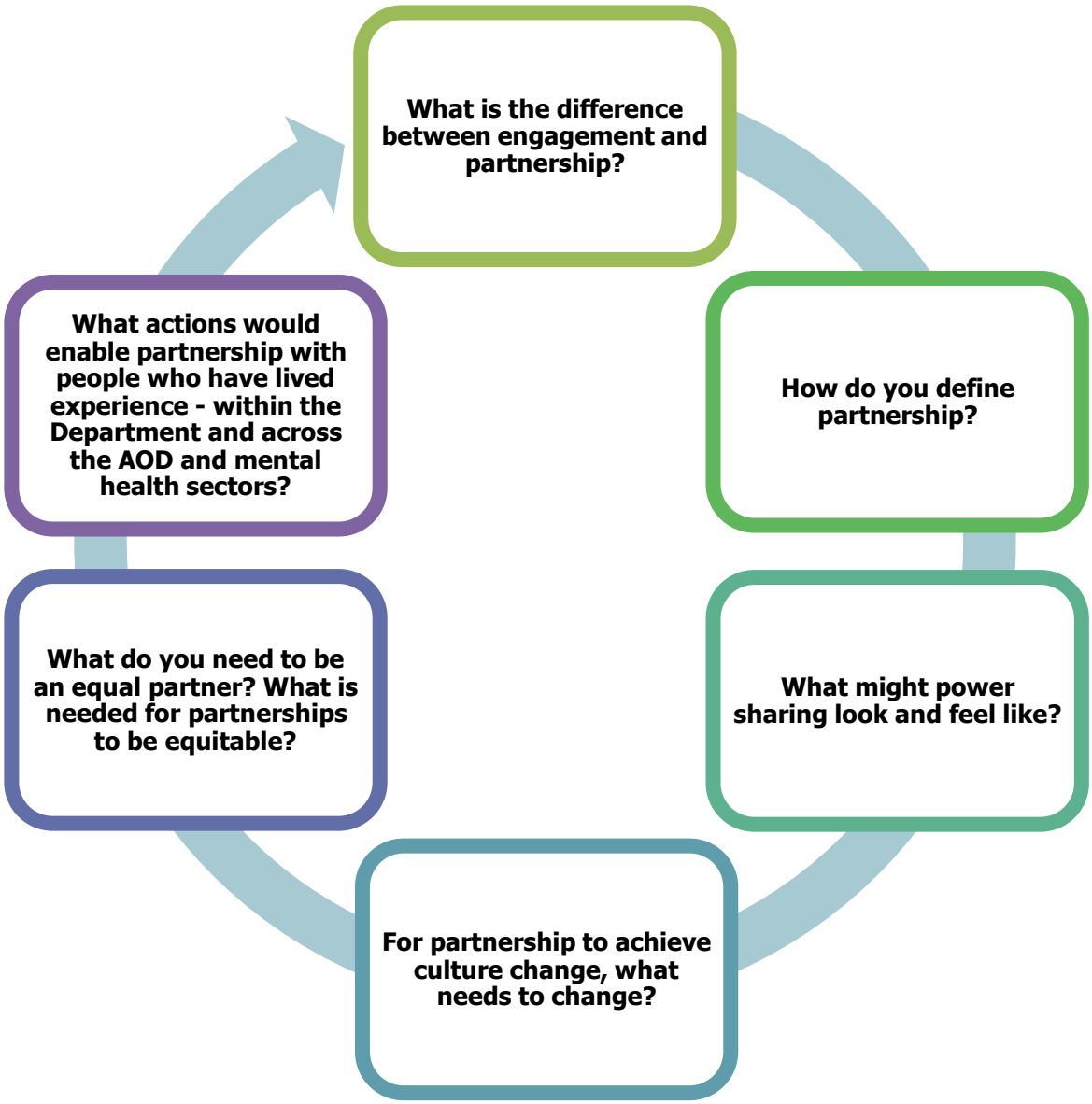
Moving from Engagement to Partnership Project

Community Conversation Starter



by inside out & associates australia

for

Mental Health and Wellbeing Division, Department of Health, Victoria
in partnership with VMIAC, Tandem Carers & SHARC

17 August 2022

INTRODUCTION

The Royal Commission into Victoria's Mental Health System repeatedly called for a more powerful role for people with lived experience in the reformed mental health system (Royal Commission into Victoria's Mental Health System, 2021a). Since the 1990s, the mental health system has applied an engagement approach to people with lived experience of mental distress and their families, carers, and supporters.

The Commission's recommendations require a move to a partnership approach. This project explores the differences between engagement and partnership and will develop a definition of partnership and recommend practical ways partnership can be realised within the Victorian Department of Health (the Department) and across the state's mental health and alcohol and other drugs (AOD) sectors. This project is informed by the following Royal Commission Recommendations:

Recommendation 2

- Governance arrangements for promoting good mental health and preventing mental illness

Recommendation 28

- Developing system-wide roles for the full and effective participation of people with lived experience of mental illness or psychological distress

Recommendation 30

- Developing system-wide involvement of family members and carers

Recommendation 33

- Supporting Aboriginal social and emotional wellbeing

Recommendation 34

- Working in partnership with and improving accessibility for diverse communities

Recommendation 45

- Effective leadership of and accountability for the mental health and wellbeing system

Our Approach

Image © Mikael Damkier / Alamy Stock Photo

As people with a lived experience of mental distress, alcohol and other drugs, and as family/carers/supporters, our approach to the transformation required to realise these recommendations aligns with *The Water of Systems Change* approach (Kania et al., 2018). We are invested in learning what it will take for the Department and the Victorian mental health and alcohol and other drugs sectors to step away from how things have been done, to have the courage to take risks in adopting new ways of knowing, being and doing.

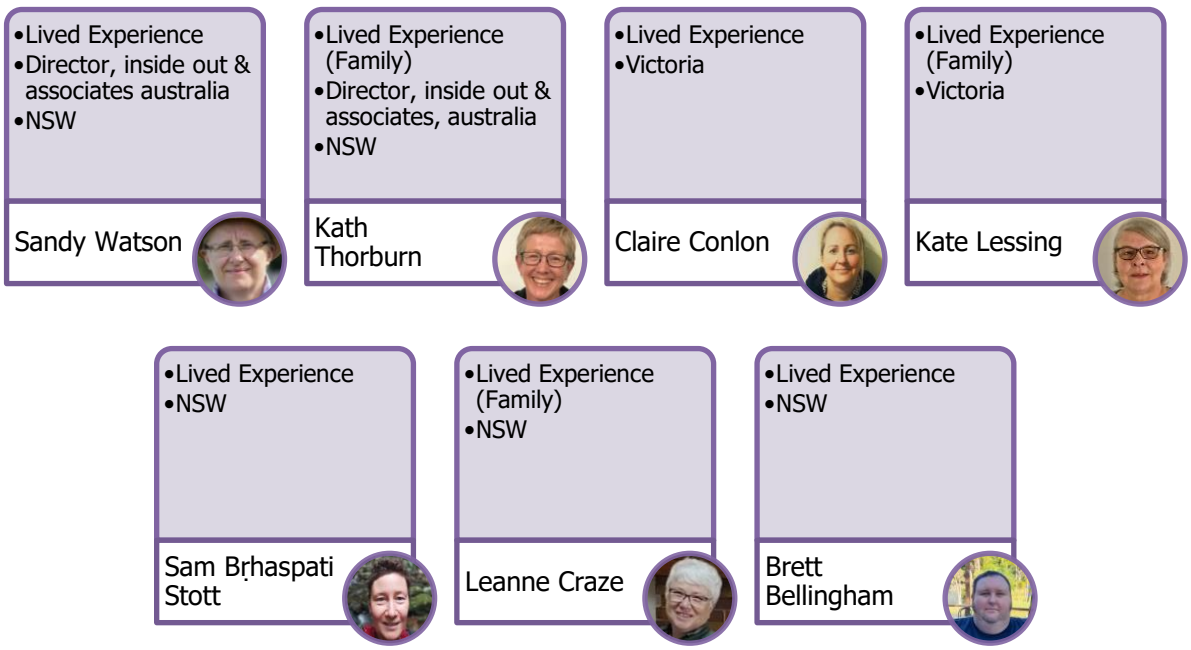
Specifically:

1. "Systems change is about advancing equity by shifting the conditions that hold a problem in place.
2. To fully embrace systems change, funders should be prepared to see how their own ways of thinking and acting must change as well.
3. Shifts in system conditions are more likely to be sustained when working at three different levels of change:
    a. Structural – policies, practices, and resource flows
    b. Relational – relationships & connections and power dynamics
    c. Transformative – attitudes and habits."

Kania et al., 2018

Who We Are

The project is being coordinated by [inside out & associates australia](#).



EXPECTED BENEFITS OF THE PROJECT

The benefits this project will deliver are:

- Improved clarity about the differences between engagement and partnership
- A sector-wide owned and shared definition of partnership
- Practical ways for realising partnership within the Department and in the community and associated services and organisations – embedding with culture and practice
- Positioning the Department with an increased capacity to model and lead the development of lived experience partnerships across the mental health and alcohol and other drugs sectors.

ABOUT THIS CONVERSATION STARTER

This conversation starter draws from our scan of the literature and aims to help people as they prepare to join one of the community conversations for this project. You can register for a community conversation [here](#).

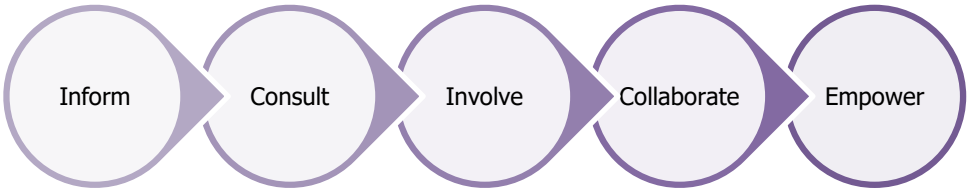
The ideas and views are by no means definitive – they are provided as a starting point for discussion.

KEY QUESTIONS FOR THE COMMUNITY CONVERSATIONS

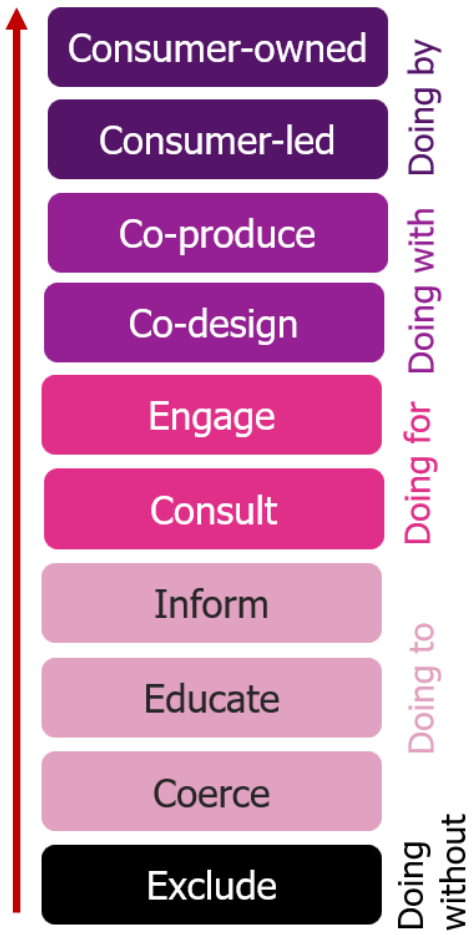
What's the difference between engagement and partnership?

What is engagement?

Understanding what is meant by engagement is tricky as it is often used interchangeably with the term 'participation'. Recent approaches to community engagement have been influenced by the IAP2 Spectrum of Public Participation (International Association for Public Participation, 2018). This model is designed to assist with the selection of the level of participation that defines the public's role in any public participation or consultation process. The model envisages increasing levels of a person's or group's impact on decision making:



The final two levels are based on the rungs of partnership and delegated power in the seminal Ladder of Citizen participation (Arnstein, 1969) and more recently adapted for mental health settings (Daya, 2020; Slay & Stephens, 2013). As you can see from this adapted ladder, 'engage' sits on the rungs aligned with 'doing for'. Engagement involves people with a lived experience of mental distress and their families, carers, and supporters in decision-making in a tokenistic way, without reallocating power or resources (Daya, 2020).



Engagement is unlikely to meaningfully involve people with a lived experience of alcohol and other drugs and/or mental distress and their families, carers, and supporters who are also First Nations people, members of the LGBTIQA+ community, migrants and refugees, people living with a disability and/or young people (Daya et al., 2020; Tritter & McCallum, 2006). To enable culturally safe participation of diverse populations requires the redistribution of power and resources – relinquishing and acquiring.

A definition of engagement consistent with the IAP2 approach is found in this Community Engagement and Consultation policy (City of Unley, 2012):

> "*Community Engagement is any process that involves the community in problem solving or decision-making and uses community input to make decisions. Community engagement can include communicating with the community about decisions made; consulting on specific ideas or proposals; involving the community in planning processes; and collaborating with the community to make decisions."*

Most definitions and approaches to engagement have an underlying theme of a more powerful group deciding whether, when and how to involve or engage a less powerful group. The more powerful group also decides what to do with views and advice of the less powerful group. For example, the IAP2 equates collaboration with:

> "*We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into decisions to the maximum extent possible."* [our emphasis]

The National Mental Health Commission attempted to address this power imbalance by describing participation (National Mental Health Commission, 2018) as:

> *"A practice that involves people directly, as equal partners, and with safety and equity, in decision making about their lives and in the co-design of relevant policies and services.' [our emphasis)*

The Commission then described engagement as:

> *"Methods used to involve people more generally but also allows for decision making and co-design and co-production processes to be undertaken."*

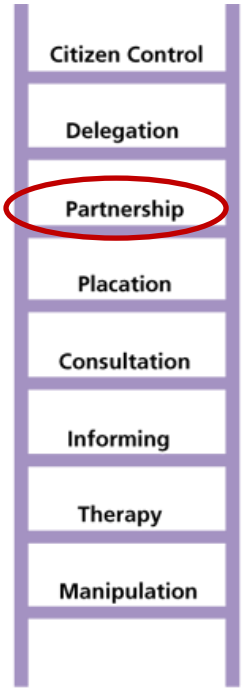
What is partnership?

Standard 2 of the National Safety and Quality Health Service (NSQHS) Standards requires partnership with people using health services as well families, carers, and supporters.

Image source: https://www.health.nsw.gov.au/mentalhealth/Pages/national-standards.aspx

"*The* Partnering with Consumers Standard *aims to create health service organisations in which there are mutually beneficial outcomes by having:*

- *consumers as partners in planning, design, delivery, measurement and evaluation of systems and services*
- *consumers as partners in their own care, to the extent that they choose."*

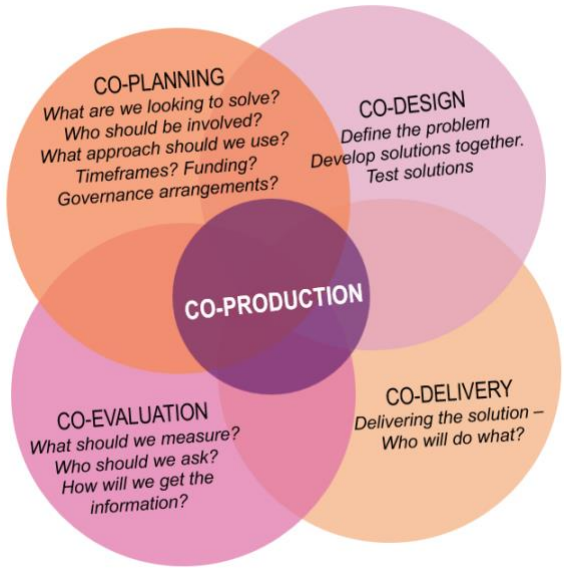


But what does partnership, partnering and being a partner mean? Sherry Arnstein (1969) describes the partnership rung of the civic participation ladder:

"[*at this level] … power is in fact redistributed through negotiation between citizens and powerholders. They agree to share planning and decision-making responsibilities through such structures as joint policy boards, planning committees and mechanisms for resolving impasses. After the ground rules have been established through some form of give-and-take, they are not subject to unilateral change*."

This stage is akin to co-production (Daya, 2020; Slay & Stephens, 2013) on the mental health consumer/survivor adapted ladders and the collaborate phase of the IAP2 Spectrum (International Association for Public Participation, 2018).

Victorian Lived Experience Consultant, Flick Grey, adapted Arnstein's Ladder in 2014, describing partnership as "a stage in which consumers and non-consumers together create, design, and implement a project".



This can be described as co-production. This occurs when people with a lived experience of alcohol and other drugs, and/or mental distress and their families, carers, and supporters work in partnership with government or non-government mental health services to co-plan, co-design, co-implement and co-evaluate solutions (Roper et al., 2018; Slay & Stephens, 2013).

How does this look different to engagement or other kinds of participation? The key is how power is shared and decisions are made (Daya, 2020):

> *"Consumers form a majority of committee and project group memberships. Government/sector ensure they privilege, hear, value, debate & act upon consumer views. Decisions are not made unless the majority of consumers agree. Power imbalances are proactively redressed."*

In co-production, people with a lived experience of alcohol and other drugs, and/or mental distress and their families, carers, and supporters are involved right from the start: "*seeking their expertise in the process of framing problems, setting priorities, designing solutions and evaluating their effectiveness*" (Roper et al., 2018).

A powerful example of partnership premised on redistribution of power and power sharing is enshrined in the Uluru Statement from the Heart (First Nations National Constitutional Convention, 2017):

> *"We seek constitutional reforms to empower our people and take a rightful place in our own country. When we have power over our destiny our children will flourish. They will walk in two worlds and their culture will be a gift to their country. We call for the establishment of a First Nations Voice enshrined in the Constitution. Makarrata is the culmination of our agenda: the coming together after a struggle. It captures our aspirations for a fair and truthful relationship with the people of Australia and a better future for our children based on justice and self-determination."*

This is reflected in the Gayaa Dhuwi (Proud Spirit) Declaration (National Aboriginal & Torres Strait Islander Leadership in Mental Health, 2015), which asserts that:

> *"Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes. Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system."*

Image © Roma Winmar 2015 https://www.gayaadhuwi.org.au/resources/the-gayaa-dhuwi-proud-spirit-declaration/

In Victoria, the solutions outlined in *Balit Durn Durn* reflect the voices of First Nations people with lived experience of mental distress & their kinship networks as well as health workers & services in the Aboriginal community-controlled sector and beyond Aboriginal and non-Aboriginal organisations and workers and enable "a

culturally-safe, sustainable, self-determining mental health system" (Victorian Aboriginal Community-Controlled Health Organisation, 2021).

"If you're not getting a seat at the table, build your own table"

This quote challenges the assumption that marginalised people must adapt to the dominant system's way of working in order to earn a seat at decision-making tables (Richmond, 2016).

Image © Simo Liu https://hbr.org/2022/06/a-seat-at-the-table-is-not-enough

A partnership of this nature translated to the current mental health and AOD context in Victoria could comprise:

- Shared governance of the partnership
- The right to self-determination, autonomy and to keep own culture
- Respect for and sharing of world views, discourses and understanding the power of language
- Equity through the sharing and often, redistribution, of resources to address power imbalances and any unequal footing
- Shared decision making and equal voice in the decision-making processes
- Negotiation through agreed means to resolve conflicting views with equal weight being given to the voices and views of each partner.

Are there legal requirements for partnership?

There are no legal requirements on Victorian Government to partner with consumers families, supporters and carers. The principles under the new *Mental Health and Wellbeing Bill* which require partnership with consumers and family, supporters and carers (section 21) only apply to mental health services, but not to government.

Alternative accountability mechanisms could include agreed definitions of what a partner is, what terms such as co-design mean, key responsibilities, financial arrangements, what each partner can and can't do and how disputes will be resolved. These mechanisms would facilitate power-sharing and risk-sharing.

What does the Royal Commission envisage?

Promoting inclusion and addressing inequities in the mental health and wellbeing system requires a central role for people with lived experience of mental distress and their families, carers, and supporters (Royal Commission into Victoria's Mental Health System, 2021b). Guiding principle 6 (Royal Commission into Victoria's Mental Health System, 2021a) for Victoria's mental health and wellbeing system provides a sense of the type of engagement the Royal Commission requires:

> *"People with lived experience of mental illness or psychological distress, family members, carers and supporters, as well as local communities, are central to the planning and delivery of mental health treatment, care and support."*

Mary O'Hagan, now Executive Director Lived Experience, Mental Health and Wellbeing Division at the Department, gave evidence and expanded on centrality (Royal Commission into Victoria's Mental Health System, 2021a):

"*The reforms we need are not about 'giving greater voice' to people with lived experience. Rather, we need to transform the system from within, so that those voices are central to the discourses and are deeply heard."*

Image source: https://finalreport.rcvmhs.vic.gov.au/personal-stories-and-case-studies/mary-ohagan-mnzm/

Agreeing with this, and in weighing up all the evidence before it, the Royal Commission determined that Victoria's mental health and wellbeing system would best be served if people with a lived experience of mental distress and their families, carers, and supporters sat equally, alongside the Department, as enduring and influential partners in decision-making and systemic change (Royal Commission into Victoria's Mental Health System, 2021b).

The Royal Commission is clearly indicating a shift from engagement to partnership.

Conversation Question 1: What is the difference between engagement and partnership?

Conversation Question 2: How do you define partnership?

How does partnership with people who have lived experience of AOD and/or mental distress or caring achieve power-sharing and culture change?

Partnership moves beyond traditional participation and engagement models and is built upon a platform of power sharing. It recognises that people with lived experience and communities are likely to have experienced "extreme power differentials" (Roper et al., 2018). Power-sharing seeks to remove these differentials and to address their adverse impacts on people's lives. Power involves those with power over others giving up that power.

Power sharing through partnership

Partnership leads to power sharing when changes including the following are achieved.

- People's human rights are afforded in accordance with the Preamble to the Convention on the Rights of Persons with Disabilities (United Nations General Assembly, 2006)

  > *"Full and effective participation in society on an equal basis with others… having the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them."*

- People have equal standing in the partnerships i.e., are equal partners
- People have an equal voice and choice
- People feel equally heard and valued
- People have self-agency and are self-empowered
- People feel safe in their roles as partners
- People equally influence positive change
- People's individuality, culture, intersectionality, and individual needs are recognised and respected

First Nations perspectives on power-sharing through partnership

In a review of how community-managed mental health services can work collaboratively with First Nations people, unpacking dominant Eurocentric habits of thought and practice were identified as an important first step, with white mental health workers needing to critically reflect on the impact of colonisation on themselves and their work with Aboriginal & Torres Strait Islander peoples

(Henderson & Navarro, 2020). They highlight the centrality of relationship-building with community, including Aboriginal community-controlled services and Elders, and concepts of mutuality and reciprocity guiding collaboration. Practices such as listening first, time for yarning, person-first introductions, and attention to non-verbal communication mitigated power differentials and exemplified cultural competence.

An appraisal of the extent to which government principles informing their work with First Nations people are reflected in government tenders or reports found that partnership did not translate well into practice, despite it appearing in health policy plans in every Australian jurisdiction (Luke et al., 2020). In these documents, the principle of partnership was defined as:

> "Governments and other stakeholders (Aboriginal and dominant organisations) actively establishing relationships and building effective long-term partnerships where there is collaborative 'knowledge exchange', 'priority setting', 'information sharing', 'pooling of resources' and 'two-way skill transfer'"

The authors noted that to shift from engagement, such as having an Aboriginal reference group, to partnership, requires the Aboriginal community-controlled sector to have ownership of decision-making and for decolonising the power dynamic such that resources are equitably shared.

An investigation into the role institutionalised racism plays in the non-Indigenous health sector advocates for governments to learn from Aboriginal community-controlled health services in effective intersectoral partnership-building and recommends the Marrie Institutional Racism Matrix as a tool for revealing the ongoing grip of colonisation in government health policy, planning and delivery (Marrie & Marrie, 2014; Socha, 2021).

Migrant and refugee perspectives on power-sharing through partnership

In their response to the Royal Commission, the Ethnic Communities' Council of Victoria in partnership with Victorian Transcultural Mental Health envisage a rebuilt Victorian mental health system that is culturally safe, culturally responsive, equitable and inclusive (Plowman & Izzo, 2021). They highlight the structural violence of the dominant Eurocentric cultural location of the current system and the harm this causes people from migrant & refugee backgrounds who have a lived experience of mental distress, psychosocial distress, and trauma. Reimagining the system requires centring people from refugee & migrant backgrounds and building structural competency into the system. This requires a proactive and intentional approach to partnering with migrant & refugee communities to commission, co-design and co-deliver mental health services. Drawing on the VTMH Partnership Framework (De Silva & McDonough, 2020), they describe partnership as both fluid and progressive,

informed by rights-based & human-centred frameworks, collaborative, reflective and relational.

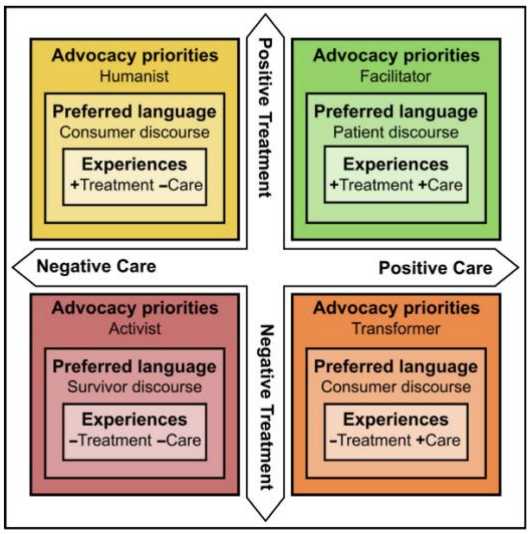
How are 'best practice' approaches to participation such as co-design experienced by people from migrant & refugee backgrounds? A review of research co-designed with people from culturally & linguistically diverse backgrounds emphasised the importance of the relationships & connections between co-designers, the need to ensure that culturally-relevant explanatory frameworks for mental distress & community are agreed upon and that co-design protocols are fit for purpose, culturally safe & responsive. (O'Brien et al., 2021).

As an indication of how far current practice is from meaningful partnership with migrant & refugee communities, a recent review of health service engagement frameworks determined that only a third specifically considered engaging people from culturally & linguistically diverse background (Chauhan et al., 2021). Mechanisms focused on addressing language barriers with limited exploration of culturally sensitive practice, let alone culturally safe or culturally responsive praxis.

LGBTIQ+ perspectives on power-sharing through partnership

The second national LGBTIQ+ mental health & suicide prevention strategy aims to embed an equity approach to governance, data availability, and resourcing which emphasises LGBTIQ+ community-led approaches (LGBTIQ+ Health Australia, 2021). This is supported by the Rainbow Tick accreditation framework which fosters LGBTIQ+ inclusive practice and cultural safety (Jones et al., 2020).

Youth perspectives on power-sharing through partnership



Integrated model: Experiences, preferred language, and advocacy priorities (Daya et al., 2020)

Drawing on a conceptual model for integrating contributions from transformer, activist, facilitator and humanist consumer/survivors (Daya et al., 2020) in their co-reflections on a youth mental health service co-evaluation, allies and service user academics emphasised the actions necessary for those in structurally privileged and positions to unlearn, sit with discomfort and act in solidarity with those in structurally marginalised positions (Gordon et al., 2021). They argue that a critical mass of people with a lived experience of mental distress mitigates iatrogenic harm and tokenism whilst effectively shifting power dynamics, whilst noting that there is still work to do to ensure that young people experiencing

intersectional oppression, such as those who are also from First Nations backgrounds, contribute as project partners rather than on advisory groups. Another approach to working more equitably with young people who have a lived experience of mental distress and their communities is participatory action research (Freebairn et al., 2022). Worth noting, however, is that in this instance, the design team included a sole young person – an example of the tokenism rife in engagement approaches – and young people's expertise is subsumed in the category of stakeholder in the engagement model they describe.

The Y-Change social and systemic change platform at Berry Street, states that:

> "Young people who have experienced disadvantage are the only people who can tell us what a policy looks and feels like when it comes to life. They are key knowledge holders in the search for 'what works' and the understanding of what doesn't, and they must be at discussion and decision-making tables, always." (Cataldo, 2019)

Among the principles that informs Berry Street's work alongside young people, they expressly recognise that young people are "not just the subjects of our work, they are our partners in it" (Cataldo, 2019, our emphasis). In keeping with this, Y-Change's very first recommendation to the Royal Commission signalled the importance of partnering with people with a lived experience of mental distress among the Commissioners. We note that one of the Commissioners brought a lived experience of caring to their role. Further, they argued that: "those with a lived experience of mental ill-health must be partnered with, and at the forefront of, of sector reform" (Cataldo, 2019, our emphasis).

Partnership leads to power sharing when obstacles and barriers to equitable participation and voice are addressed.

Through the sharing of power, partnership also provides a bridge to delegated power where people make decisions for themselves.

Partnership and culture change - Partnership leads to culture change by changing thinking, practice and the way decisions are made.

- △ ***Changing thinking*** – Partnership promotes an openness to learn from each other and to embrace new ways of thinking by:
    - Recognising, valuing and elevating Aboriginal and Torres Strait Islander peoples' wisdom, expertise and leadership (First Nations National Constitutional Convention, 2017; National Aboriginal & Torres Strait Islander Leadership in Mental Health, 2015)

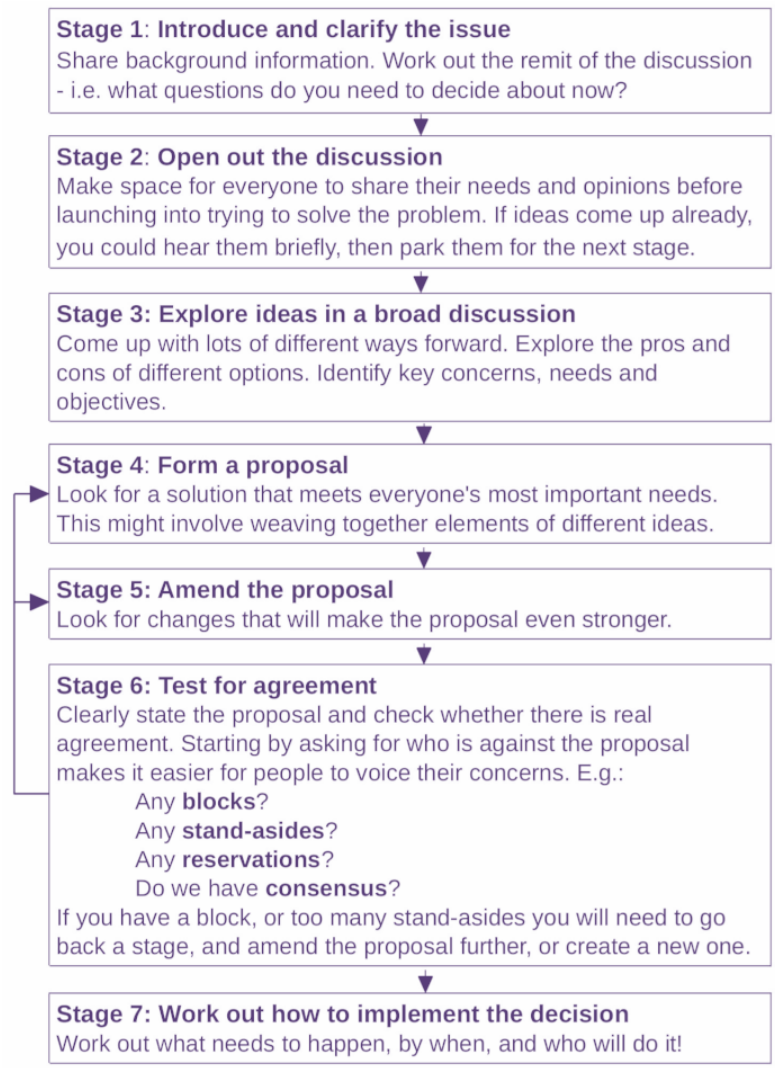
- Prioritising the six mindsets of co-design (McKercher, 2020)

△ *Changing practice*

- Acknowledging, exploring and address power differentials
- Affirmative action by structurally powerful partners to relinquish and share power
- Prioritising and building relationships
- Co-production
- Co-creating self-empowering environments
- Developing lived experience leadership and capacity, such as through the Live Learn Lead Collective at the Centre for Mental Health Learning Victoria and the Coming Together Forum (for Lived and Living Experiences Workforces in the mental health and AOD sectors)

△ *Changing how decisions are made*

- All partners are involved from the outset and throughout the entire process
- Decision-making structures and processes are co-created, agreed, and clear
- Making space and time for the viewpoints of all partners to be heard and reflected upon
- Negotiation, compromise, and consensus building



Consensus flowchart adapted from https://www.seedsforchange.org.uk/consflow.pdf

Partnership establishes a culture which embraces exploration and learning. It genuinely and equitably values the knowledge and expertise of people with lived experience of mental distress & their families, carers, and supporters. It creates a culture that recognises the quality of services and decisions are improved through the wisdom of the people who use them and whose lives they impact.

Conversation Question 3: What might power sharing look and feel like?

Conversation Question 4: For partnership to achieve culture change, what needs to change?

WHAT OBSTRUCTS PARTNERSHIPS BETWEEN PEOPLE WITH LIVED EXPERIENCE OF AOD AND/OR MENTAL DISTRESS OR CARING AND ORGANISATIONS IN THE SECTORS?

Some frequently identified obstacles to partnership include:

- Lack of partnership opportunities
- Lack of adequate resourcing to enable participation as partner
- Dependent on people having the right or sufficient resources, knowledge, and expertise to participate in partnership processes
- Lack of information in community languages with language interpreting and cultural advice
- Insufficient time for partnerships, short notice, or inappropriate timing of partnership activities e.g., during work hours and Monday to Friday
- Unequal standing or power imbalances
- Previous experiences of harm by the system (iatrogenic trauma)
- People not feeling safe – a lack of trauma-informed practice (Kezelman & Stavropoulos, 2020)
- Processes where there is lack of disability access or not accessible by public transport or not close to where people live
- Accessibility issues such as lack of Auslan or captioning and the use of assistive technology and equipment for people with disabilities
- A focus on adults
- Technology dependent processes, which requires internet access and/or computing skills
- Written word-based and requiring considerable prior reading
- Using jargon or language people do not relate to, are afraid of or traumatised by, or shamed by
- Restricted reach or only involving a small number of selected individuals (National Mental Health Commission, 2018)

> A further commonly cited barrier is the use of jargon, acronyms, or language that people do not relate to, are afraid of, or shamed by. A 'one size fits all' approach denies the uniqueness of the individual (Australian Health Ministers' Advisory Council, 2013) and is a barrier that arises when diverse communities and groups are viewed as homogenous and when intersectionality and the diversity within and between groups is not recognised. For this reason, a goal of equality will not achieve meaningful partnership – equity is required.

"Equality essentially means providing everyone with the same amount of resources regardless of whether everyone needs them…Equity is when resources are shared based on what each person needs in order to adequately level the playing field."

Global Citizen www.globalcitizen.org

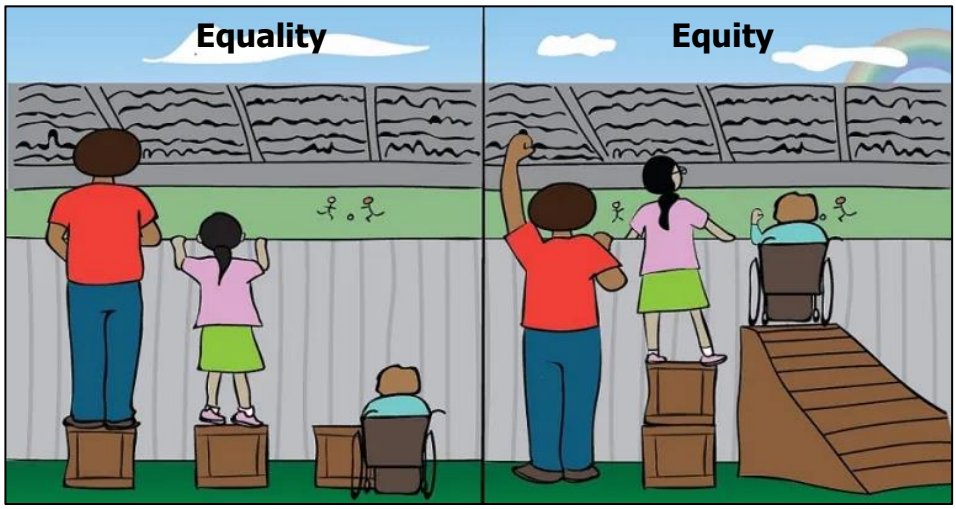
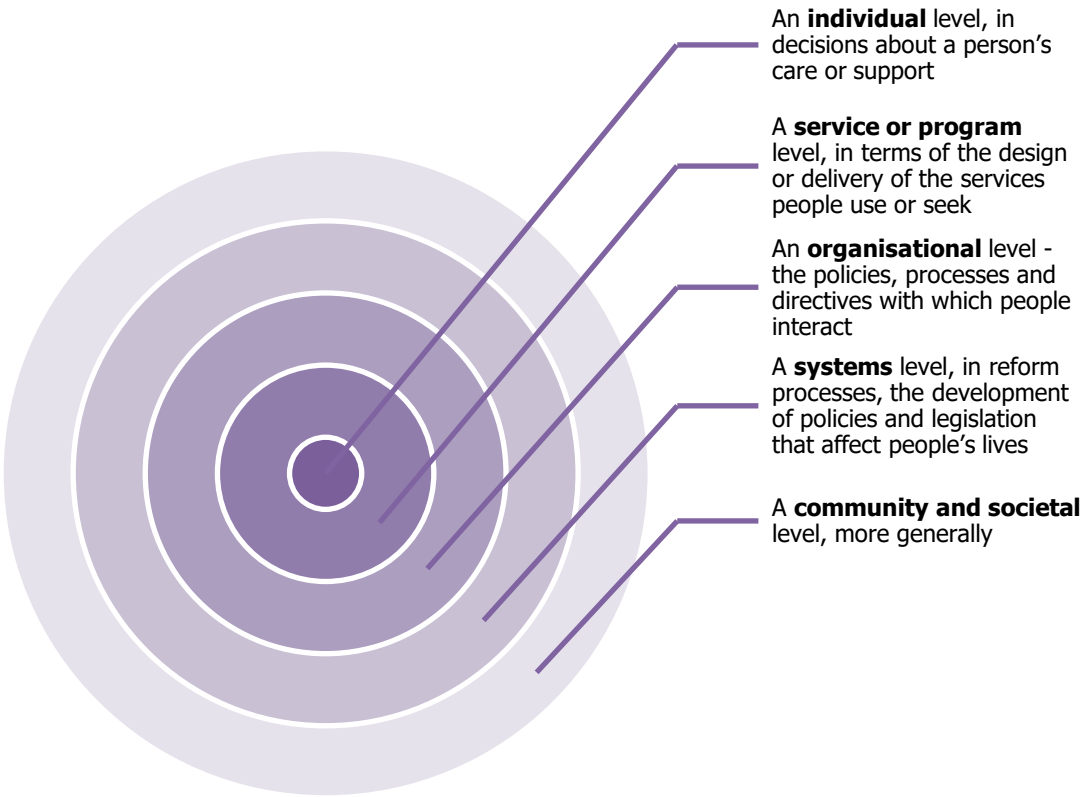


Image © Maryam Abdul-Kareem https://muslimgirl.com/heres-care-equity-equality/

Conversation Question 5: What do you need to be an equal partner? What is needed for partnerships to be equitable?

WHAT ARE THE IMPLICATIONS FOR THE DEPARTMENT AND SERVICES AND ORGANISATIONS ACROSS THE SECTOR?

Partnership in the mental health sector is required across many levels including:



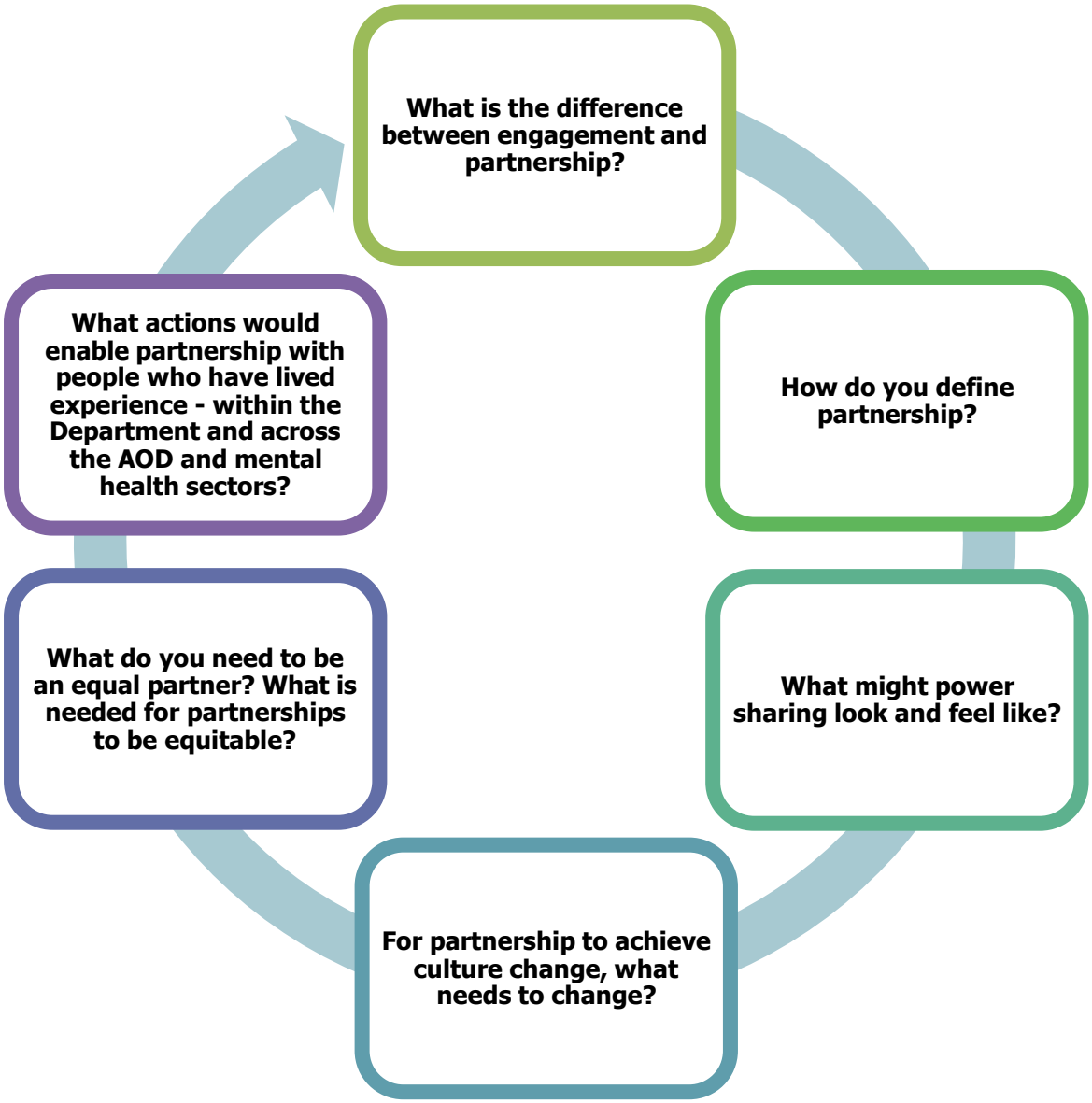
This project is seeking ideas about how the Department achieves genuine partnership across all these levels. What needs to change – big or small? What practical recommendations could this project make – what solutions could it enact?

Partnership with Government

The multi-layered and hierarchical structures of power and decision-making in Government present challenges to partnership. The Minister's decisions are informed via bureaucratic approval mechanisms, with lived expertise often provided in an advisory capacity. Partnership in this context requires understanding and addressing some of these specific structures and mechanisms. This project aims to identify the changes that are needed within these structures and mechanisms.

Conversation Question 6: What actions would enable partnership with people who have lived experience of alcohol or other drugs and/or mental distress and caring - within the Department and across the AOD and mental health sectors?

SUMMARY OF CONVERSATION QUESTIONS



MORE INFORMATION

Details of the community conversations to be held in July 2022 can be found at this online schedule & registration site.

For further information, please email projects@insideoutconversations.com.au.

FURTHER READING

Arnstein, S. R. (1969). A Ladder Of Citizen Participation. *Journal of the American Institute of Planners*, 35(4), 216–224. https://doi.org/10.1080/01944366908977225

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