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 **Power Sharing** 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.

Power Sharing

Partnerships require, indeed necessitate, the sharing of power. The aim is to achieve a "power balance and equity to ensure voices are heard" (LE).

> *If one person has the power, it will never work - it needs to be shared. The person living with an addiction can strongly sense any power over them. (FSC AOD)*
>
> *…. partnership…. sits at the top of the participation ladder. It is about managing power dynamics and ensuring equal opportunity for key stakeholder groups to contribute and work together at every stage of a project, from planning through to the implementation and evaluation. They're doing it together and allowing for co-leadership. (LE)*

Dynamics of power:

How power is shared is a critical concern for the success of the partnership, and a factor that requires attention throughout the lifespan of the partnership. Suggested strategies for ensuring shared power within a mental health/AOD partnership context included the need for some parties

to acknowledge and let go of power previously held, elevating the power of lived experience voices, and reconsidering the impact that funding management strategies have on power dynamics.

Letting go

Partnership is scary for both sides - as a holder of power you have to let go - as a 'new' partner there is more responsibility, lots to learn, uncertainty about what you are now 'allowed' to say and do, pressure to deliver while getting up to speed. (LEDep)

[Power sharing would look like] people with all the power, acknowledge it and actually give up some of that power. (FSC)

That those with power work hard to address the inequities that exist in the room - and look at who is actually in the room. (LE)

Elevating lived experience voices

I would like to see people in positions of power who have a lived experience of mental distress/ AOD. (FSC AOD)

[it would be good to have] those with lived experience on boards with equal decision-making power. (LE)

Having expertise valued, and recognising that not all expertise is traditional looking, that it can take different forms. Understanding that it is productive even if [the] journey takes longer. (LE)

Funding and power

Appealing to people's good will to change the power dynamic doesn't often work - need to change structures. (FSC)

The power needs to move! Remove the fact that the funding is controlled by organisations, and that they have the power to decide how it gets spent. (FSC)

A number of significant outcomes of sharing power within a partnership were emphasised, comprising cognitive, emotional, and logistical impacts.

Power sharing feels like your perspective is being valued, impactful, and transformative. (LE)

Power sharing would be the opposite of anxiety and helplessness. (FSC AOD)

[Power sharing would feel like] those who have felt unequal now feel equal. (FSC)

It looks like you're making real progress and change. (LE)

Good power sharing feels like you are safe to share, your input is valued and sought after, you have the ability to make key decisions and have responsibility and accountability. (LE)

Importantly, the process of moving toward equal power sharing is not immediate. Suggestions of what to expect the transition to require touched on anticipated discomfort, challenged attitudes, and changed values.

<u>Anticipated discomfort</u>

Process [power sharing] can feel uncomfortable to begin with. (LE)

[Power sharing] Can feel anxious, exposed, vulnerable, uncertain. (LE)

[Power sharing would be] bit of shock for everyone at the start – this is not what we are used to! (FSC)

<u>Challenged attitudes</u>

The training and education that clinicians do changes how they see things – [currently they are] learning from other clinicians and reports, rather than learning from people with lived experiences of mental distress (for example, concepts of 'risk'). This continues [the] power imbalance. [For partnership and power-sharing would mean] putting lived experience of mental distress as equal and valuable as the professional expertise. (LE)

Traditional power holders stepping back and letting us speak up for what we believe in. (YP)

<u>Changed values</u>

Government needs to devolve some responsibilities and hand over some power to partners - a level of support is still needed. (LE AOD)

[processes need to] … change in practices that ensure safety, adjusting the power imbalance. (LE)

In order to progress toward genuine power sharing, the legacy of power, oppression, and injustice; unrecognised, deep seated discriminatory attitudes; and the effects of white privilege, racism, and cultural blindness, all require acknowledgment and conscious, intentional action that addresses past and present manifestations.

The legacy of power, oppression, and injustice:

People with power having to acknowledge that they have a part in the imbalance and need to be part of addressing it. (LE)

The amount of power - most power is held over people with psychiatric disabilities/mental illnesses - atrocities committed when power taken away – that legacy hasn't been dismantled. (LE)

Stepping away from what can sometimes be a punitive treatment approach in the hospital system and stepping into a more compassionate safe and inclusive approach. (LE)

[there is a..] stigma and reluctance to share power with stigmatised groups e.g., Centrelink tell people how they are to spend their money. We are told how to use funds. Funding held by those who hold power can misappropriate funds. (LE AOD)

So many people with significant mental health challenges have experienced interpersonal trauma, and yet the systems there to support us are so traumatising. (LE)

Unrecognised, deep seated discriminatory attitudes:

There is so much fragmentation, stigma, and discrimination experienced in the addiction space, partnership is difficult. (FSC AOD)

In my experience, when I grew up there were unconscious biases from European Australians. (CALD)

Everything gets blamed on 'mental health issue' - not whole person seen - underlying medical conditions are missed. This is seen so much in Emergency Departments, once they are aware there is a mental health history. (FSC)

Remove high level or structural/systemic stigma - how a person with a lived experience should be interpreted – work with people as people. (LE)

Effects of white privilege, racism, and cultural blindness:

….somehow there is racism with mental health as well. As an international student, I experienced racism here just because I am Asian. (CALD)

Representative type of work (in partnership with organisations and communities) even more of a barrier due to a legacy of distrust and discrimination that means that families would see it as 'white culture work' and not true to own cultural identity. (CALD)

…unless we address equality on a systemic level, the sector will continue to dismiss minority groups with less power. (LGBTQ)

Unlearning and critical reflectivity:

The necessity and value of unlearning was stressed across multiple domains. "Unlearning ingrained ableism" (LE), "stereotyping and generalising" (YP), and "deconstructing ways of working" (LE) will move a partnership toward a "more equitable approach" (LE).

> *Unlearning ways of working…. Many clinical workers been in the system and the Department for a long time and have ways of working that are indoctrinated into those systems. There needs to be a level of vulnerability for people to step into relationships and spaces and wanting to be introspective and how they show up and how are they prioritising voices. (LE)*
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> *Clinicians and services will need to examine, address, and let go of the power they hold and often hide behind i.e., stop weaponizing clinical decisions above all else. A lot of work will be needed to get psychiatrists/medical doctors to give up all the power of being a doctor in our society! (FSC)*
>
> *Organisational language - creates barriers to understanding. Get rid of jargon, things need to be in plain language and include diverse examples in documentation. (LE)*

The importance of reflecting critically on approaches and practices is positioned to inform how power might be shared for mutual benefit moving forward.

> *Working out what has worked in the past, and changing those things that haven't, to what people believe will work or could work. Keeping check on how the programs and services are progressing. (LE)*
>
> *Deconstructing the practices and policies and having shared reflection with people from all perspectives & diverse backgrounds – equal input into generating new approaches. (LE)*

Power Sharing – First Nations perspectives

The idea of power and how it manifests in partnerships was discussed by all participants in various ways, particularly those with lived experience of mental distress, who shared harrowing stories of how they have felt 'disempowered' seeking support time and again.

When discussing power with Aboriginal community-controlled sector workers, many spoke about how power dynamics are a barrier in terms of how safe people feel to be honest with each other and how this can impede the nature of working together. With some elaborating on the following key examples, of when power is felt, in a partnership:

- The dominating view was that writing is the only method of engagement.
- Government uses coded language which is hard to deal with or get your head around.

- There is a ‘false urgency’ with government and some NGO’s – with obstruct community timelines.
- Government often does not send the right decision makers, or policy influencers.
- Government often does not own the funding contract; and not sharing it.
- Unrealistic timelines and pressures – not understanding that good governance takes time.
- Government having access to unequal resources, policy writers, funding – makes it hard to walk alongside each other.
- Government withholding information that they deem unsuitable, without consulting the wider partnership.

This is the power imbalance – both knowledge systems have their place. Listen to us, we know what works for our people. Let’s bring both systems of knowledge together and work alongside each other.

‘Aboriginal communities have been inputting into a process but not being a decision maker. This is engagement and it is a less empowered approach. Partnerships require governments to give up a bit of power and prioritise self-determination or organisations and individuals.’

A deeply fascinating interrelated finding was that one person spoke about a ‘collaborator’ model which her organisation had adopted which places two people in a shared role, with a non-Indigenous person shadowing a First Nations person. They spoke about this being deeply linked to a ‘two-way model’ which was based in Yolnu principles, which have shown great promise in modern science, when a scientist teams up with a Traditional Owner to yield better outcomes (Muller, n,d). And interestingly another person, offered the same, or similar solution, by suggesting that public health teams within the department collaborate with the Aboriginal health unit to have a more robust and interdisciplinary team to lead and maintain the project, with cultural and health governance being understood and appreciated. Person One spoke about this as an effective model to practically share power.

Whereas another talked about membership options that allowed Indigenous associate members (without voting rights). Coalitions change record – Aboriginal organisations and non-Aboriginal organisations respect the need for self-determination. ‘We built in an Aboriginal caucus into the structure. This is a powerful way to give up power.’ Space and time to talk amongst us before we come to the bigger group. But this person also stated that addressing power should not be token and that ‘the government must be honest with themselves about how much power they are willing to give up, and respect self-determination.’

Yet another person with a lived experience of mental distress, and was admitted to hospital once, shared the following anecdote on how power and privilege was apparent when she and her family were seeking treatment. 'When I was 17 years old, I had an eating disorder. The hospital asked us to go to family therapy. Our therapist was a non-Aboriginal woman and I sat down with my mum and stepfather. The therapist had very bullying behaviours and made my mum and I cry. She said to my mum, 'Do you think you did a good job?' She didn't understand how much hurt she caused. Mum was a member of the Stolen Generations and did the best to support me.' Another interviewee believed that if she had an Aboriginal worker; they wouldn't be so careless with their language and caused so much harm to an already hurting family.

Power sharing is a non-negotiable when developing a partnership with First Nations people, and other marginalised and oppressed people. Recognising the legacy of institutionalised racism, colonisation, power imbalances, and the ongoing impacts they have on communities is an initial step for the government and mainstream health providers to transition to an equal partnership.

> *'An ideal partnership should be based on strong relationships, shared power, understanding each other's needs and expectations, and being grounded in sovereignty and self-determination. Partnerships need strong conflict resolution and robust, honest conversations, an ongoing learning and reflective process.'*