"Consumer led transformational change"

Consumer workshop & survey results

www.vmiac.org.au

VMIAC
by and for consumers

“The Psychiatrist” by Arwin Kraze

Contents

1. Introduction and Background

Following the establishment of the Royal Commission into Victoria's Mental Health Services in early 2019, VMIAC worked to ensure that the voice of lived experience was placed at the centre of what could be considered the biggest mental health system reform opportunity in recent history. Utilising peer support specialists, a network of consumer advocates and systemic advocacy work, we supported our members and the broader consumer community to provide input into the Royal Commission through individual and group submissions; community roundtable consultations; hearings; and our organisational systemic responses. Many consumers, fed up with a system that is broken and harmful, welcomed the opportunity to finally have their stories heard, asserting the integral part that lived experience must play in creating a system that is safe, fair and responsive to all.

In November 2019, the Commission released its Interim Report outlining nine initial recommendations. In response to the Interim Report, VMIAC prioritised understanding the views and opinions of consumers on the five recommendations where lived experience –informed design and development was essential, specifically:

- Recommendation 1 – Victorian Collaborative Centre for Mental Health and Wellbeing
- Recommendation 2 – Targeted Acute Mental Health Service Expansion
- Recommendation 5 – A service designed and delivered by people with a lived experience
- Recommendation 6 – Lived experience workforce
- Recommendation 7 – Workforce readiness

1. Introduction and Background

1.1 Consultation Process and Demographics

Given that the Interim Report recommendations were made largely in response to hearing the harms and failures of Victoria's mental health system, in our next phase of consultations, VMIAC took a strengths based approach – broadly structuring our workshops and surveys around the question "What does the mental health system look like, when it is working brilliantly?" The intention of this was to ensure that the implementation of these recommendations would be guided by the real wants and needs of consumers, rather than quick fixes that would merely remedy the ills within the current system.

Originally, VMIAC's consultation strategy on these recommendations included face-to-face workshops in regional[1] (and metropolitan areas); however, the emergence of COVID-19 in early 2020 led this to be an unviable option. VMIAC's Royal Commission team adapted the workshops to take place in an online format (Zoom), and, as an adjunct to the online workshops, conducted a series of surveys encompassing the recommendations more broadly and on specific topics.

Beginning in April 2020, a total of 15 workshops were held on the five prioritised recommendations, with an additional two workshops completed at the end of June exploring broader systemic issues that emerged as a result of our Royal Commission work (Peer Work and Gender Considerations in the Mental Health Service Delivery). Regional areas included: Swan Hill, Mildura, Shepparton, Wangaratta, Wodonga, Horsham, Warrnambool, Bendigo, Castlemaine, Bairnsdale, Sale, Wonthaggi, and Inverloch

1. Introduction and Background

1.1 Consultation Process and Demographics

Workshop Logistics:

Thirty-two consumers participated in the online workshops with some signing up for multiple sessions to ensure they were able to provide feedback across all recommendations. Workshops were limited to eight participants per session and ran for one hour, covering one recommendation each. Sessions were recorded for VMIAC use only – consumers were made aware of this at the start of each session. Consumers were remunerated for their participations in the workshops.

Survey Considerations:

Our adaptation to the online format brought access challenges for consumers who were unfamiliar with and/or did not have access to the required technology. This was particularly prevalent under the reality of the COVID-19 lockdown, where access to libraries and other services was even more limited. In response, VMIAC developed additional ways for consumers to provide feedback, including:

An option to send responses in via post and email via a downloadable worksheet based on the questions covered in the workshops.

Online surveys covering each recommendation and follow up surveys exploring more deeply the issues and options developed by consumers in workshops and initial surveys. The surveys were promoted through a range of channels including social media, newsletters, and shared within other mental health organisations.

1. Introduction and Background

1.1 Consultation Process and Demographics

A total of 142 consumers participated in the surveys and workshops and an additional group was interviewed to follow-up on some issues of interest including the Collaborative Centre and the Peer lead service. The findings of all processes are included in this submission.

Three different terms have been used to describe those who took part in our consultations:

- Participants who took part in the workshops
- Respondents who completed the on-line surveys and interviews
- Consumers when both groups agreed on their responses.

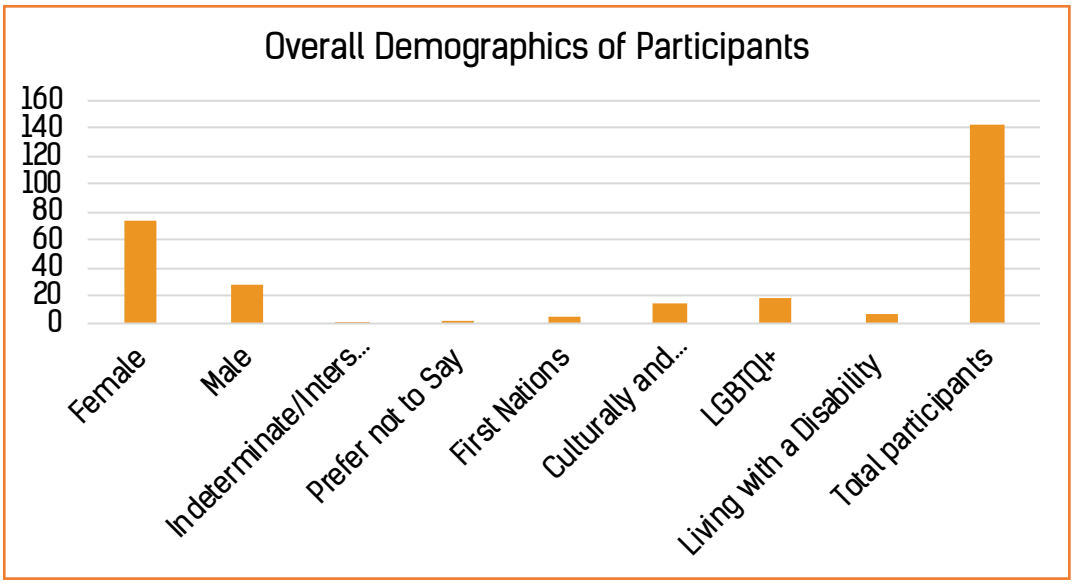


Figure 1 – Overall Demographics of Participants

Consumers were also invited to create and share artwork of the system when it is working well, as well as attend art therapy workshops . The artwork displayed in this report came from these invitations.

[1] Regional areas included: Swan Hill, Mildura, Shepparton, Wangaratta, Wodonga, Horsham, Warrnambool, Bendigo, Castlemaine, Bairnsdale, Sale, Wonthaggi, and Inverloch

1. Introduction and Background

1.2 Consumer Feedback on Consultation Process

Additional to their feedback about the Interim Report recommendations, many consumers who attended our workshops or completed the surveys expressed positive sentiments about the consultation process itself:

"Thank you again for providing this opportunity. It was really empowering to be able to share my experiences and I think the workshops, overall, were really engaging and productive."

"Glad to be given the opportunity."

"I was really pleased that VMIAC figured out a way to involve us and get our comments."

"It was good to hear from many different people's experiences. I feel like it paints an all-rounded view of the system and what is needed for its clients."

1. Introduction and Background

1.3 VMIAC Declaration

For the Royal Commission to understand what a consumer-led vision of mental health looks like, VMIAC created a collective vision of consumers called The Declaration: https://www.vmiac.org.au/declaration/.

This Declaration was created by people from around Victoria with lived experience of emotional distress, trauma, neurodiversity, and mental health challenges. It was first launched on November 1st 2019 at VMIAC's 'Listen Up, Listen Louder' conference where it was presented to The Hon. Martin Foley, Victorian Minister for Mental Health. It has also been referenced extensively by the Royal Commission into Victoria's Mental Health System's interim report. The feedback provided in these current consultations was found to align with the mental health system that consumers envisioned in VMIAC's Declaration.

Figure 2 – The VMIAC Declaration Word Cloud

1. Introduction and Background

1.4 Summary of Key Findings

Several themes were identified by respondents as being key to the implementation of the Interim Report recommendations:

- The mental health system will adopt a transdisciplinary approach that is lived experience led
- The mental health system will be safe to access for women, Indigenous communities, different cultural and linguistic groups and LGBTIQ+ people
- Most workers at all levels of the mental health system will be people with lived experience
- The training for workers and the design of the mental health system will be trauma-informed, holistic and strengths based
- The staff will specialise in person-centred co-design and co-production
- The involvement of psychiatrists in the mental health system will be limited to valued consultants and not as managers of the system
- There will be a wide range of therapy and support options and professionals who provide them
- The mental health system will be accessible for everyone and all mental health needs.

Following is the analysis of the data taken from the results of the online workshops and surveys. The results have been collated under each of the Royal Commission's Recommendations and in the final section the results are discussed by key themes that emerge from discussion of each of the Recommendations. These key themes were identified in a number of discussions regardless of the specific topic and are therefore highlighted in this report.

2. Victorian Collaborative Centre for Mental Health and Wellbeing

The Royal Commission recommends that the Victorian Government establish a new entity, the Victorian Collaborative Centre for Mental Health and Wellbeing, bringing people with lived experience together with researchers and experts in multidisciplinary clinical and non-clinical care to develop and provide adult mental health services, conduct research and disseminate knowledge with the aim of delivering the best possible outcomes for people living with mental illness.

What does the Victorian Collaborative Centre for Mental Health look like when it is working brilliantly?
A Collaborative Centre that is responsive to the needs and wants of consumers will be:

- Accessible for all
- Holistic and Trauma Informed
- Inclusive and safe
- Psychiatrist-free and staffed by a peer workforce
- Lived experience driven and based in co-design and co-production

2. Victorian Collaborative Centre for Mental Health and Wellbeing

2.1 Accessible for all

Workshop participants identified several issues around accessibility which would be essential to the Collaborative Centre's success, specifically:

- An after-hours service, where you can get straight through to a peer worker/social worker/support system at all times
- Year-round operation, including public holidays such as Easter, Christmas as these can be triggering times of the year.
- A centralised location – accessible by car and public transport.

Workshop participants from non-metropolitan areas expressed a wish for this centre to provide outreach services and travel compensation for regional and rural residents.

These services will address the gaps in regional and rural mental health care and ensure consumers' access to mental health specialist services.

2. Victorian Collaborative Centre for Mental Health and Wellbeing

2.2 Holistic and Trauma Informed

There was a clear directive from consumers that both the research and service delivery arms of the Centre need to focus on more than just the medical model, suggesting that the social determinants of health and "real" trauma informed practice (not just in name only) need to be at the forefront of the minds of the practitioners and researchers.

"The Centre needs to be a place where there's a lot of networking and information to give to people on all the things that affect people's mental and spiritual health"

Workshop participants suggested that models of care within the Centre need to be developed that allow for easy integration of allied health and other support services, with the Comprehensive Cancer Centre being proffered as good example of a "one stop shop" that could be replicated for the mental health space. Services provided by the Centre should assist people with the issues that exacerbate mental health issues such as:

- Homelessness
- Financial Difficulties
- Domestic Violence
- Alcohol and Other Drugs

2. Victorian Collaborative Centre for Mental Health and Wellbeing

2.2 Holistic and Trauma Informed

As well as being holistic in terms of service delivery, participants suggested that research should cover the broad mental health context, with priority research areas identified by people with lived experience. Non-medical and trauma informed interventions were highlighted as key focus areas for research specifically:

- Early intervention
- Trauma-informed recovery
- Alternatives to drug interventions and the medical model
- Consumer focused issues, including human rights and the Mental Health Act
- Research on the social determinants of mental illness

Workshop participants also expressed their want for the Centre to be "innovative" and "cutting edge" using the most up to date research to develop good quality service rather than replicate models that have existed historically and seen as the norm.

One participant's story highlighted the need for these changes:

"I have a very specific mental health condition... it's been treated the same since I was diagnosed 15 years ago. There have been many research studies showing better treatment options in other countries... but here I am stuck with treatments that are outdated and actually only proven to work for other illnesses."

2. Victorian Collaborative Centre for Mental Health and Wellbeing

2.3 Inclusive and Safe

There was a strong request for cultural safety and inclusiveness within the Collaborative Centre.

"Everyone within the centre – whether a consumer or a carer – feels spiritually socially and emotionally safe, and physically safe as well".

Twenty-six out of twenty-eight survey respondents answered 'Very important' or 'Important' to the question of "How important is it that the Collaborative Centre demonstrate inclusivity?". The survey then asked respondents how the Collaborative Centre would go about achieving inclusivity and respondents felt that this should be done in the following ways:

- Diversity in staffing and training, including within management and stakeholders. "Have a board or advisory group with representatives from the widest possible range of mental illnesses, ethnicities, genders etc."
- Inclusivity in the design of the space, ensuring that the areas are "sensitive to the needs of diverse groups, large open spaces, limited locked spaces, comfortable seating, spaces specifically for certain groups (women/women identifying, Aboriginal)."
- Lived experience at the forefront to ensure the Collaborative Centre is working for those it is designed for.

Figure 3 – "An inpatient unit that is safe"

2. Victorian Collaborative Centre for Mental Health and Wellbeing

2.4 Psychiatrist Free and Staffed by a Peer Workforce

There was strong agreement by consumers that the Centre needs to lead the way in challenging the power held by psychiatrists in the mental health system.

"Responsibility should not be held solely by psychiatrist needs to be shared. Might be good to have someone who has experience of being the CEO of another organisation that has a vested interest in mental health, who can bring leadership skills from another organisation outside mental health."

"Needs lots of different disciplines to address the social determinants of mental health."

"Psychiatrists to be consultants only. Nurses or OTs etc would be better placed to manage and look at alternatives in mental health and the reasons for mental distress."

Survey respondents requested a psychiatrist-free centre and proposed ideas of who should staff the centre, including:

- Lawyers (to provide advice on options regarding involuntary treatment)
- Doctors (to advise consumers on how to manage, cease and withdraw from medication)
- Peer workers
- Nurses
- Social Workers and Allied Health Staff

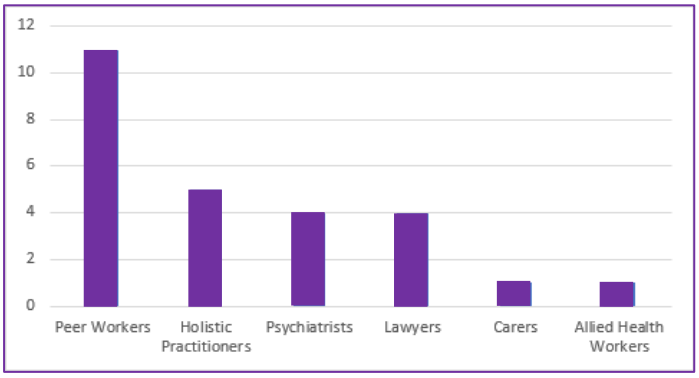
Interestingly, all workshop participants expressed a desire for *"the majority of staff, if not all staff, to be lived experience workers".*

2. Victorian Collaborative Centre for Mental Health and Wellbeing

2.4 Psychiatrist Free and Staffed by a Peer Workforce

Question: On a scale of 1-7 (1 being the least import and 7 being the most) who would you like to see at The Collaborative Centre?

Figure 4 – Who would you like to see at The Collaborative Centre results



As a parallel to general staffing feedback, VMIAC also received responses stating that lived experience should be embedded in the leadership structures and governance models that directed the Centre, suggesting that there needs to be a concerted effort by the Royal Commission's Implementation Team (MHRV) to ensure the lived experience perspective was considered across all management and leadership roles.

"There should be a collective participatory board, where the work of the centre is co-produced and designed with people with lived experience (more than one), professionals and bureaucrats."

"Other professionals need to come from a lived experience perspective even if they don't have lived experience themselves."

There was also broad agreement that co-design, co-production and evaluation must be the foundation of maintaining a strong consumer voice throughout the centre. To do this effectively it will take solid investment in a consumer-led framework, implementation and ongoing evaluation.

"Evaluation of principles of co-production (are needed). Structures and evaluations along the way to evolve the culture need to be created... brand new, not tacking on. Ground up has more success."

3. Targeted Acute Mental Health Service Expansion

The recommendation of an increase of 170 acute beds across the state was seen by VMIAC as a contentious issue, with members perceiving the current state of inpatient care to be inadequate at its best, and harmful at its worst.

Considering this, VMIAC sought responses from consumers about processes and models of care that need to be embedded into the implementation of these beds to ensure that those in crisis are better supported – namely, what is needed in the acute system to move it from a holding space into a healing space.

The overall feedback was that, if they are going to exist, the new acute beds will need to:

- Champion consumer agency and choice
- Be less clinical and more welcoming
- Eradicate involuntary treatment
- Ensure that consumers feel safe
- Be staffed by lived experience workers
- Provide consumers with person-centred and holistic care
- Ensure gender safety and gender appropriate healing.

3. Targeted Acute Mental Health Service Expansion

3.1 Champion Consumer Agency and Choice

Consumers will have greater agency in their treatment, especially regarding duration of stay and their preferred clinical staff. Participants also expressed a strong desire for the eradication of involuntary treatments.

"...greater agency for consumers in their own treatment, greater freedom for consumers to choose which team members they do and don't work with. Being able to have control over this can improve the quality of someone's stay"

There was strong agreement that consumers will have greater access to information regarding their choices, suggesting that the beds be co-managed by a variety of specialists so that "*a range of viewpoints and treatments are available.*" One consumer suggested having more posters/signage about Independent Mental Health Advocacy (IMHA) the Mental Health Legal Centre (MHLC) in wards to help ensure that consumers have greater access to information about their rights and the choices available to them.

What 'choice' looked and felt like for consumers, accessing these beds was explored, with many participants focusing on key areas of access, preferred treatment options and freedom. An acute model that allows for consumers to make choices for themselves will:

"...support for a person's own narrative, understanding, autonomy, diversity and choices, with support to tailor make programs to the person's design"

"... be where people can freely come and go".

"...consider consumer wishes on how their admission could best help them, not harm them!"

"...ensure there are (lots of)... lived experience consumer peer support workers, as well as independent mental health advocates, social workers and access to legal aid and other reps etc. who ensure that patients' primary 'rights' are upheld."

3. Targeted Acute Mental Health Service Expansion

3.2 Less Clinical and More Welcoming

The aesthetics of the environments in which acute care is delivered was a key discussion point across the consultations, with the 'clinical' and 'cold' nature of current acute settings seen as particularly problematic. Improvements that make the space more welcoming and home-like included natural lighting, views of (and access to) gardens and outside space, and comfortable furnishings.

A number of participants suggested that the PARC model or an entirely new model that replicated the 'welcoming' aspects of PARC facilities (e.g. private rooms, ability to come and go, amenities that the consumer would have at home) would be best for the new acute beds. Additionally, there was strong support for these beds to be placed in the community via a hospital in the home model.

In a follow-up survey on this topic, consumers were asked how they would feel about the new acute beds if they were implemented in a new model outside the hospital system. The below results demonstrate that it is extremely vital that any new acute beds are outside the current system with more consumer choice. This is a critical issue for the implementation of this recommendation.

Question: 170 new acute beds will be brought into the mental health system. You told us that you did not want them in the current system, and they need to be in a new supportive model outside the hospital system. How important is this new model for acute beds?

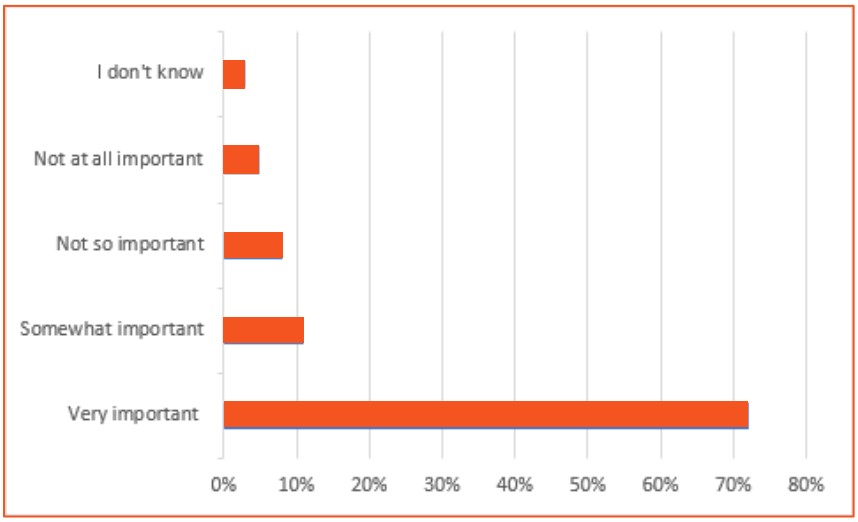


Figure 5 – Importance of the new model for acute bed results

3. Targeted Acute Mental Health Service Expansion

3.3 Be safe for consumers

Safety and security were paramount in discussions for participants – a person in an acute stage of distress should never feel at risk of harm when in the care of the public health system.

Most participants wanted the beds to include secure, private rooms and additional safe spaces. These safe spaces should be relevant to the needs of women, LGBTQIA+, CALD and First Nations consumers.

"It is vital to make sure that these spaces are safe for gender diverse and CALD consumers."

3. Targeted Acute Mental Health Service Expansion

3.4 Staffed by lived experience workers

There was a clear request for lived experience peer workers to be located in the proposed acute settings; participants suggesting that having someone who "knows what it's like" is important to recovery and overall feelings of safety. There was also a concerted push for the voice of lived experience to be embedded in the development and management of the beds with many participants commenting in favour of this:

"They need to ensure there are (lots of) representatives from the lived experience consumer peer support workers, as well as independent mental health advocates, social workers and access to legal aid and other reps etc who ensure that patients primary 'rights' are uphold."

"Obviously, if we have to have them [acute beds], they should be developed using a consumer-survivor-led co-production process and they should be consumer-survivor-managed and consumer-survivor-staffed."

"Jointly managed by consumers, psychiatrists, psychologists, social workers etc so that a range of viewpoints and treatments is available."

"They should be managed by regional health facilities and staff should include people with lived experience of MH and people of all ages. They should also include female staff for female patients as required and CALD appropriate staff as required."

"The focus should be on embedding the experience of survivors of the medical model who can use their own journey of healing and recovery to support and assist people in distress, despair and suicidality."

3. Targeted Acute Mental Health Service Expansion

3.5 Person-centred and holistic care

Survey respondents were clear that there was a need for the new acute service to have empathetic, person-centred and trauma-informed approaches to care:

> *"[The beds] should be staffed by persons who will respect full rights and safeguard them and who are open to and understand a huge range of different perspectives".*

There was a strong desire for the model of the new acute beds to "*consider the social determinants of health"* and be holistic in its treatment options; the most common suggestions of holistic services being art therapy and music therapy.

Figure 6 – "Mean It" by Jeanette Chan

3. Targeted Acute Mental Health Service Expansion

3.6 Gender sensitivity and responsiveness

Gender emerged as an issue to be considered in the initial VMIAC consultations with many workshop participants speaking about their experiences in inpatient units where gender was not considered. This led to further exploration of this in an additional consultation, asking a specific question on whether the new beds should be separated by gender. Sixty percent of these respondents believed this was very important:

Question: Should the additional beds be arranged by gender?

Figure 7 – Should the additional beds be arranged by gender results

Answer Choices	Responses	
Yes, I believe this is important	60%	27
No, it doesn't really make a difference to me	24.5%	11
I don't know	13.3%	6
	Answered	44

Additional comments supporting the need for gender safe spaces:

"Women need to be and feel safe when they are in a mental health facility and probably feeling fragile."

"Yes, as requested and required by the patients"

"I'm NOT going in a locked ward or even an unlocked ward with aggressive men. As a DV survivor, how would that help me?"

It has been noted that the abuses women face within the Victorian mental health system caused by the links between general gender discrimination in society and the abuses of mental health consumer Issues. Women are more likely to be abused by other consumers in wards and also by staff. This has been identified most recently through reports such as the Mental Health Complaints Commission's *Right to Be Safe Report.*

If gender safety is going to be guaranteed, there will need to be single gender wards or rooms with locks. It was also noted that staff need specialist training about gender and cultural appropriate approaches as well as training about LGBTQI+

4. A service designed and delivered by people with a lived experience

The first of its kind in Victoria – a residential mental health service designed and delivered by people with lived experience, will be a game-changer for consumers. For far too long, the system that seeks to support us in our most vulnerable times has been propped up by policies and practices that do not understand or meet our needs and wants.

A service, one designed and delivered by those with lived experience of mental health issues, is a chance to rectify this – an opportunity for consumers to create a mental health response that is based on compassion, trust and connection rather than old ways of working that maintain the power imbalances of the current clinical system.

This recommendation received strong support from the consumer community, with all participants in our Royal Commission consultations and surveys in favour of the idea. Consumers suggested the key factors to be considered in the implementation of this service are:

- Access
- A homelike environment
- Responding to the individual (one size does not fit all)
- Diversity in the care provided
- Lived experience workforce

4. A service designed and delivered by people with a lived experience

4.1 Access

While there was a demonstrated need for good linkage to other mental health supports, participants stated a preference for the peer led service to be self-referred, without access being determined by participation in any other specific program or service. Consumers also suggested that individuals should be able to choose the duration of their stay.

There was also a clear indication that the service must be made available to all consumers rather than those with a specific diagnosis, focusing on the support needs of the individual rather clinical presentation. Workshop participants also said attention needs to be paid to diversity, stating that consumers from ATSI, CALD, and LGBTIQ+ communities as well as those with dual disabilities need to feel that the service is safe, supportive and free from discrimination.

There was agreement that proposed services should be located close to public transport, amenities and support structures such as shopping centres, health services and volunteering opportunities, to provide access to services in a central location.

4. A service designed and delivered by people with a lived experience

4.2 A homelike environment

There was consensus that this peer led service will reflect a home-like environment with three widely agreed upon requirements: private rooms and safe communal spaces, minimal guests (between five and ten at any given time), and outdoor and green spaces.

One consumer described their ideal service as a "*large suburban home*", another summarised the feeling of this service as "*welcoming, warm, de-institutionalised, homely and safe".*

Generally, there was an emphasis on non-clinical design and physical comfort and calming and inviting spaces.

Below is a snapshot of the responses to the question "What should the service look like?":

"a calming, safe environment, bean bags, blankets, no white walls, calming colours, no clinical feel".

"A sense of peace and safety, nurturing and comfort. Lots of green gardens and indoor plants. Walls painted with natural colours like green and blue, warm orange like a sunset or yellow of a sunny morning. Lots of pillows and comfortable spaces to interact in comfort and safety."

"What I would love to see is just a normal house, in different locations throughout Victoria. They could be in the mountains, near the beach, in the countryside, in the city. Maybe you live in the country and you're sick of the cows and the paddocks so you want a complete change in environment; you could have a break in the city."

4. A service designed and delivered by people with a lived experience

4.2 A homelike environment

Further responses from the survey on how the service will look, highlight the calming and inviting space this service needs to be:

"Relaxing colours, lots of access to outside gardens, all rooms with views of the garden."

"Should look and feel like the kid's oncology ward at the children's hospital. A sense of peace and safety, nurturing and comfort. Lots of green gardens and indoor plants. Walls painted with natural colours like green and blue, warm orange like a sunset or yellow of a sunny morning. Lots of pillows and comfortable spaces to interact in comfort and safety. Activities to calm and soothing like mindful colouring or sensory activities. Safe and breakout spaces for quiet and safe solitude."

"An outdoor garden, everyone has their own bedroom and bathroom, a communal lounge room for TV watching/video games, a quiet space for time out, a music room and an art room. The space could be decorated with positive messages from previous consumers about their time using the service."

"Homely. Access to outdoors, kitchen/laundry. Quiet spaces and communal space for meetings. Access to arts, gardening, dance- so space where people can choose to participate or chill quietly."

4. A service designed and delivered by people with a lived experience

4.2 A homelike environment

It was also important for workshop participants that this service will allow 'guests' so that consumers will be able to maintain their regular routines as much as possible, helping to ensure a smooth transition out of the service.

In a follow-up survey VMIAC asked consumers to think about the following question.

You told us that this service will be in a homelike setting with peaceful, garden spaces, designed to support a diverse range of experiences and accessible when you need. When you can access the above service, how will this make you feel?

Seventy-nine percent of consumers responding to this question felt positive about accessing the service.

There were some consumers who questioned whether there would be enough of this type of service to support everyone. For instance, one respondent stated they would feel:

"Heard, cared for, but seems unrealistic as the needs outweigh the beds, and will it be accessible to all areas?"

Here are some further responses from consumers about how they will feel when this service is supporting them:

"I will feel really good and, I hope, at home in an environment that not only supports but also facilitates my, and everybody else's, on-going battles, as well as successes with mental health journeys."

"Like I'm at home and not in a sterile hospital environment. When suitable my friends and family will be able to come to see me and show their support. There will be less paperwork to fill in and fewer 'interviews' to gather information. It will have a warmth and safeness that will allow people to open up and not feel exposed (less vulnerable)."

"when they leave the service, they have a peer worker embedded in the community case management system who can help them."

"Less stigmatised, more understood, better supported and connected"

"Fabulous!!!!"

4. A service designed and delivered by people with a lived experience

4.3 Responding to individual (one size does not fit all)

Participants in the workshops acknowledged the differing mental health complexities amongst consumers and the need for customisable care. It was important to consumers that the services cater not only to differing mental health disorders but also to other forms of diversity e.g. separate services for young people, adults, and gender identity ("common needs… grouped together"). Furthermore, participants were concerned that all services ensure they are culturally sensitive.

Similar to the feedback given in the workshops, survey respondents also desire consumers to have more 'agency' in accessing the service and their treatment decisions. One consumer spoke of the need for "people taking their lead from me."

According to respondents, in the ideal lived experience led service, consumers will have a service that is welcoming and will be able to receive support when they need, not just when they reach a crisis:

"There would be a cafe and drop-in associated with the service as well as spaces just for the residents, so that people always knew there was somewhere safe to go".

Figure 8 – "Untitled"

4. A service designed and delivered by people with a lived experience

4.4 Diversity in the care provided

Consumers said holistic care is necessary in a peer led service, suggesting that the services offered need to go beyond the realm of the mental health space. As well as activities that address health and wellbeing needs such as art therapy, music therapy, yoga, meditation and gym access, consumers suggested that recreational activities be embedded into the model of care (outings, craft groups and movie nights). For one participant, holistic care means communication and an intersectional approach:

"If I could have had my massage therapist collaborate with mental health professionals about the impact of my chronic physical pain on the state of my mind. If I could have had my autism consultant collaborate with mental health services to educate them on the difference between autistic traits and psychotic features."

The service should be also set up in a way that promotes healthy living and personal growth, with participants suggesting:

"Large group rooms, exercise areas, kitchen areas for healthy eating education, smaller rooms for individual peer support, outside spaces for physical activity and reflection".

"Education to understand self with greater to focus on living and enabling one to look after them and other".

In addition, participants stated that there should be access to additional services that may help alleviate worries associated with their "normal lives", common suggestions include: pet boarding, childcare, dentists and GPs.

4. A service designed and delivered by people with a lived experience

4.5 Lived Experience Workers

For this service to be successful it will be staffed by people with lived experience and include a wide range of specialists, with limited involvement of psychiatrists who are involved by invitation only.

"Lived experience workers will make up the majority of staff and receive ongoing training and supervision."

For example, one consumer described the peer service like this:

"Peer workers would run groups for the current consumers including: Grow groups, life skills groups, groups to share feelings and groups to learn coping skills. Peer workers who have a lot of experience, training and stable mental health would work in managerial positions and clinical staff would be accountable to the peer workers."

Community outreach by peer workers was also an important aspect that participants want considered, asking whether the service could provide supports for consumers who were re-entering daily life in order to reduce return visits and manage the waitlist.
These responses show that the peer led service will have considerable support.

4. A service designed and delivered by people with a lived experience

4.6 Management and Governance

There was an assumption that the management and governance of this peer run service would be by people with lived experience of mental distress. There was a strong desire to believe that it is possible to have such a service and that it would truly be run by consumers with lived experience and not be tokenistic.

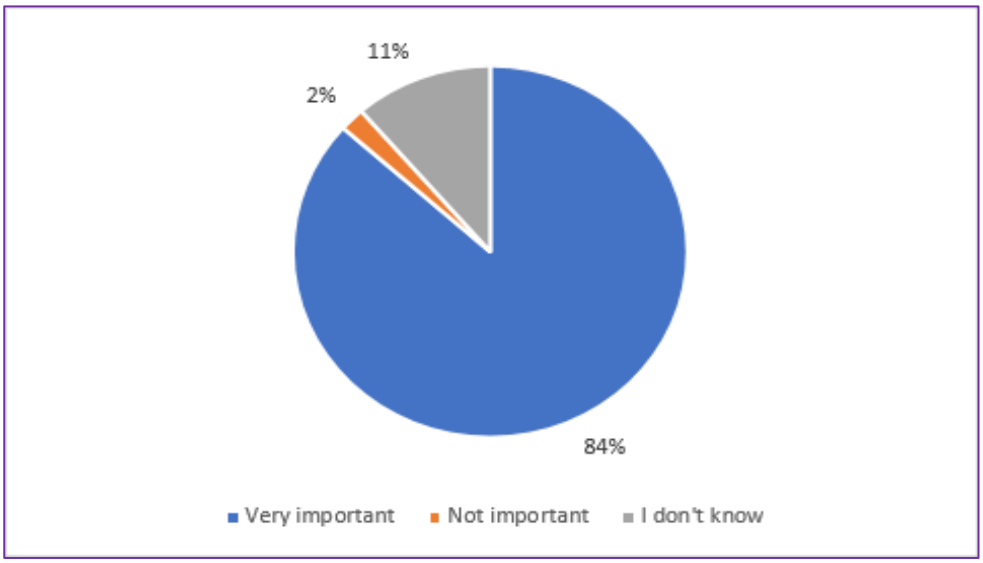
The sense that this could really be possible left consumers with a sense of exhilaration tinged by a little cynicism. The need for such a service run totally by consumers will require support and training particularly in the management and governance areas.

5. A Lived experience workforce

When asked how important a lived experience workforce is in the Victorian Mental Health system, eighty-four percent of respondents stated that it was very important as "it gives people hope".

In answer to a question about the importance of people with a lived experience being part of staffing mental health services there was overwhelming support. In fact, there was a sense that this is essential if the system is going to be successful in healing people with mental distress. This is shown in the chart below.

Figure 9 – Importance of the new model for acute beds



There were two main aspects to implementation for the employment of a lived experience workforce: support for the workers and for the workforce to express empathy.

The key issues that emerged about the lived experience workforce are of some concern, however. There was a strong statement across the workshops and surveys that the peer workforce is not respected and valued and that this needs to change.

5. A Lived experience workforce

5.1 Valued and Respected

There was expressed concern that while peer workers and consumer consultants are critical to positive service development, currently many of the agencies that employ peer workers do not value them or treat them with respect.

Several participants highlighted that it is important that the peer workers are respected and valued as much as psychiatrists and other treatment professionals. Further discussions identified that in some cases peer workers are sometimes employed in a 'tick the box' way to ensure that the hospital has done its duty.

5. A Lived experience workforce

5.2 Workplace safety

Perhaps of even greater concern were the claims that there are places where the safety of peer workers is not guaranteed and that this needs to change. Consumers in the workshops and surveys stressed the need for workplace safety and supports for the peer workforce. They also stressed that "...organisations need to be safe places" implying that that is not always the case for peer workers.

Workshop participants stated that peer workforce safety will be ensured if the following suggestions are implemented: whistleblower protection, training and an anonymous complaints system to encourage open reporting of workplace abuse.

"[Lived experience workers] need to feel safe in their job... and given protection for them to be honest about their experiences, they need to be able to do that without their jobs being threatened."

"Peer workers will have greater job security, with permanent contracts, flexible working hours, and regular supervision and opportunities to train/advise senior clinicians"

This feedback suggests that mental health workplaces have not been safe spaces for peer workers. With more peer workers set to enter the workforce, as a result of this recommendation, it is imperative that peer workers are supported within their organisations.

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5. A Lived experience workforce

5.2 Workplace safety

There was also a clear statement that lived experience staff need to be supported in their workplace with ongoing training, professional development opportunities and an awards scheme to legitimise the profession.

To further support the lived experience workforce, consumers highlighted the need for training for all mental health staff around the importance and role of peer workers in the system.

"[There will be] detailed and ongoing training for ALL other staff on the need for Peer Workers and how they can best work with and support their role."

While some survey respondents acknowledged that not everyone who has a lived experience will be suitable for the workforce, there will be ongoing mental health supports for lived experience staff. One consumer said:

"It will be acknowledged they may still have some triggers or areas of concern and these should be worked through & given support for."

This is a critical issue if people with lived experience of mental distress are going to have and increased role in the workforce. There will be times when a situation may trigger the peer worker and this needs to be acknowledged and planned for in the workplace.

5. A Lived experience workforce

5.3 Increased Professional Development

There was enthusiastic support for peer workers having access to more professional development opportunities, career progression, permanent positions, flexibility in work hours, proper supervision and understanding of roles.

Participants in the workshops stated that to feel supported, peer workers will be formally trained and have access to training at all stages of their career.

"We need to use our expertise of our experiences to help other people"

Accordingly, training will:

- Be trauma-informed, free and ongoing
- Be more accessible, i.e. provide an online option for the Cert IV for those who have other commitments
- Include short courses, TAFE, undergraduate and postgraduate options
- Include an outreach model to keep peer workers informed of opportunities as opposed to "stumbling" across it
- Include peer-to-peer models including Intentional Peer Support Training[2] and Emotional-CPR[3] which were highly valued in the feedback.

Other suggestions included:

"...trained in Emotional CPR and intentional peer support, alternatives to suicide, hearing voices etc."

In addition to specific training it was generally agreed that peer workers will also have regular supervision and mentoring *"...from line managers who also have a lived experience".*

The peer workforce will have flexibility in working arrangements and *"...staff will be provided with adaptable learning materials, be able to learn at their own pace, and have their experiences valued and respected."*

[2] According to the Intentional Peer Support Website: Intentional Peer Support is a way of thinking about and inviting transformative relationships. Practitioners learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and support and challenge each other in trying new things.

[3] Emotional CPR (eCPR) is an educational program designed to teach people to assist others through an emotional crisis by connecting, empowering and revitalising

5. A Lived experience workforce

5.4 Throughout the mental health system

Participants stated that for it to work effectively there will be lived experience workers at every level of mental health treatment: hospitals, community treatment, planning and management levels, public health services, and all levels of decision making.

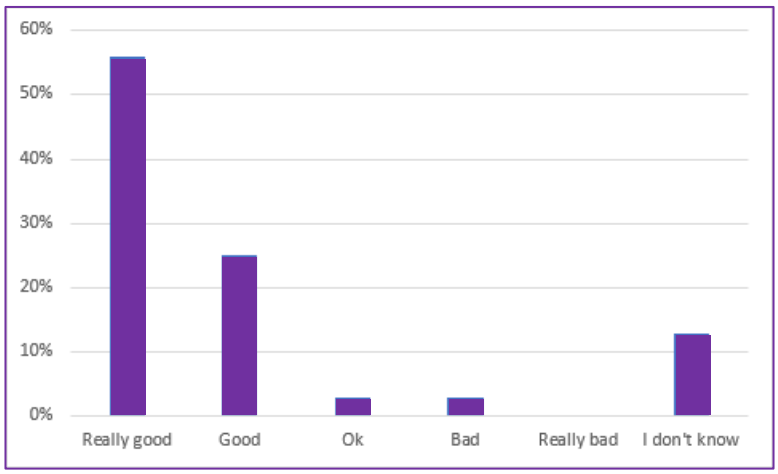
It was important to participants that the peer workforce be diverse in its mental health experiences and backgrounds to help consumers form trusting relationships and feel understood throughout the treatment process.

"Connection is central to forming a trusting relationship with someone."

"Peer workers will act as supervisors to clinical staff" – this collaboration was described as an "essential component" of supervision. Lived experience workers will also provide coaching and support, i.e. consumer perspective supervision, buddy systems, mentorships for new, existing and prospective lived experience workers with introductions to the workforce via mentors.

In a follow-up survey, consumers were asked to think about the following question. **When the peer workforce is more influential than clinicians, how will you feel? With the following response.**

Figure 10 – Peer workforce influence results



With eighty- one percent of respondents to this question feeling "good" or "really good" about this action being taken, it is vital that the lived experience workforce is integrated throughout the mental health system and highly respected.

For example, one consumer suggested the need for *"an award that is clear, detailed and upheld by Fair Work Australia. A classification scheme that recognises years worked, level of education and further study/extra qualifications".*

5. A Lived experience workforce

5.5 Importance to Consumers

As previously noted, consumers were extremely positive about an increase in peer workers and an increase in all parts of the system for people with lived experience. In large part this was because the system would then express what was commonly described as Empathy.

Consumers stated that as a result of this initiative there will be more understanding in the diversity of experiences, treatment needs, and the diversity of people seeking treatment.

For consumers, the lived experience workforce will be a huge help for people with mental health issues to see that others have overcome the struggle and come out the other side.

To further understand how important the lived experience workforce is to consumers, VMIAC followed up participants with the question: When there are peer workers supporting you in all areas of your treatment, what will this mean to you?

Eighty-four percent of responses to this question expressed feelings of positivity and hope and other respondents highlighted that choice is still very important when accessing support. These responses are just some of the positive responses to this question:

"I hope to feel less alone and it will mean everything to me to know that everyone who is supporting me actually wants to be there and all believe in positive outcomes as well as guiding the journey in healthy ways, given from their own experiences."

"It will mean I will feel more comfortable talking about my issues."

"That there is someone who can understand the similar experiences I may have had."

"Feel understood and valued."

6. Workforce readiness

For the workforce to be ready to take on the challenges already proposed by the Royal Commission there will need to be major changes made to the current and potential workforce. There were four major aspects to this:

- preparation for the lived experience workforce as discussed in the previous chapter
- re-training of the current clinical workforce
- diversifying the professions within the workforce and
- reforming the system that currently exists with lived experience at the forefront.

For the workforce to be ready it will need:

- Re-training for the current clinical workforce
- Trauma informed approach
- Training in co-design and co-production
- Consistency in support for consumers
- Understanding that de-escalation is a critical skill
- An empathetic approach
- Increased consumer choice

6. Workforce readiness

6.1 Re-training of the current workforce

There was clear support for the need to re-train the current workforce in some of the fundamentals that will be required if the recommendations of the Royal Commission are to be successfully implemented. Workshop participants stated that mandatory co-design training is required for the current workforce in the mental health system:

- There was agreement that all training for clinical staff will be person-centred, trauma-informed and co-designed by consumers of those services.
- The workforce will be better trained in dealing with the consumers' support networks. One consumer suggested an anonymous feedback channel to report when a clinician is not supporting them wholly.
- Training will also reflect the holistic approach to care.
- There will be a multidisciplinary workforce as consumers believed this would help reduce the "silo mentality" within the system.
- "*bring psychologists and psychiatrists together in their training to work together for consumers".*
- Training will include de-escalation training to minimize violence and aggression and address stigma and discrimination. Consumers have continually expressed that when they are acutely unwell or distressed, they require calm, kind and warm responses from psychiatric staff in order to feel supported and understood.
- *"The workforce needs the skills to think in acute situations that "I'm dealing with a really unwell person, not a person who is immoral or badly behaved".*

6. Workforce readiness

6.2 Consistency in support

Workshop participants spoke about a mental health system that has a *"revolving door of psychiatrists"* and that it is important to their healing that they have consistent care, especially in regional areas where there is a higher staff turnover.

"Consistent support is crucial – establishing trust with clinicians can take years. There should be mandatory longer placements would be better for continuity".

Consumers also commented the need for consistency in the choice that they have when staff are able to be open to *"... feedback when they have misunderstood".* This quote suggests that the current workforce can be difficult to communicate with for consumers.

It was important to consumers that the mental health system be consistent for everyone. One consumer wrote:

"It would be fantastic if workers have an understanding of some individual and systemic barriers people from CALD communities face, so some meaningful cultural training, framework, practices when working with non-English speaking people".

Survey respondents outlined that there needs to be more holistic approaches to the mental health workforce. This holistic approach will encompass *"recovery-oriented practice, coaching, positive psych/wellbeing, motivational interviewing, alternative communication strategies (e.g. art, movement, music etc.)"*

There was also some concern that there potentially could be a shortage of peer workers to fill the positions that will be created. To ensure that peer workers and consumer consultants are prepared for the roll out of new positions this needs to be addressed with some urgency.

6. Workforce readiness

6.3 Empathy and updated training

Once again, empathy and person-centered approaches were raised as traits for the mental health workforce to embody when working with consumers.
Consumers would want workers.

"...to look beyond the behaviour and see the person as a whole person with hopes and dreams and passions, the same as anyone else".

In the responses to a question regarding the training of the mental health workforce there was firm support for the workforce to undertake trauma-informed practice and Intentional Peer Support training. Many consumers need to feel like the people supporting them are *on their side*. For one consumer the workforce needs:

"Up-to-date knowledge and extra caring attitude, with a willingness to advocate for the patients and challenge those in higher up positions".

Further suggestions around training for the mental health workforce include:

"...it would be fantastic if workers have an understanding of some individual and systemic barriers people from CALD communities face, so some meaningful cultural training, framework, practices when working with non-English speaking people."

"They should be trained with a client centred approach and a trauma informed care approach. Also, to listen to the client as they are the expert in their lives. And to listen to carers and families"

"... trauma informed practice - recovery oriented practice - coaching -positive psych/wellbeing - motivational interviewing - alternative communication strategies (e.g. art, movement, music etc)"

"Recovery-oriented practice. Turn rhetoric into reality and policies into real-world everyday practice. Use lived experience workers and research in training mental health staff all through their training."

6. Workforce readiness

6.4 Building the workforce

In order to expand and make the mental health sector more accessible, respondents recommended scholarships and subsidised study fees for people entering the mental health workforce.

Another suggestion was for a *"regional and rural reward programs where clinicians are offered extra financial reward not just to move to a location and provide service, but also to stay hopefully for the long term."*

Suggestions were also provided on how to build the lived experience workforce. One respondent suggested:

"...innovative fast-track targeted training to the consumer workforce to embed them in wider, more diverse roles, including management, quality/service improvement, research, project development/management, admin, allied health."

Respondents to the survey made a range of suggestions as to how to recruit additional workers into the mental health workforce, some of the suggestions included:

"Get in touch with allied health students. Go to universities, go to schools, go to areas where mental health students volunteer – phone counselling services etc. Mental health students want to work in our industry, but we are not given adequate information on where we are needed."

"Place a lived experienced trained carer or consumer to take part in the recruitment process."

"Get the values right on recruitment and ensure that training covers off on the skills required. You can teach skills, you can't teach values"

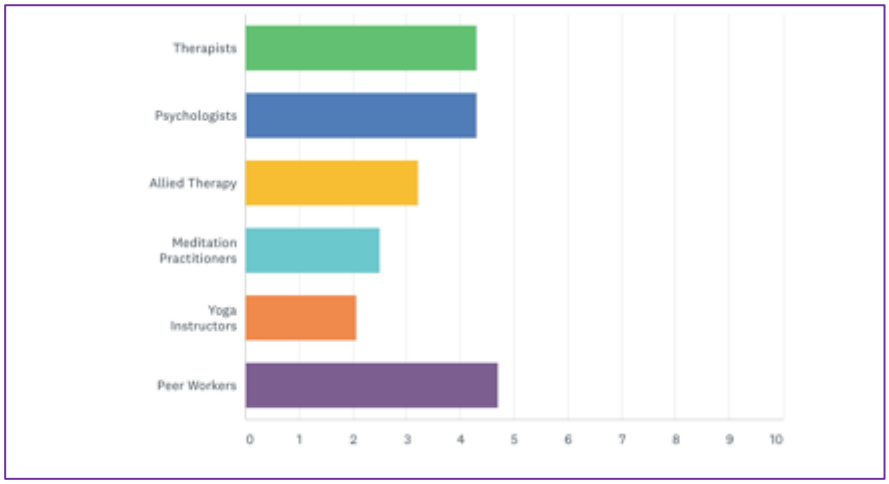
"Regional and Rural Reward Programs where clinicians are offered extra financial rewards not just to move to a location and provide service, but also to stay hopefully for the long term. The salaries in regional, rural and remote areas are not representative of the difference in the communities i.e. city v's remote, yet perhaps should be. University programs to encourage locals to retrain/add to their current training to assist their community e.g. train and work in the region you live in and be rewarded for this via less Uni fees or something similar."

6. Workforce readiness

6.5 Diversify the Disciplines

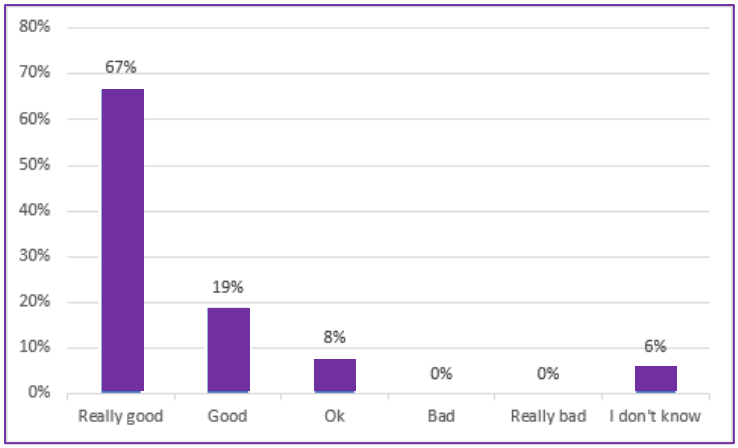
Consumers are clear that the mental health workforce needs to be diversified and have a higher percentage of lived experience workers. The following table shows the disciplines that respondents deem the most important to have in the workforce:

Figure 11 – Disciplines most important to have in the workforce



After receiving the above feedback from consumers on their workforce preferences, VMIAC conducted a follow-up survey which asked how they will feel when the diverse workforce is also trained in trauma-informed, person-centred practices that are co-designed with the lived experience workforce. The results of which highlight how vital it is to implement these requirements.

Figure 12 – Diverse workforce training results



Eighty-six percent of respondents will feel good or really good when the mental health workforce is trained in ways that ensure that consumers receive the support and healing that they need. Clearly the recommendations of the Royal Commission will make a difference to consumers feeling that they can trust the system if they are implemented.

6. Workforce readiness

6.6 A supportive society

For an ideal system, training will be introduced to teachers, police and other emergency services throughout Victoria to recognise and understand the signs of someone experiencing an acute state i.e. in schools and the police force. Consumers also mentioned that in the current system, only clinicians/ consumer facing positions are trained. However, the aim is for everyone within the system will be trained, such as receptionists.

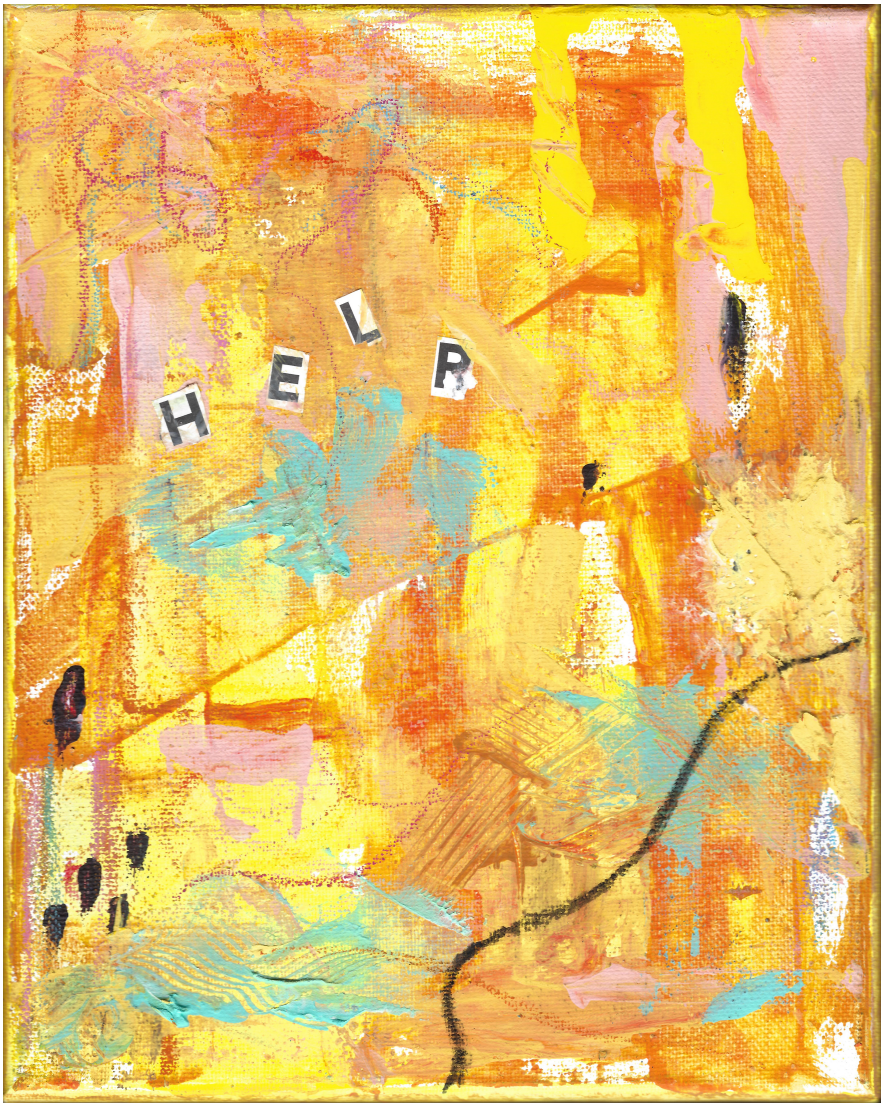


Figure 13 – "You There" by Jeanette Chan

7. Planning the Future Mental Health System

Based on the feedback outlined in this report, we have the following priority recommendations for the Royal Commission to implement into the Victorian mental health system:

- A transdisciplinary approach that is consumer led
- A range of disciplines involved in the provision of therapies and support
- Psychiatry as part of the system and not the centre
- Agreed quality standards and accountability
- Co-design and co-production will be the norm
- The mental health system will be safe to access
- Most workers at all levels of the mental health system will be people with lived experience and those workers who do not currently have lived experience will be trained to have a lived experience perspective
- Training for workers and the design of the mental health system will be trauma-informed
- Staff will specialise in person-centred and holistic treatment either through additional training or employed because of this.
- A wide range of therapeutic and support options and professionals who provide them
- The mental health system will be accessible for everyone and all mental health needs.

7. Planning the Future Mental Health System

7.1 A Transdisciplinary Approach that is Consumer led

A transdisciplinary approach breaks down the boundaries between the disciplines/ professions involved in a complex situation and ensures that the range of perspectives is brought to the situation so that the best outcome is achieved. The advantage of using a transdisciplinary approach in mental health is that it brings together the best thinking from different disciplines including the consumer and their peers.

A transdisciplinary approach moves beyond multidisciplinary approaches in that it brings different disciplines together with a commitment from the team to create a collaboration that moves beyond the disciplines for the best possible outcome.

In a transdisciplinary approach consumer lived experience and expertise would be at the core in order to co-produce the vision, strategy, and quality standards that meet the needs of consumers. The post-Royal Commission mental health system will have lived experience at the centre with other professionals included psychiatry placed as a valued consultancy and not at the pinnacle.

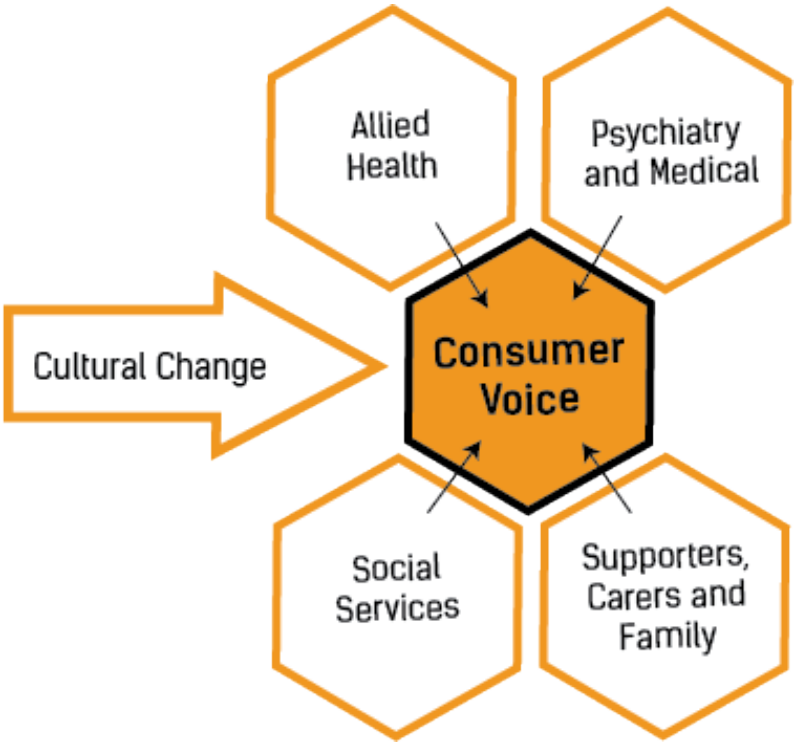


Figure 14 – Post-Royal Commission mental health system

7. Planning the Future Mental Health System

7.1 A Transdisciplinary Approach that is Consumer led

In this manner, the mental health system and its services will focus on the holistic wellbeing of the individual, rather than merely responding to the treatment of a 'disorder'. Allied health and community workers will bring their disciplines and specialist skills to the collaboration and be trained in the transdisciplinary approach along with such skills as co-design and co-production and taking the perspective of lived experience of mental distress.
Allied health workers will also be trained in the implications and possible triggering of their discipline on a person with mental distress by asking the right questions, for example before giving someone a massage.
More investment, time and research need to be put into finding out what will ensure the wellbeing of people who seek out mental health services. This can only be achieved by tapping into lived experience expertise at all levels of the mental health system.

Given the diversity of lived experience in the mental health area, even peer workers will require training so that they understand the range of mental health lived experiences and that one size does not fit all. Peer workers and consumer consultants also need to be able to determine the difference between their own lived experience and those of other consumers they will be working with.

The vision that has been set by the Royal Commission into Victoria's Mental Health system will be translated into a vision and strategy that will create a new culture in mental health. In order to achieve this bold vision, we need to ensure:

- services have a minimum quota of one third lived experience staff who are spread across the service at every level. Wherever possible and increasingly across future years there will be managers, supervisors and CEOs who have lived experience of mental distress. This will be achieved by providing peer workers with training in these areas.
- a model of service delivery which is transdisciplinary (see diagram above)
- psychiatry to act as consultant to, rather than manager of mental health services. Given their expertise and experience it is critical that psychiatrists see consumers with the diversity of psychosocial disabilities and should be able to individualise them and assist in the process of healing.
- mental health service managers to demonstrate transdisciplinary skills as well as a deep understanding of co-design and co-production.

7. Planning the Future Mental Health System

7.2 Setting Standards for Quality

In its Interim Report, The Royal Commission created a vision of a mental health system that addresses the current problems which have created additional trauma for many of the people who use the services provided. Consumers in the workshops and survey respondents welcomed this vision.

In the VMIAC Declaration, there are strong statements about the need for a very different culture, requiring a major paradigm shift in mental health. In the current consultation, there were comments across all topics about standards being set to ensure quality in therapies and support that are broader than the psychiatric medical model and that embrace approaches which focus on healing based in an understanding that many, if not most, people who have mental distress are survivors of trauma. There was also agreement that the current approaches to quality and standards are inadequate and have very little impact on the service system.

A high-quality holistic approach will hold service providers accountable in ways that are not currently practiced, and this will include listening to the voices of consumers who often feel more traumatised as a result of being in a service than when they first entered. A focus on healing should be the minimum standard.

Our respondents showed strong support for the Collaborative Centre for Mental Health and Wellbeing which will be co-designed and co-produced and where there will be a clear focus on healing and wellbeing. For many consumers, this Centre holds a level of hope that there can be an approach to therapies and support that listens to the voices of consumers and will engage them fully at all levels of decision making; even having a consumer as co-Director.

7. Planning the Future Mental Health System

7.3 Commitment to Co-design and Co-production

Co-design and co-production should involve a dialogue between lived and non-lived experience positions. Co-design needs to happen at several levels:

- In the design of the process of healing for anyone who enters a service or healing program. *"Each consumer needs to be the architect of their own healing".*
- In the development of new therapies and support within each unit of care and healing through a transdisciplinary approach.
- Co-design of the mental health system which will come into place at the completion of the Royal Commission work and final recommendations.

Co-design and co-production are the foundations of the approaches recommended by the Royal Commission and are essential to achieving the vision that has been articulated.

7. Planning the Future Mental Health System

7.4 Choice and agency

There was strong agreement by consumers that there needs to be choice at a number of levels in the system. First, there needs to be choice about the type of service they have access to including its location and approach.
Currently consumers can only access the service in their catchment area. This is not the case if a person has cancer or some other ailment. The mental health system needs to emulate all other health services where the patient can choose where they seek treatment.
Consumers will also be able to access services when they need and will be able to self-refer.

Mental health treatment options will reflect the diversity found in mental health needs assessments. Services will cater to a range of mental health needs including complex mental health. There will not be a 'one-size fits all approach', consumers will have tailored, person-centred treatment options that focus on healing and wellbeing.

Consumers have been clear that they prefer a community-based model, outside of the medical and hospital system. The diversity in care will need to consider options for culturally and gender specific care.

7. Planning the Future Mental Health System

7.5 A culturally and gender safe system

Across the workshops and surveys, regardless of the topic being explored, the issue of cultural and gender safety was highlighted. This is a major issue for the implementation of the recommendations of the Royal Commission.

There is evidence that the gender specific beds or units in the acute system are not always maintained and that women will often be harassed by male patients and even staff. This is not acceptable and has the potential to retraumatise women who have already been traumatised by similar experiences often which has led to their mental distress. Some specific suggestions were made about each of the recommendations:

- The Collaborative Centre: will be safe for all to access and use for support. Diversity will be embedded in the management of the service and research will be inclusive of First Nations, CALD, women and LGBTQIA+ outcomes.

- Additional Acute Beds: Although there is still opposition to the new acute beds, if there are going to be additional beds there is strong feeling about the need for these to be in a new model where there are gender safe spaces and separate gendered services to access. All staff in this model will have culturally and LGBTQIA+ training to be able to support all consumers that access this service.

- Peer Run Service: The peer run service will be safe for all who need to access it. Staff will have extensive training in culturally and gender inclusive practice and support. To plan for the system that consumers require, there will be additional peer run services that are cultural, gender and LGBTQIA+ safe.

- Workforce: Training in culturally competency and gender appropriate approaches should be compulsory for all staff including that of the lived experience workforce. In addition, there will be training about the specific issues facing LGBTQI people in the mental health system.

7. Planning the Future Mental Health System

7.6 Investment in training and education

There are two major aspects to building the mental health workforce:
Building and supporting the consumer lived experience workforce, and
Re-training the current mental health workforce to deal with a very different system.

The VMIAC Declaration was a resounding call for more consumer consultants and peer support workers on the ground and through to the higher echelons of the mental health system. This call was supported by this consultation.

Additional Peer workers:

Respondents and participants in this latest consultation were clear that there needs to be increased numbers of peer support workers advocating for individual healing and recovery, as well as consumer consultants who provide systems advocacy. There is now wider recognition that a minimum number of lived experience staff is required in order to bring about real system change. This should never have to rest on the shoulders of solitary lived experience workers.

A commitment to investing and developing a viable career structure for lived experience staff will do much to increase staff retention and pave the way for genuine career progression. It is up to mental health services to ensure that pathways are made available for lived experience staff to gain relevant and useful professional development and given appropriate training and opportunity to hold leadership positions of substantial influence.
For this reason, training for lived experience staff must encapsulate the foundations and history of the consumer movement, the major teachings of peer work such as the principles of Intentional Peer Support, as well as training in the workings of systems and organisational governance, management and, above all, leadership.

Re-training Clinical Staff:

As well as training additional peer support workers and consumer consultants, there is a need to re-train most of the clinical and medical staff in existing services. For example, clinicians can be trained in trauma informed practice, Intentional Peer Support (IPS), Emotional CPR (eCPR) and the principles of Open Dialogue.

7. Planning the Future Mental Health System

7.6 Investment in training and education

Training in Cultural Change:

It is not appropriate to have consumers responsible for bringing about a major cultural change; a key paradigm shift in an entrenched service system, especially when they are not trained as social change agents. The management of cultural change needs to rest with the management and leadership of the system both at the systems level and within each hospital and service.
Champions of change must be trained in each of the public mental health services. Mental health services should have Key Performance Indicators (KPIs) based around non-lived experience staff developing their knowledge base of lived experience expertise and other strengths-based approaches.

The Royal Commission's Interim Report highlighted the importance of turning to a new trauma-informed paradigm, where approaches that recognise the trauma of people seeking help from the mental health system are used to build their own capacity.

'Psychiatric medication, at best, can only be an adjunct to therapeutic trauma work, rather than a primary treatment' Indigo Daya, Witness Statement to the Royal Commission, 2020.

This is what must be in place:

- More investment in voluntary treatment such as Prevention and Recovery Centres (PARC) and peer support workers to cultivate an environment of safety and wellbeing.
- Appreciation of what makes a good therapeutic relationship between those seeking help and services.
- Providing therapy and support in treatment settings that people actually want to use *'I consider there should be obligations on the State and mental health services to provide services to people experiencing mental health issues, rather than relying on compulsory treatment.'* Chris Maylea, Witness Statement to the Royal Commission.

7. Planning the Future Mental Health System

7.7 The importance of Language

As was shown in the VMIAC Declaration, there is a lack of agreement across the consumer movement, about how we describe ourselves or how we describe our experience. And yet we know that language is powerful in shaping perceptions of the self, therapeutic approaches and supports available, the attitudes of those who provide such support and the general community and the stigma that is associated.

"People with lived experience" has a more positive feel than patient, client or service user and moves the individual outside the medical model and into a model that is focused on their own experience.

A key part of cultural change is the adoption of more appropriate language which describes the world as we want it to be.

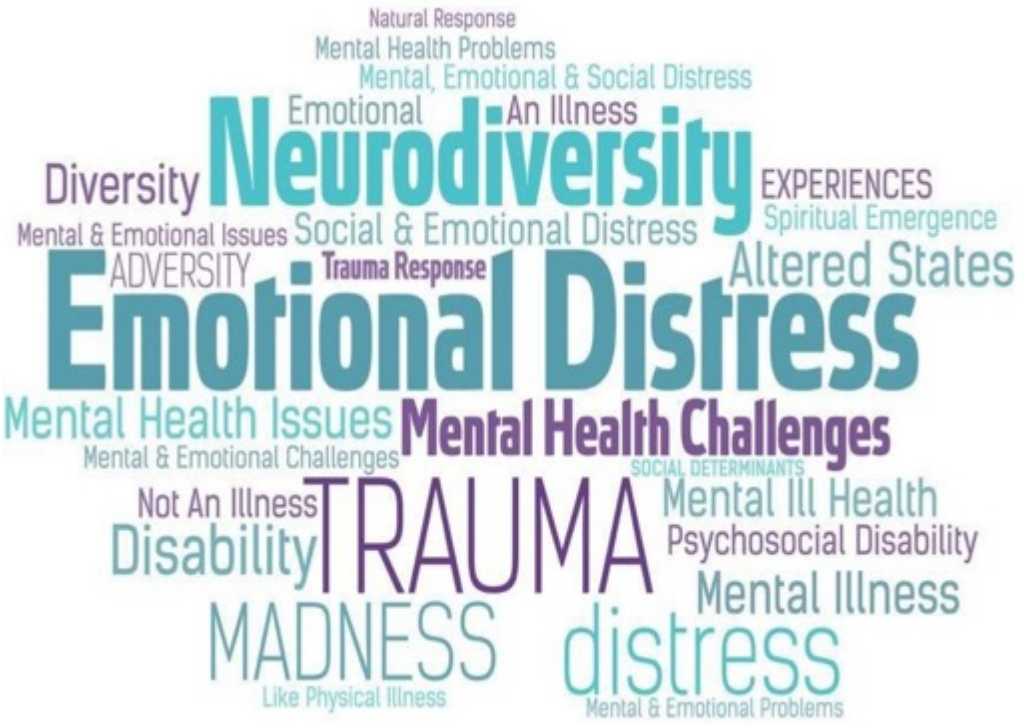


Figure 15 – Language word cloud

We are people with lived experience of emotional distress, trauma, mental health challenges and neuro diversity and these are our statements of how we want the system to work.

Figure 16 – "Change"

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