Moving From Engagement to Partnership

Following years of public hearings and written submissions, Victoria's Royal Commission into Mental Health handed down sixty-five recommendations in February 2022. These recommendations cited a broken and fragmented system, which tended to operate from a place of crisis and failed to provide holistic, adequate and timely support to those experiencing mental distress and/or addiction and their families/supporters/carers/kin.

The need for the mental health system to undergo a complete rebuild was recognised, and a new way of engaging and collaborating with all stakeholders within the sector was required. As a result, the Victorian Department of Health (The Department) sought out recommendations on how the mental health system can move from an engagement to a partnership approach.

This document summarises the findings regarding **Acknowledgement of Harms Done** from fourteen community conversations inviting perspectives from people with lived experience of mental distress (LE) and/or alcohol and other substance addiction (AOD); families, supporters, and carers of those directly experiencing these challenges (FSC); and people working within the sector (Lived Experience Department, Community Peaks and Agencies). Some conversation participants additionally identified as a Young Person (YP), as part of the LGBTQ community, or having a Culturally and Linguistically Diverse (CALD) background. The framework for discussion and analysis was developed by First Nations people, using a First Nations partnership lens.

Acknowledgement of Harms Done

Negative experiences of tokenistic relationships labelled as partnerships:

People with lived experience of mental distress or addiction may also have lived experience of harm arising from using services and/or attempting to partner with the service system. It is essential that the Department recognise the impact of these negative experiences, including the cumulative impact.

> *It is important to recognise and acknowledge that not all of us may have had positive experiences with systems and services. (YP)*
>
> *Need to consider the impact of bad history between the Department & those with lived experience. (LEDep)*
>
> *Coming into these spaces of potentially partnering often coming from a position of many years of a system that is often traumatising, and on top often of our own trauma… we don't leave that behind when we come in to these spaces - when we speak, our trauma comes with us, this has been used to dismiss me. (LGBTQ)*

This extends to the Lived Experience workforce.

> *Having 'Lived Experience' in our job title – almost certain to earn less but be required to do more of the educating and other culture change work. It's a harm to people with lived experience to have to do more than others have to in this way. (CPA)*

Tokenistic relationships initiated by the Department are experienced as disempowering, devaluing, intimidating and they reinforce power imbalances.

> *Tokenistic engagement certainly does occur – there is a top-down hierarchy, can feel like you're not on the same level. Partnership is hand-in-hand and power is dispersed. Methods vary between engagement and partnership. Engagement led by employees whereas partnership led by community members with local/lived expertise. (LE)*
>
> *Works well when it's done right... but when it's not it is devaluing and disempowering. (CALD)*
>
> *If diverse young people are put in disempowering situations with people in traditional power holding positions, they can make you feel intimidated. (YP)*

This leads to mistrust of government and non-Indigenous services for First Nations people:

Mistrust arises when the motivations for lived experience engagement are service-centric and undertaken in a tokenistic way.

> *Engagement can be tokenistic and done for the perception of a company/organisation to make them look like they are remaining relevant and in tune. (YP)*

Many partnerships are seen as purely ticking a box:

When lived experience participation is limited to consultation, it is likely to be perfunctory rather than meaningful – engagement for the sake of engagement rather than sustained listening to a wide variety of perspectives and integrating these into policy and practice.

> *Engagement is quite tokenistic and a tick box thing. (YP)*
>
> *Too often the family/carer perspective is included but not and seen but not - additional, token, tick a box. (LEDep)*

Partnership, based on current experience, appears elusive.

> *I haven't really seen partnership! (LGBTQ)*

Working towards trust:

A trauma-informed system

A trauma-responsive mental health and wellbeing sector is fundamental to building trust with people who have lived experience.

> *Making sure non-Lived Experience folk are trauma informed... and that systems and structures are also trauma informed. (LGBTQ)*
>
> *Trauma informed practice is required for equal partnership. (LGBQT)*

Services must listen to people who have survived traumatic experiences, recognise what it has taken to survive and thrive and honour their duty of care not to cause harm.

> *I need someone who understands and can sit with that, the intensity. (LGBTQ)*
>
> *Sharing experiences without fear. (FSC)*
>
> *An understanding of the emotional load that people have carried. (FSC)*
>
> *Actual acknowledgement of past traumas. (LGBTQ)*
>
> *Need trigger and content warnings. (YP)*

Further, partnering with people who have experienced trauma unlocks their lived expertise, which can transform the system.

> *Using trauma as a basis of knowledge... and using it as an asset, as good as a qualification, to create change for others, to prevent the same things from happening to other people. (LGBTQ)*

Transparency

Internal Department processes ought to become more visible to sector peaks and partners. This will enable better governance while fostering confidence in the Department's preparedness to meaningfully partner.

> *The sector doesn't necessarily know what the Department is doing – more transparency is required to build trust – enable access to information, decision-making processes. (LEDep)*

This is mirrored in clinical services, where decisions are made which are not person-centred, let alone person-directed.

> *Health system says they put the user first but has been a lack of follow through with that! (FSC)*

Integrity

People with lived experience of mental distress, addiction or caring assess the partnership capability of organisations, including the Department, by personal recommendation and by what they do rather, than what they say.

> *It needs to speak for itself and then word gets around – ah, this organisation is doing it properly e.g., The Royal Children's Hospital has runs on the board. (LE)*

Honesty and accountability are valued more highly than inflating claims or deflecting responsibility in advance.

> *Responsibility for when they're not genuine. (CPA)*
>
> *Covering ass, being tokenistic is not ok. (LE)*

Handing over decision-making power

At present, governance is concentrated within the Department, with clinical governance similarly located primarily within area mental health services. Achieving a more even distribution of decision-making power requires the department to trust people with lived experience of mental distress, addiction and caring, as well as their peak bodies, to share responsibility for governance.

> *Mental models, around madness, mental health, mental illness, core beliefs around what these things mean for our relationships and our capacity. There is work to be done for people to really explore, understand and think for themselves about what's under the surface in these dialogues – these influence willingness to handover decision making to consumers – handing over power, resources, money to stigmatised communities – explore what gets in the way of this, where is the reticence. (LEDep)*
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> *Feeling powerless… person who has the power ultimately has control of the decisions. Thinking about son's voluntary admission … within 24 hours was stripped of power as his parent. We need family involvement in decisions. (FSC)*

The risk averse stance of mental health and AOD services and systems has led to a reluctance to invest in meaningful partnerships, however people with lived experience argued that the Department needed to learn by doing.

> *Implementing it [partnership] properly first and then perspectives change as a result. (LE)*
>
> *People and communities need to be involved from the planning stage, stage one! This is really crucial, real partnership needs to start from grassroots convos. (LE)*

Valuing lived expertise

When partnering with people who have lived experience of mental distress, addiction and caring, it is essential that policymakers, managers and clinicians affirm that complementary nature of lived and learned expertise and demonstrate humility in spite of their professional standing.

> *It is my experience that those who traditionally hold power think they are well educated, and knowledgeable people and they know all of the answers. Seek to listen to understand. (AOD FSC)*

People with lived experience of caring for and supporting their family members highlighted that they have an important contribution to make to partnerships. As the movement of carers, families and supporters develops, so too will their lived expertise grow.

> *Knowing that family/life role and experience is not perceived as enough by those in authority. (FSC)*

> *Recovery means a lot of things to a lot of different things, recognising that we all have something to bring to the table – establishing real concrete shared understanding of why carers/family members are here & what we can contribute. Actions needed are to break down the stigma of family/carers as an 'add on'. (LEDep)*

Curiosity rather than judgement

Non-punitive approaches to mental distress, addiction and caring are key to a more humane and respectful service response which supports people to make their own meaning of their lived experiences rather imposing an explanatory framework or value system.

> *Mandates that require psychiatrists to let go of judgemental and stigmatising attitudes. (AOD FSC)*

> *Decriminalise AOD-related offences so that people experiencing addiction don't end up in the prison system. (AOD LE)*

> *Stop looking at it [treatment] from a biomedical model - doesn't fit and [addiction] can't be treated solely that way. (AOD FSC)*

> *Not made to feel like you're the 'bad' mum or it's all your fault. (FSC)*

> *Understanding and empathy as to why someone [with a lived experience of addiction] has been through these kinds of experiences and the consequences of them. (AOD LE)*

> *People seeking support are people first. (AOD FSC)*

Acknowledgement of Harms Done – First Nations perspectives

Distrust of government is a barrier to building strong partnerships with community. Government and mainstream health workers need to recognise the harmful and ongoing impacts of colonisation and racism on the health of Aboriginal people and their communities. Factoring in the time and space required to build a genuine partnership based on mutual respect and trust is necessary to moving from engagement to partnership.

> *Being accountable for wrongdoing, apologising when you are making mistakes. Doing what is needed to prepare. With mob trust is a hard one which is easily lost. This is because Mob have been controlled and dispossessed and the enormous power the funders have wielded over us through stolen wages, missions, and the genocide of our people.*
>
> *A lot of reworks due to cancelling meetings and not honouring commitments.*
>
> *Guiding principles are important if the government is genuine about partnerships. Welcome critic and see it as a gift, receiving it to take it on and commit to doing better and move towards transformation.*