a short pre-worded statement was a necessary approach to ensuring some emotional safeguards for family members.

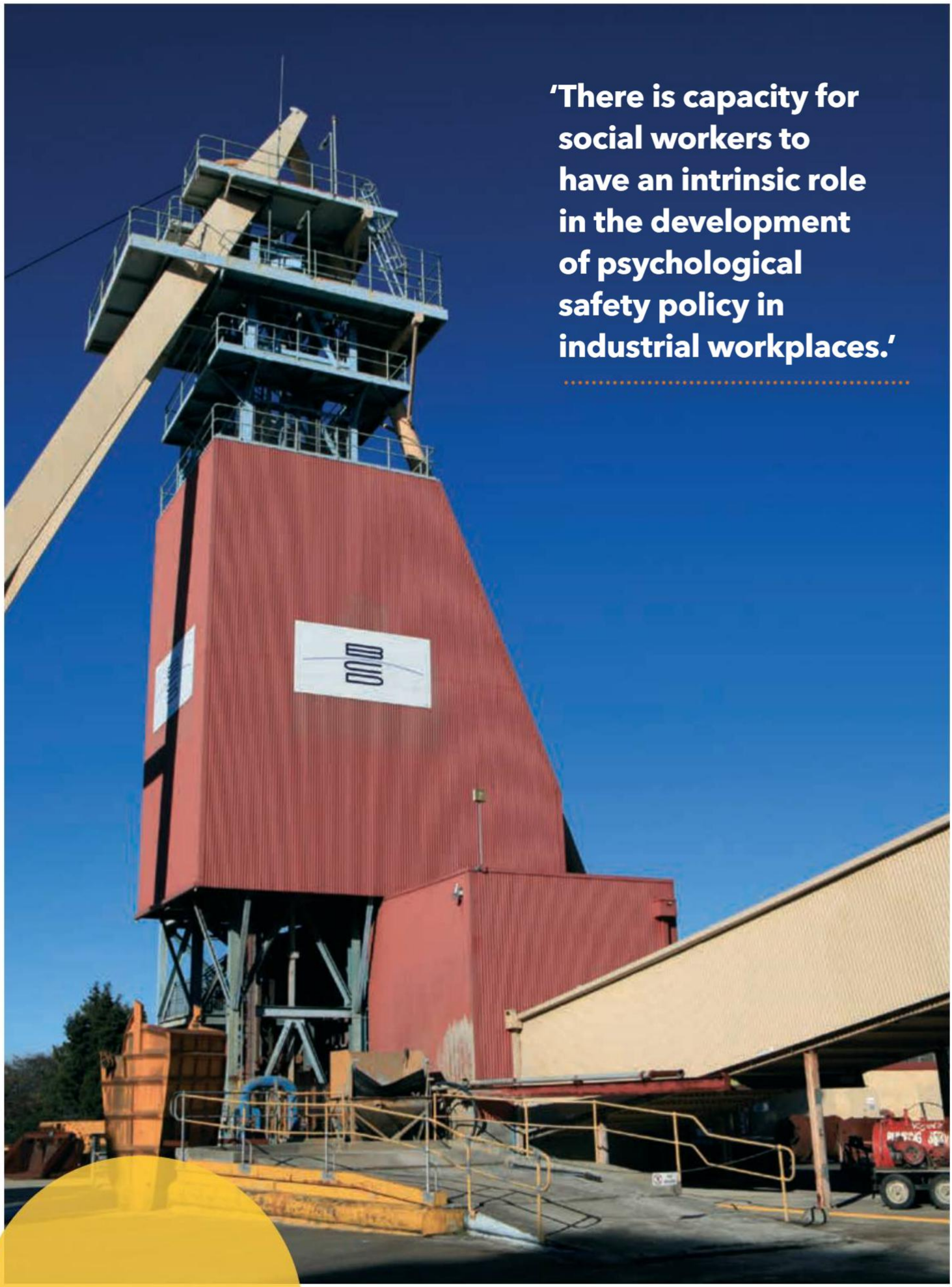
Like many other family systems in distress we worked with presenting issues familiar to structural family therapists: power differentials and hierarchies within and across interrelated family systems, boundaries of acceptable behaviours, and some re-alignments of child–parent attachments, triangulations and rivalries of various family members. The relatively stable sets of equilibriums, whether positive or negative, were no longer sustainable for some families. Home visits enabled us to provide space for education in relation to trauma, especially in normalising some of the more erratic family behaviour.

In the light of the Beaconsfield mine collapse those of us in the Blue Door Employee Assistance Program formed a number of recommendations.

Employee assistance providers need to establish clear response guidelines with employers prior to events. Better outcomes for workers are achievable

About the author

Deborah Klye has a Bachelor of Education and Bachelor of Social Work. She is a member of the AASW College of Social Work and an Accredited Mental Health Social Worker. Deborah has worked as a teacher, educator and social worker in Queensland and Tasmania. Her work includes individual counselling, group work, professional supervision and professional development for education, health professionals and community members. Deborah's counselling experience includes working with children, young people, families and adults. She is an experienced Employee Assistance Provider.



'There is capacity for social workers to have an intrinsic role in the development of psychological safety policy in industrial workplaces.'

if workers have a relationship with psychological support teams prior to an incident and it is clear that those teams have understanding of the work practices and culture. Establishing a culture of psychological support in the workplace is an important part of occupational health and safety (OH&S). Psychological support responses need to be based on increasing the social capital of workers. Psychological education for workers as part of the OH&S response can increase social capital in the workplace and reduce the need for more formal psychological interventions.

Familiarity with on-site culture and language is crucial to any response. In rural areas, employee assistance support cannot operate in isolation to the community. Clearer protocols between community and industrial recovery teams need to be established in preparation for events. Community response teams need to be aware that in an industrial event an employee assistance response may be happening on-site. A worker self-care plan for critical incidents should include regular external supervision during the intervention and adequate debriefing after the event. Psychological responses to industrial events need to include attention to media intrusion. Community recovery training could begin to cover responses that are during the event not immediately after.

A secure, accurate communication pathway for rescue teams needs to be a high priority. Despite the urgency and chaos of response, time must be taken to provide detailed handover information between shift changes. Psychological responses to industrial events need to have adequate policy and protocols to ensure a quality response but with enough flexibility to ensure capacity to respond to the unexpected. Services need to include both mental health and psychosocial responses.

There is capacity for social workers to have an intrinsic role in the development of psychological safety policy in industrial workplaces. A comprehensive psychological occupational safety response was developed by Beaconsfield Mine Joint Venture, Blue Door and other industry consultants. The initial policy was a finalist in the Tasmanian Industry Safety Awards for 2008. It could easily be adapted for other heavy industry. We are hopeful that it will be eventually accepted as standard practice for all industrial sites.

MINDFULNESS AND RESILIENCE IN SOCIAL WORK PRACTICE

RUTH CROWLEY BROWN

The profession of social work is associated with social justice and individual well-being, and often involves the need to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others. This can be depleting, and resilience in the face of emotional challenges can make the difference between suppression and containment of feelings. Although the importance of self-care for professionals is more understood these days, it can still be hard to prioritise it under the weight of everyday commitments.

Although it seems like a modern term, a buzz word almost, the word 'mindful' is drawn from an ancient tradition. In the Indian languages of Pali and Sanskrit the word mindful actually has two connotations: awareness and memory. It is unfortunate that the 'memory' dimension hasn't survived translation to the West, because it is important. Being mindful is being aware in the present moment, the 'here and now': but a normal mental phenomenon is for the mind to frequently wander off into 'psychological time', replaying the past, imagining the future. Thus, reminding the mind to return to the present is also a key part of mindfulness. A definition of mindfulness might therefore be: remembering to keep being aware in the present moment. Mindfulness meditation first gained popularity in the West in the 1960s, and since that time has gradually spread into the mainstream.

Cognitive Behavioural Therapy (CBT) was also being pioneered in the sixties by psychiatrist and psychoanalyst Aaron T Beck. He formulated the concept of 'automatic thoughts' and found that they were rampant, particularly the negative ones; moreover, he realised that they could be categorised into a 'higher level order' as 'cognitive distortions'. Cognitive distortions (CDs) are types of distorted thinking, and can be signified by rushes of negative automatic thoughts. On the other hand, rational responses, the antidote to CDs, occur when the mind is more settled. CBT has gone on to become one of the primary mental health interventions in the West.

CBT differentiates thinking into 'process' and 'content'. The process is how a person is thinking (cognitive distortion or rational response), whereas the content is what they are thinking about (automatic or consciously-generated thoughts). Heightened perspective leads to a 'wide-angle' view of experience (process) from which to observe the narrow 'zoom-lens' streams of automatic thoughts (content). When we become aware that we are immersed in a CD – 'catastrophising' or taking things 'personally' or having an excess of 'shoulds' – awareness itself can actually help to burst our distorted thought-bubbles.

Discerning the difference between a cognitive distortion and a rational response enables people to gain psychic distance from their negative automatic thoughts (NATs), because once NATs enter into consciousness, we can label them, refute them and substitute a rational response. This has the effect of reducing stress and distress, and freeing-up energy.

Perspective is also a key concept in mindfulness, and whereas CBT focuses on unravelling distortions, mindfulness focuses on awareness and acceptance. Acceptance doesn't mean passively giving-in to the chattering 'monkey mind', or NATs. Rather it means accepting the chatter by not reacting to it or engaging with it; other than by letting it go, and returning awareness to the point-of-focus. Focusing mental intention on a single point, such as the breath or a mantra, and repeatedly returning to this point, helps build mental 'muscle': and like any

About the author

Ruth Crowley Brown is an Accredited Mental Health Social Worker and a psychotherapist. She has been a practitioner of Vipassana meditation for more than 30 years, and has delivered services in child and adolescent mental health, children with disabilities, foster care and domestic violence, in London and Brisbane.

muscle the more it is used the stronger it becomes.

This meditative 'observing mind' capacity has real strength; it is the ability to cut-through emotional distractions to the heart of matters by 'skilful means'. And it also has integrative and healing qualities that can foster a deep sense of 'stillness' and harmony.

By the 1980s, mindfulness began to be taken up by cognitive psychology and made a vast contribution to changing the nature of therapeutic interventions in the West. Child psychiatrist and mindfulness expert Dan Siegel reports that mindfulness training helps to 'reduce subjective states of suffering, improve immune functioning, accelerate rates of healing, and nurture interpersonal relationships and an overall sense of well-being'. Mindfulness Cognitive Behavioural Therapy (MCBT), Dialectical Behavioural Therapy (DBT) and Acceptance and Commitment Therapy (ACT), to name just a few, have emerged out of this 'East–West meeting of minds', and all of them have approaches that combine acceptance and change.

Traumatic events trigger mental, emotional and physical responses, which, once activated, need to run their course. Analogous to healing from physical trauma, psychological repair is a process that takes time, and benefits from support from the environment. This healing process involves insight and working-through that follows a similar trajectory to the stages of grief: initial shock and disorientation (surprise and fear); followed by a defensive response (anger that valiantly tries to stave off the inevitable); and when the defences can no longer hold, there is a descent into deeper levels of feeling (sadness and anguish) and meaning; that finally leads to new integration and reorientation. If, however, the cycle is blocked at a particular stage, whether it is confusion, defensiveness or despair, reverberations will be felt throughout the whole system, and symptoms triggered. For many, then, the mind can be experienced as a disjointed aggregate or 'amalgam' of disparate thoughts and feelings, defused and diffuse, with recurring themes that nevertheless remain mysterious in their relevance and origin.

Mindfulness skills can be instrumental in re-sculpting information-flow in the brain by means of focus and redirection (neuronal growth follows attention). Siegel describes how 'disengaging automatically coupled pathways' in the mind can create greater freedom from 'automatic reactivity, habitual responses and the enslavements of prior learning'. He also points out that the process of 'objectifying' the mind helps people 'dis-identify from mental activities as being the totality of who they are'.

The dynamics of vicarious trauma are most potent when workers are in structural relationships with their clients, such as case work or therapeutic work, and when the sufferer is symptomatic; because repressed emotions are more susceptible to projection than felt ones, workers can find themselves in situations of not knowing 'where these intense feelings have come from'. For professionals who are constantly fielding challenges of various types, including multiple potential triggers, functioning obviously involves peaks and troughs: but there will be a relatively stable base-level to which people return. Therefore, raising this base-level is a positive goal. Most people, of course, would benefit from being more resilient.

As children, we all have an effortless sense of 'here-and-now' awareness, but it can gradually fade or rather be covered-up, as mental activity gains ascendance during the course of development. Mindfulness training can help us to (re)-master and maintain this natural skill, and the advent of modern technology has made it more possible than ever to personalise learning and practice.

Everyday life can be used as 'practice', and indeed bad habits can actually become useful areas to focus on: when we become aware that we are habitually rushing, we can start to slow down and mindfully walk, talk, drive and eat. Mindful positive self-talk (devising our own mantras) can also be helpful. However, mindfulness is also an ongoing practice that requires perseverance and patience, because old habits linger, and even good change can involve dealing with feelings of loss and regret, which may trigger the grief cycle.

If mental life is skewed too far towards the negative then general balance and functioning are impaired. The psychologist Rick Hanson points out that, unfortunately, negative experiences are much more easily held onto by the mind than positive ones. In order for positive experiences to be consolidated into longer-term memory, and accessed in the future as a resource, they need an extra helping of sustained conscious awareness to 'take in the good'. This can go some way to redress what Hanson calls the 'negative mental skew'.

Mindfulness itself enhances resilience by enabling a shift of perspective from thinking that the mind represents the totality of who we are, to realising that it is a tool, with both positive and negative attributes. The ability to choose our thoughts, rather than our automatic thoughts choosing us, helps us to more often escape the clutches of 'psychological time', where energy can be wasted in rumination and worry. Expending the effort to explore the benefits of mindfulness is a sound investment, because it can lead to the realisation that it is not the amount of effort but 'skilful means' that makes the difference – benefitting both ourselves as practitioners as well as the people we serve.

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