Marie McInerney reported on the Victorian Mental Illness Awareness Council (VMIAC) “Listen Up, Listen Louder” Conference in Melbourne on 31 October – 1 November 2019, for the Croakey Conference News Service.

Croakey is a social journalism project for public health based in Australia. https://croakey.org
# Contents

Listen up, listen louder: consumers call for an enlightened mental health system......................................................................................................................... 3

As Productivity Commission report puts focus on mental health reform, what do young people want?......................................................................................................................... 7

Mental health consumers present a “collective dream” for a wonderful future............................................................................................................................................. 14

What will it take to expand the role of peer workers in mental health?........... 22

Listen to the “canaries in the coal mine”, urges a psychiatric survivor........... 29

Calls for alternatives to police in mental health crises ................................. 34

Victoria’s Royal Commission into mental health says system “catastrophically failed”......................................................................................................................... 39
Listen up, listen louder: consumers call for an enlightened mental health system

Introduction by Croakey: Mental health reform is in the spotlight as critical national investigations – the Productivity Commission inquiry into mental health and the Royal Commission into aged care – release their interim reports, ahead of the interim report from Victoria’s Royal Commission into the state’s mental health system.

Earlier this month, 108 organisations in the mental health and suicide prevention sectors, led by Mental Health Australia, came together to launch Charter 2020 on mental health, describing the Productivity Commission inquiry as a “once-in-a-lifetime opportunity” for mental health reform.

As reported at Croakey, one of the Charter’s nine key areas for reform is for a system “centred on what people with lived experience mental health issues and their carers say they need”.

Mental health consumers will showcase their concerns and priorities at a timely three-day conference in Melbourne, hosted by the Victorian Mental Illness Awareness Council (VMIAC), the state’s peak consumer body.

Journalist Marie McInerney will cover the Listen Up, Listen Louder conference, which begins with a one-day youth forum, for the Croakey Conference News Service, tweeting from @WePublicHealth at the hashtag #VMIAC2019.
Marie McInerney writes:

Mental health consumers in Victoria want the state’s Royal Commission on mental health to go beyond recommendations on bed numbers and funding models to recommend profound cultural change to a system they say causes significant harm and breaches their human rights with “regularity and carelessness”.

More than 200 consumers from across Victoria and interstate will meet at a conference in Melbourne that will shine a light on their priorities, weeks out from hearing whether the Royal Commission into Victoria’s Mental Health System has heard their calls.

The Victorian Mental Illness Awareness Council (VMIAC) is urging wholesale cultural change to address harm caused by the system, including a fundamental focus on trauma, an end to the escalating use of seclusion and restraint in mental health services and significant investment in a strong peer workforce across research, policy making and service delivery.

VMIAC, the peak body for mental health consumers, says its Listen Up, Listen Louder conference will provide an avenue for people with lived experience to be “front and centre” in discussions about mental health reform, human rights activism and social change against the backdrop of the Royal Commission.

Keynote speakers include US psychiatrist and consumer Dr Daniel Fisher, co-founder of the National Empowerment Centre, who advocates alternatives to the medical/institutional model of distress and healing, and Adelaide-based Matthew Ball, who has written on his journey from psychosis to Australian College of Mental Health Nurses’ nurse of the year.

Among other sessions, leading mental health consumer researcher Indigo Daya will present on a new model for “welcoming diverse and challenging consumer and survivor views” in mental health research, policy, and practice.

Daya has also spent many months consulting for VMIAC with consumers across the state about their vision for an ideal mental health system.

Their declaration will be presented at the conference to keynote speaker State Mental Health Minister Martin Foley.

It will coincide with reports from both the Productivity Commission inquiry into mental health and the Royal Commission into aged care, which mental health experts hope will include a major focus on mental health issues for older Australians.

Ongoing consumer concerns

Victoria’s Royal Commission will release its interim report in late November, with much hope riding on change, but also ongoing consumer concerns that it will focus too much on clinical and service priorities.

That follows early disappointment that none of the four Royal Commissioners had lived experience as a consumer and that abuse was not expressly included in the terms of reference, in the way that individual and systemic cases are being investigated by the Royal Commissions into aged care and disability.

In an interview with Croakey, VMIAC CEO Maggie Toko did not want to dwell on these disappointments, saying “the horse has bolted” on those matters, but she hoped the Commissioners had heard the voices of consumers during their deliberations.
She said the peak body has been able to play a strong role in the Royal Commission process – having a seat “at the table” in a range of forums and providing formal support for many consumers who have told their stories in public hearings and round table discussions.

The Royal Commission has conducted four weeks of public hearings and received more than 2,500 submissions from organisations and individuals since it was set up in February to address what Premier Daniel Andrews described as a “broken mental health system”.

Toko said:

- “I hope it brings an enlightened system that is consumer-driven and consumer-run.
- I’m hoping it’s a way forward that we can all embrace.”

VMIAC’s submission to the Royal Commission, titled From Harms to Humanity, lays out its case for change based on human rights, “do no harm”, and a social determinants approach.

It makes the point to the Commissioners that many consumer calls for change may be contradicted by other submissions, in part because of “bias, stigma and discrimination” within the system that “assume consumers are violent, or that we lack capacity and need others to speak on our behalf, or in our ‘best interests’.”

**Human rights breaches**

The submission urges the Royal Commission to take account of lived experience of a system which “fails to help many people, is often significantly harmful and seriously breaches many human rights”.

VMIAC says those breaches include:

- 7,215 people were bodily restrained in mental health units during 2016/17
- 90 complaints about sexual violence in inpatient units were documented in 2018
- most people admitted to mental health inpatient units are under compulsory detention and treatment
- voluntary patients are regularly denied leave from inpatient units, and
- Victoria uses Community Treatment Orders (CTOs) at a rate that is amongst the highest in the world, “despite the lack of evidence for their effectiveness”.

You can track Croakey’s coverage of the conference [here](#).
The submission says:

“Every aspect of the system needs reform to prevent harm, including rethinking the system’s main activities and intended outcomes, workforce composition and skill requirements, accountability and oversight and service types.”

Priorities

VMIAC says it understands that changes of the magnitude it wants to see will take time. As early steps, it asks the Royal Commission to recommend for Victoria to:

• set a date, as New Zealand has, for the elimination of seclusion and restraint in mental health services
• take urgent statewide action to ensure sexual safety in inpatient units, including women’s only units and patient controlled locks
• implement standards to ensure consumers are fully informed about possible adverse effects of medication and other treatment
• abolish compulsory electroconvulsive therapy
• tighten the criteria for compulsory treatment from ‘harm to self’ to ‘imminent risk of death’
• ban chemical and psychological restraint and strip searches in mental health services
• report more consistently and accurately on harms that occur in services.
As Productivity Commission report puts focus on mental health reform, what do young people want?

Introduction by Croakey: The mental health and wellbeing of children and young people is one of the key areas identified for action in a two-volume draft report released by the Productivity Commission urging wide-ranging reforms in mental health.

The report, which nominates schools, universities and the Vocational Education and Training (VET) sector as key sites for intervention, calls for:

- Expanded social and emotional wellbeing aspects of routine health checks in pregnancy and early childhood
- Governments to work towards ensuring that every school has a designated wellbeing leader to coordinate whole-of-school and individual programs to support students at risk of mental ill-health
- Expanded outreach services intended to support students with mental illness
- The COAG Education Council to develop a strategic policy on social and emotional learning in the Australian education system, including national standards for initial teacher education and professional development programs.
The report notes that children and young people are far less likely to access treatment and support, although young adults experience higher rates of mental illness than the rest of the adult population, and about three-quarters of adult mental health disorders emerge by age 25.

“Supporting the mental health and wellbeing of children and young people has been on the policy agenda for many years.

But despite substantial efforts – including billions of dollars spent, countless hours of work by teachers and other education professionals, doctors, nurses, specialists and experts, and Australia being considered globally as a country with proactive, comprehensive early intervention and prevention measures – improvements in the mental health of children and young people have been limited.”

Meanwhile, young people attending a mental health consumers conference in Melbourne stressed the importance of building the peer workforce and addressing intersectional mental health needs, reports Marie McInerney for the Croakey Conference News Service.

Marie McInerney writes:

Mental health and other services need to stop treating people with lived experience as “cheap labour” and focus urgently on building more peer informed, inclusive services that can treat the complex, often intersectional mental health needs of many young people.

That was one of a number of calls for change to emerge from a dedicated Youth Day held as part of a biennial conference for mental health consumers hosted by the Victorian Mental Illness Awareness Council (VMIAC).

Keynote speaker Elvis Martin opened the conference with a call to arms to young people with mental health issues, urging them to take to social media with their stories to combat an ongoing “environment of shame and stigma”.

You can track Croakey’s coverage of the conference here.
That can be particularly damaging for young mental health consumers who are LGBTIQ+ and/or from culturally and linguistically diverse (CALD) communities and “don’t feel safe” to speak up or reach out for help, he said.

Martin said:

“You don’t have to have a PhD or Masters. Your lived experience is enough.

Don’t be ashamed of your mental health journey because your mental health is nothing to be ashamed of. There is nothing wrong with you but there is a lot wrong with the world you live in.”

Grow the peer workforce

Martin is an Ambassador of National Youth Commission Australia and RUOK? and a ‘changemaker’ for the Australian Red Cross. His advocacy work is focused on mental health, homelessness, domestic violence, suicide prevention and the LGBTIQ+ community.

Urging a bigger and broader peer workforce in mental health, he said he wanted to “live in a world where being vulnerable is not seen as incapable”.

But he said too many services and organisations employed people with lived experience “in a very tokenistic way to tick their boxes and win tenders and grants”.

He told of one person he had met recently who had been volunteering with an organisation for four or five years and in return was only occasionally given money for public transport.

Martin said:

“That is not paying for the person’s time.

Lived experience people have their expertise and they should be reimbursed for their expertise and not [used] as cheap labour.”

Martin also highlighted the mental health risks for international students studying in Australia, an issue of growing concern in mental health.
As well as stigma and isolation, cost of health care is a big barrier for many students, he said.

Martin said he had recently accompanied a suicidal international student to a hospital, only to be told the student could not access treatment or support unless he paid a $570 fee or was arrested and brought for treatment by police.

Watch this interview with Elvis Martin

Focus on intersectionality

Martin’s calls for a more inclusive mental health system were echoed by other young mental health consumer advocates and peer workers in later panel discussions on peer support, consumer advocacy and intersectionality.

One panellist was a young transgender person who talked about often having to educate health services and professionals about the issues they were dealing with, and of having to go to one service for support with trauma issues and another for support with gender transitioning rather than having integrated support.

“LGBTIQ posters and ‘he/she’ buttons are not enough,” they told the session, which also heard calls for health services and professionals to take greater responsibility for educating themselves on issues of intersectionality, and not just blame their past studies or training for not knowing.

“It’s not my responsibility to teach my psych what I’m going through (as a trans person),” the panellist said.

Mainstream services can also make too many assumptions about the support a young person can access from family, the discussions heard.

“Because you live at home, they assume you get support,” said one panellist.

This is also a problem for young people who have had to leave home because of problems associated with their mental health and who may be estranged from family. They often end up without support if they are hospitalised because their friends – “their ‘chosen’ families” – aren’t given family status by the health system.
Jamie Sea, from VMIAC’s Youth Leadership Program, who facilitated the panel discussions, told Croakey:

“I’ve been sent to hospital a couple of times. The first thing they want to do is call my mum and dad.

The reason I was going to hospital was because of trauma-based illness that’s caused by my family so inviting family is the last thing I need, it’s only going to aggravate the symptoms I’ve come to hospital for.

In the queer community we talk a lot about our chosen family, our community but the hospitals don’t recognise that friendship is family.

The system isn’t designed to allow that, so we’re isolated and terrified and alone. We can’t get the support that other people can take for granted.”

Panellists also talked about missing out on support because of costs, with little mental health support available through the public health system and many young people, particularly those without family support, unable to afford private health insurance or fees.

They also raised geographic barriers, including lack of services in outer metropolitan areas and lack of privacy in services in rural areas, where the relevant clinician may be related or a family friend.

See this Twitter thread of the panel discussions.

Watch our interview with Jamie Sea who, as well as talking about service system issues for young people, calls for “grassroots” change on racism, homophobia and transphobia which play critical roles in mental health issues.
As Productivity Commission report puts focus on mental health reform, what do young people want?

#VMIAC2019
You can track Croakey’s coverage of the conference here.

As Productivity Commission report puts focus on mental health reform, what do young people want?

• For more on the Productivity Commission’s draft report, see this analysis of the report and call to action for health equity responses, as well as this 58-page compilation of the Croakey team’s Twitter summary.
Mental health consumers present a “collective dream” for a wonderful future

Indigo Daya presents the VMIAC Declaration

Marie McInerney writes:

“If we replaced the current mental health system with something wonderful, what would it look like?”

That was the question at the heart of a Declaration, launched at the Victorian Mental Illness Awareness Council (VMIAC) biennial conference in Melbourne, which asked nearly 200 mental health consumers across Victoria to dream about a new mental health system.

The resulting VMIAC Declaration talks about a system “shaped by compassion, love and the social determinants of health”, which is trauma-informed and holistic, addresses climate change, is accessible, and has music, politics and green space at its heart.
Aiming to be a “vision of hope” as major national and state inquiries are now reporting on mental health reform, it won a standing ovation at the conference and much love on Twitter.

You can track Croakey's coverage of the conference [here](#).

New alliance

The biennial VMIAC conference also saw the formation of a National Peak Consumer Alliance, bringing together six consumer peak bodies from Victoria, New South Wales, Tasmania, South Australia, the ACT and Western Australia to have more influence on national policy.

Alliance members told Croakey they had not been able to contribute as strongly as they wanted to national forums and inquiries such as the Productivity Commission's because the state peaks did not speak with a national voice.

In a joint statement, they said:

> “After many years of discussions and at the request of consumers across the country, we have today committed to establish a national consumer peak alliance led and owned by state peak bodies that will influence, lead and advocate on behalf of people who experience mental health challenges.”

Watch the announcement by Alliance members.

Imagining a miracle

VMIAC strategic project manager Indigo Daya told the conference the Declaration was a deliberate shift from the Council's traditional advocacy work, which is usually focused on addressing specific harms and human rights breaches in the mental health system.

For the Declaration, VMIAC did not ask mental health consumers to re-tell their stories of pain, distress and harm in the face of a broken system but rather to dream of what could be.

It asked them to “imagine a miracle had occurred”, and that society had changed to be wonderfully supportive. What would that look like?

It asked what services and professionals they would most want to go to, what would be helpful and healing, and what society would be like in such a system.

Daya collected people's dreams via surveys, workshops and a private online forum, telling the conference that the heartfelt and often heartbreaking responses were of course as diverse as the experiences of those who were making them – and that they made her laugh and cry.
Some were huge dreams, like ending capitalism and getting rid of the DSM (Diagnostic and Statistical Manual of Mental Disorders), she said.

There were others that “on the surface seemed tiny but perhaps were the biggest of all...to be able to afford enough food”, or for a social security system “designed to support people instead of punish them”.

But the message that stood out above all others was about the importance of choice, she said.

“The volume and complexity and diversity of what people want and need is massive, and at the moment what we get is a GP and some pills at this end of the system or a hospital and some more pills at the other end, or we get locked out and get nothing,” she said.

Peer-run

Daya, who is also a consumer academic at the University of Melbourne, said the places that consumers most wanted in an ideal mental health system were peer-run services, in many variants: respites, recovery houses, crisis centres, peer support groups, recovery colleges and retreats.

Their comments included:

“People providing support would be those like ourselves, people who know what it's like to live in this world, who have experienced similar issues/challenges and lived similar experiences.”

“Having people to talk to who don’t panic and go into rescue/ carer/ freak out mode. And who let you be.”

A big standout was the importance of nature in an ideal healing space: gardens, trees, lawns, flowerbeds, and the role of art, music, political action, and animals.

People wanted to be listened to, to experience compassion, to be free from violence and coercion, and to be “welcomed, not judged, feared and controlled”.
Asked about what types of health professionals were important in their visions, most of the professions in the system were nominated – from social workers and occupational therapists through to nurses and psychiatrists.

But Daya said the two roles that most consumers nominated for their ideal system were peer workers and therapists: “the two roles that get the least funding and have the least presence in our mental health system – and they are the ones people want the most”.

A challenge and an invitation

In a later interview with Croakey, Daya said the Declaration aimed to offer hope for mental health consumers, as well as providing a challenge and invitation to governments and inquiries shaping mental health reform, particularly the Royal Commission into Victoria’s Mental Health System, which will release its interim report later this month.

Consumers would judge the findings and recommendations of these investigations and government responses according to “how well they align with our dreams”.

“We’re the people who live it,” she said.

And while there is ongoing concern that consumer voices won’t be heard enough in those inquiries, particularly given disappointment that Victoria’s Royal Commissioners did not include a consumer, Daya welcomed comments at the conference from Victorian Mental Health Minister Foley on compulsory treatment and detention.

Stressing the need for a consumer-led, consumer-directed system, Foley said that while he recognised the desperation that drives some families and carers to call for a more “authoritarian system”, the mental health system could not go back in time and condemn another generation to that “cul de sac of pain and misery”.
The Declaration says that for too long, governments have “listened to the wrong people” about what’s needed in the mental health system, including the sector, which “will always lobby for their interests first: more hospital beds, more clinical jobs, more funding”.

“And with that comes many things that we don’t want,” it says.

“We call on governments and mental health leaders to listen to our dreams, and to help us create the kind of society, systems, services, places and supports that matter to us.”

VMIAC CEO Maggie Toko presented Minister Foley with the Declaration.

Watch this interview with Indigo Daya
You can track Croakey's coverage of the conference here.

Mental health consumers present a "collective dream" for a wonderful future

**From Twitter**

The #VMIAC2019 Declaration is up: vmiac.org.au/declaration/

"We asked people to imagine a miracle had occurred, and that society had changed to be wonderfully supportive. What would that look like?" #SDOH

Less than 20% of consumers engaging with #VMIAC2019 Declaration thought that 'mental illness' was a helpful or accurate description.
Mental health consumers present a “collective dream” for a wonderful future.

#VMIAC2019
Mental health consumers present a "collective dream" for a wonderful future.
What will it take to expand the role of peer workers in mental health?

Marie McInerney writes:

The Productivity Commission inquiry into mental health has called on health services and medical colleges to address the bias, discrimination and bullying that peer workers are experiencing from other health professionals, and which is hindering the benefits they can deliver in mental health care.

In its draft report, the Productivity Commission also says peer workers – people employed on the basis of their lived experience of mental illness – should have their own professional body to influence policy change and be supported with a comprehensive system of qualifications and professional development.

Mental health consumers have welcomed the support for peer work in the report but have reservations about the Productivity Commission’s approach and understanding as part of broader concerns that the consumer voice is missing in its inquiry to date.

The Productivity Commission says a professional mental health peer workforce is “a relatively new and still developing concept” and backs calls from consumer and carer groups for an expansion of the peer workforce and the roles peer workers can perform.

It cites “growing evidence that peer workers can facilitate better outcomes because having lived experience gives them a unique ability to develop trusting relationships with clients and provide them with hope”.

Word cloud from the VMIAC Declaration

Revealing stigma and discrimination

However, it highlights major “problems” raised during its inquiry that not only hinder the impact of peer workers but also put their own wellbeing and recovery at risk and expose worrying levels of stigma and discrimination about mental health among health professionals.

It says that peer workers are “often under-valued, marginalised, discredited and sometimes bullied by the people they work with because of scepticism about the abilities of people with lived experience of mental illness, their professionalism and validity of their qualifications”.

Croakey reported on some of these issues in a 2017 story about the “anxiety and hostility” shown by clinicians at a Victorian adult mental health inpatient unit when plans were unveiled to introduce a peer workforce.

One of the project leaders said she was “taken aback” by the level of opposition to the plan from clinical staff, who feared for their own jobs or roles, and also worried they may have to work alongside people who were not fully “recovered”, and no longer be able to “joke or let off steam” in the lunchroom about patients.

Other problems highlighted by the Productivity Commission (in its own words) were:

- Role confusion — the role of peer workers is not always clearly defined, leading to confusion about their scope of practice, responsibilities and how other health professions are expected to work with them.
- Re-traumatisation — by advocating for the people they support, peer workers can be repeatedly exposing themselves to the risk of re-traumatisation if the professions they work with do not value and understand the role of peers.
- Few opportunities for career development and advancement — there is rarely a career path for peer workers to have the basis for a long-term vocation in mental health services.
- Underdeveloped system of qualifications and professional development — there is currently only one specialised qualification (a Certificate IV in Mental Health Peer Work offered through the TAFE/VET sector).

Strategies identified

To address these issues, the Productivity Commission recommends a number of strategies, including educating health professionals about how peer workers can improve outcomes for their patients, and demonstrating those benefits “are real” in more trials and projects.

It says governments have an important role to play in this, as major funders and providers of mental health services, but that non-government service providers “will also need to drive improvements in their workplaces”.

And it calls on health professional bodies, including the medical colleges, to “play a role in changing attitudes in their professions”.

Identifying the “under-utilisation” of peer workers as a major mental health workforce issue, the report includes recommendations of peer and clinician led after hours and mobile crisis services that are alternatives to Emergency Departments, such as the Safe Haven model, and possible support for prisoners experiencing mental health issues.
It also highlights structural barriers to peer work, saying mental health care for people with more complex or severe problems is optimally organised through a multidisciplinary team – for example, a psychiatrist, a psychologist, a GP, a mental health nurse, a social worker, a peer worker, an employment support worker, a housing officer and others.

But it notes: “This fact, and together with the inability of fee for service to generate this kind of teamwork, has already been acknowledged by the Department of Health.”

“Not a pathway, a career in itself”

The Productivity Commission report was published as around 200 mental health consumers met in Melbourne at the recent biennial conference of the Victorian Mental Illness Awareness Council (VMIAC), which showcased the benefits of peer workers and peer work in a number of sessions.

Former VMIAC chair Vrinda Edan, who has held consumer roles in mental health services and research for the last 20 years, said she had concerns about the report’s approach to peer work.

She was particularly unhappy with its draft recommendation that a national review on qualifications and professional development should “consider how peer worker qualifications would be recognised as prior learning for health professional qualifications”.

“I find that really, really concerning,” she told Croakey, adding that many people like her had dedicated their working lives to peer work.

“We don’t need pathways into other occupations, we need appropriate responses to our needs as a workforce, appropriate remunerations and supports as a workforce,” she said.

“It’s not a pathway to another profession. It is a profession, it is a career,” she said.

Consumer peer worker Tim Heffernan, Deputy Commissioner at the Mental Health Commission NSW, told Croakey he was pleased the report highlighted the need for a national peer workforce organisation but said the more urgent need was for a national consumer voice to government.

He said there had been significant investment from the former Labor Government and the then Mental Health Minister Mark Butler in 2011 to develop such a voice but it was “abandoned” in 2014 by the incoming Abbott Government.

“Until we have such a voice we only hear the voices who hold the power in mental health in Australia today,” he said, welcoming the announcement at #VMIAC2019 of the formation of the National Consumer Peak Alliance as “an effort to construct that national voice with no funding”.

Heffernan said he was also concerned the Productivity Commission “does not yet have a fully developed understanding” of the mental health peer workforce and overlooked some important, long-established peer-run services, such as BookRED in Queensland.

“The section on peer work focuses mostly on the problems that need to be fixed rather than on the positive stories about what is happening in this sector,” he said, adding his concern that “this reflects the lack of a strong consumer voice” overall in the Commission’s report.

Victorian experiences

Victoria has been running and assessing the Expanding Post Discharge Support Initiative, where peer workers are providing additional support for consumers with complex mental health issues following their discharge from a number of specialist mental health services.
Research assistant Emily Castagnini, Co-Design Officer at NorthWestern Mental Health, and Emma Cadogan, Senior Policy Advisor, Department of Health and Human Services, presented on the benefits and challenges of the initiative.

**Phase one: Case study development**

Case studies developed with three different health services in Victoria to provide some different examples of ways in which services have developed and implemented the initiative.

**Phase two: Health service and workforce perspectives**

Explores the experiences of peer support workers and the people they work alongside as the Expanding post-discharge Support Initiative was implemented.

**Phase three: Service user perspectives**

Third phase of the research that will capture service user experiences of peer support – co-designed tools and approach.

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**What happens when it doesn’t work well?**

We heard about a wide range of challenges for peer support workers:

- Consumer and carer peer support workers feeling unsupported – training, discipline specific supervision, access to basic resources such as computers, phones, cars, office space
- Being a non clinical worker in clinical setting – the culture and language of clinical settings, becoming ‘clinicalised’, managing triggering environments
- Carer peer support workers reported challenges with the IPS model not ‘speaking to their work’, with training, sharing information and shared documentation
“It really does come down to individuals feeling less alone or hopefully having some more hope or feeling a reduced stigma. I often have conversations with people and they say it’s the first conversation they’ve had with someone that has a similar diagnosis or that has returned to study after being in hospital. I think they’re things that you can’t really measure in the program but they’re really invaluable to individuals.”

- Consumer Peer Support Worker

“I love this role. I’m not a clinician so I don’t have to follow those models of talking. I can follow the intentional Peer Support model, I can do the world view and the mutuality and all of that and, through all of that, I learn such wonderful things about people.” Consumer Peer Support Worker

“Peer support workers go into a clinical system and because they are relatively isolated they end up getting ‘clinicalised’. Their role gets blurry around the edges. Clinicians ask them to do things that are not peer support work. The peer support workforce is being used by the clinicians as another way to get at a patient, a consumer, another way to influence them.” Consumer Peer Support Worker
What will it take to expand the role of peer workers in mental health?

Having a peer support workforce in clinical settings can have a number of significant benefits:

- Benefits for organisations included enhancing recovery-oriented approaches and promoting an organisational culture that treats people with mental illness with dignity and respect.
- Living proof that recovery is possible for clinical staff, and consumers and carers.
- Being a peer support worker plays a role in restoring hope and sense of purpose; can turn experience of distress into a strength.
- Decreasing the feeling of isolation and stigma for consumers and carers.

"A lot of clinicians and psychiatrists don’t get to see the people they’re working with when they’re doing well. They only get to see them when they’re distressed. That’s why we (the peer support workers) like to bring back the stories. And we’re – you know – living, breathing examples that you can … go through all of that and …. come out the other end, integrate it, grow or at least learn to manage symptoms." Consumer Peer Support Worker.

"... I stopped being in that sick role and got a job, got my life back and passed that learning on. That’s the best thing for me – because otherwise the whole eight or nine years has been for nothing and what positive do you take? Now this is a paid positive, you know? ... They’re not wasted years, they are education." Consumer Peer Support Worker.
From Twitter

Friends of CPN, @CMHL #LornaDownes and #CraigWallace providing consultation on their webpage for and about lived experience workforce and seeking your feedback!! #vmiac2019 #mentalhealth #cmhl cmhl.org.au/peer-inside

Dr Daniel Fisher talks about need for Peer Run Respites - places where people in distress can receive care & understanding from people w/ lived experience. They have a small number of them in the US & it would be great to have them here. We need hospital alternatives! #VMIA2019

“The introduction of peer workers to the work force is refreshing and hopeful. As long as we are able to do the real work and aren’t tokenistic” - Janet Karagounis in the closing keynote at #VMIA2019

• Also, see this three-page Twitter summary of peer worker discussion by Janet Karagounis.
Listen to the “canaries in the coal mine”, urges a psychiatric survivor

Marie McInerney writes:

United States psychiatrist Dr Daniel Fisher believes that people like him, who have been diagnosed and labelled with mental illness, are like the “canaries in the coal mine” – early victims and warning signs of the toxic culture that so many of us live in.

Fisher, who began his high profile career as a biochemist, says theories that mental illness illnesses are due to a chemical imbalance in the brain have “set us back in a lot of ways”. 

“It’s just some of us are more vulnerable to the pressures of our culture,” he told the Victorian Mental Illness Awareness Council (VMIAC) biennial conference in Melbourne.

Fisher is co-founder and CEO of the National Empowerment Center, an advocacy and peer-support organisation in Massachusetts, and co-founder and president of the National Coalition for Mental Health Recovery (NCMHR), a voice for mental health consumer/survivors.

In a keynote address, he talked about the growing stresses of modern life: isolation, alienation from nature, extreme capitalism, climate change, and how much we could learn from the Indigenous cultures of Australia and the United States.
Listen to the “canaries in the coal mine”, urges a psychiatric survivor

He said:

- “The nature of the problem is we have lost the ability to be ourselves, we’ve lost the ability to know our hearts, and we’ve lost community a great deal.”
- Some of us are more sensitive to those losses.
- I think of us as the canaries in the cultural mine.”

A survivor

Fisher describes himself as more of a psychiatric survivor than a mental health consumer – explaining the distinction as someone who sees the mental health system as beyond repair and needing to be replaced, versus those who are happy if they can make “a few little reforms”.

He now travels the world promoting and training people in what he calls Emotional CPR, which he has helped develop with the belief that people with mental illness, or what it describes as emotional distress, can recover completely with holistic emotional support.

He has visited Australia a number of times and conducted two days of workshops hosted by VMIAC in the leadup to the conference.

Fisher is also a rare figure in mental health, a clinician who has lived experience and speaks out about it.

It’s a role and experience that he says has created many tensions and conflicts – some psychiatric survivors did not trust him, initially at least, because of his clinical training, while others in mental health have described his approach as “dangerous”.

He admits to being surprised, given his unorthodoxy, to have been appointed to the White House Commission on Mental Health in 2002 by President George W Bush.

Fisher began life with a privileged “white Anglo Saxon Protestant” background, attending the private school that was founded by his great grandfather, he told the conference.

He went on to study biochemistry in a bid to find a cure or treatment for his sister who suffered anorexia, but experienced psychosis in his mid 20s and was diagnosed with schizophrenia.

He was locked up, forcibly injected, and put in seclusion.

There he “vowed to myself that if I ever got out of this place I was going to become a psychiatrist and unlock every one of these facilities, so no one would ever have to go into them again”.

He did so, but it has not been a standard clinician journey.

Matters of heart and soul

Fisher said he was pleased to do his residency in Boston, not for the opportunity to study at Harvard Medical School, but because it was a base for the Mental Patient Liberation Front, a key group in the mental health consumer/survivor movement that worked to end harmful psychiatric practice and raise human rights issues.

Such groups and his studies confirmed his sense from his own lived experience that mental health issues were not traditional illnesses and propelled his search for different understandings and treatments.
He said:

"Imagine if just two years prior you had been hospitalised, forced to take medicine and then you are the psychiatric resident [consultant] at an inpatient unit, told to ‘order medications for these people’.

The pills that I hated, the pills that made me feel like I was dying."

Fisher said he is not anti-medication but he knows personally the terrible side effects that can arise and does not see medication as a solution in itself. Nor does he wish to “bash” clinicians – “I’m a clinician myself” – but he believes the training is wrong.

He told the conference:

"The more I delved into the biochemical basis of psychological approaches, the more I felt it dehumanises us, takes away our soul."

Matters of heart and soul are now at the basis of his work in Emotional CPR and outlined in his recent book.

The program aims for a world where:

• Every person who experiences extreme emotional states is engaged in respectful, hopeful, humanistic, and empowering relationships that enable them to heal and recover full, meaningful lives in the community.

• Instead of being seen as threats to society, people with lived experience in mental illness are seen as a source of wisdom obtained through recovery.

• Suffering will be seen as an understandable human response to trauma rather than a chemical imbalance or a defective fear circuit.

• Voluntary, community-based, recovery-oriented, culturally attuned, trauma informed services and housing will replace psychiatric hospitals.

• The mental health system will be run by persons with lived experience of recovery from extreme emotional states.

A caution

Fisher sounded a warning to #VMIAC2019 participants to beware being “co-opted” by the system, even when reform is being promised, as with the Productivity Commission inquiry into mental health and the Royal Commission into Victoria’s Mental Health System.

He said the US once had a very strong consumer movement “that got bought off and is now trying to reconvene”.

"Beware what you ask for,” he warned in reference to consumer calls for more peer workers within the existing system.

“I know so many people who have gone into that, who feel so disempowered that it works against their recovery,” he said.

“Self-determination is one of the most critical elements and the system is explicitly set up against self-determination.”
Now in his 70s, Fisher believes the mental health movement needs to go back to its roots, to once again learn from its early champions, people like Judi Chamberlin, who started Mad Pride, Leonard Frank, a survivor and opponent of electroconvulsive treatment (ECT), and Howie the Harp who founded many psychiatric survivor organisations.

“They laid down that it has to be a separatist movement, you don’t go and get jobs in the system, you don’t rely on the system for money, you can’t expect the system to change itself, it has to be changed from outside,” he said.

And he said the problem goes beyond the mental health system, “it’s the larger culture we live in”.

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**From Twitter**

Dr Daniel Fisher at #VMIAC2019

> “We’ve lost the ability to know ourselves...to know our hearts. We’ve lost community. Some of us are just more susceptible to that. People labelled with mental illnesses are like the canaries in the coal mine for society as a whole”

Dr Daniel Fisher speaking his dream at #VMIAC2019 That desire to work to fix the health system you spent a lot of time being a part of is very relatable to me!

Dr Daniel Fisher talks about the difficulty of prescribing medication/therapies that he himself hated. That cognitive dissonance is a struggle for all health professionals who are also consumers #VMIAC2019
You can track Croakey's coverage of the conference [here](https://www.croakey.com.au/).

#VMIAC2019

Listen to the “canaries in the coal mine”, urges a psychiatric survivor

See more tweets [here](https://twitter.com/).

Watch this interview

Listen to the “canaries in the coal mine”, urges a psychiatric survivor

#VMIAC2019

"People diagnosed with mental illness are the c..."
Calls for alternatives to police in mental health crises

Marie McInerney writes:

Police should not be involved in most frontline mental health crisis responses because too often their interactions escalate and result in further distress, trauma, physical harm, and death for the person in crisis, a mental health consumers conference was told.

The call for “alternatives to policing mental health crises” comes as the Productivity Commission’s draft report documented a dramatic increase in the numbers of police callouts to people with mental health issues.

In Western Australia, the number of police responses involving a mental health element climbed from 4,766 in 2007 to 18,902 in 2015, it said.

In Victoria, police facilitated about 14,000 ‘mental health transfers’ to hospital, but attended 43,000 psychiatric and suicide related events in 2017-18, with the number of psychiatric events up an astounding 88 per cent from 2014-15. See extract from draft report below:

Police spend a significant amount of time interacting with people with mental illness — about 10% of police time in New South Wales (NSW LRC 2012). In 2018, New South Wales police completed about 14,700 orders under section 22 of the Mental Health Act 2007 (NSW) (NSW Police, unpublished data). In Victoria, it is estimated that police apprehend about 500 people (under the State’s Mental Health Act) each month (Allen Consulting 2012). At least 20% of all mental health referrals to the emergency department come from police (Scott and Meehan 2017). In 2018, police-assisted mental health transports to hospital were about 1260 in Western Australia (WA Police, unpublished data) and 1130 in South Australia (SA Police, unpublished data).
Meanwhile, a police investigation is underway into the fatal shooting in September of an Aboriginal woman in Geraldton, Western Australia, after police were called for help.

Family and friends of Yamatji woman Joyce Clarke are demanding to know why police drew their guns instead of deploying a taser or other non-lethal method.

Clarke’s case is yet another tragic reminder that people experiencing mental illness, particularly Aboriginal and Torres Strait Islander people, are not only massively over-represented in the justice system but also in incidents involving both fatal and non-fatal police force.

“When police are involved in mental health crises, when there’s high pressure and high emotions, terrible things can happen,” Hamilton Kennedy told a session of the Victorian Mental Illness Awareness Council (VMIAC) biennial conference.

Kennedy and co-presenter Rory Randall said their presentation was not related to their professional roles as mental health consumer researchers but from their personal concerns as people with lived experience and advocates of better mental health care.

They said people in mental health crisis are often manhandled, dehumanised, restrained in transport to hospitals, and left in police watch-houses without support or medications.

Kennedy, who personally experienced the “psychic harm” of a police emergency response three years ago following a suicide attempt, described the experience:

- “(I was) put into the back of a paddy wagon, taken to hospital, sliding around in the back.
- It was painful.”

While Kennedy and Randall say that ultimately they support police and prison abolition, they now want to open up conversations about emergency alternatives to police that go beyond the types of services highlighted last week by the Productivity Commission inquiry into mental health.

The Commission’s report recommends better equipping police to handle mental health crises, including by working alongside mental health specialists and embedding mental health expertise in emergency communications centres to guide police responses in real time (see table below for more examples).

However, it doesn’t look specifically to reduce their involvement or at how risky and problematic a police presence is for many people, particularly Aboriginal and Torres Strait Islander people, as again was seen tragically last month in the fatal shooting by police of 19-year-old Warlpiri man Kumanjayi Walker in the remote community of Yuendumu.
“Uncouple” police and mental health

Victoria’s own Royal Commission into mental health is being urged to take a much broader view to reduce police involvement in mental health matters.

Like others campaigning for change, Kennedy and Randall want to “uncouple mental health crises from the emergency system” and encourage health and community service providers, as well as members of the public, to think before they call the police.

“We want people to ask themselves: ‘Is this my only option, is this a good option?’”

“We need every person walking past us to not assume if we’re talking to ourselves that we need a call to police or a crisis intervention,” Randall said.

They point to the work in the United States of the Oakland-based Critical Resistance, and are planning to produce a local version of this flowchart that encourages alternatives to calling the police in a crisis.

Other initiatives in the US include the 30-year-old Crisis Assistance Helping Out On The Streets (CAHOOTS) program in Oregon that diverts nonviolent mental health-related 911 calls to a health specialist instead of police, and San Francisco’s mobile app Concern that provides connections to “compassionate responders” as an alternative to police.

Kennedy and Randall said Australian police did not necessarily have “heinous intent” but pose a threat to people in mental health crisis. This is not only because they lack enough specialist training but also because, fundamentally, they are instruments of the state and equipped for deadly force.

Adding to this risk is ongoing stigma about mental health, with people with mental health issues much more likely to be victims of violence than to perpetrate it.

Like people of colour, they are “over-policed and over-criminalised”, Kennedy and Randall said.

“They surveil people with mental illness, they detain people with mental illness, they imprison people within the actual forensic system or in hospitals and force people to have mental treatment,” said Kennedy, who presented at the 2017 VMIAC conference about the trauma involved in working as a peer support worker at a youth psychiatric inpatient facility.

“Misuse and abuse”

Melbourne’s Police Accountability Project, based at the Flemington and Kensington Community Legal Centre, which has done much work on racial profiling by police, is also calling for an end to having police as first responders to mental health call outs.

Its submission to the Royal Commission into Victoria’s Mental Health System says it is aware of families that “no longer call the police to assist ill relatives for fear their loved one may be shot or injured”.

The Project says there have been shocking cases of “misuse and abuse” of police powers in Victoria, including that of an invalid pensioner who last year was “beaten, abused and humiliated” by police in a mental health callout that was captured on CCTV footage.

It reported that all but six of 48 fatal encounters with police in Victoria from 1982-2007 involved victims with histories of mental health problems.
But even when incidents are not fatal, “in an unacceptably high number of cases, the attending police response has resulted in increased fear, anxiety or distress of the person in crisis”, prompting a “cascade of escalation” which can end in injury, the laying of charges and sometimes death, the Project says.

The Police Accountability Project says it has no faith that new or more training for police will produce significant change – it says that hasn’t worked in efforts to stem racial profiling by Victoria Police.

Calling for greater accountability to manage complaints against police, it also wants the Royal Commission to recommend a new “non-aggressive, de-escalatory, care-based” response that is led by health professionals and does not involve police or, if so, only in support roles.

“This therapeutic response contrasts with the policing model, with its focus on constraint, control, use of force, arrest and deprivation of liberty,” it says.

**Tweets from the #VMIAC2019 session**

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**What do we mean by abolition? #VMIAC2019**  “Just like the abolition of the slave trade, this too can end”.

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“When you go to call the police, you have to think ‘is this my only option’ & you have to think ‘is this a good option’” – Rory & Hamilton talking about police involvement in mental health crises and calling for abolition of the police and prison system #VMIAC2019
#VMIA2019
@WePublicHealth

Questions for health, mental health, community services to ask in a mental health crisis: #VMIA2019

Briefly, turn to your neighbor for one minute and share your experiences of police in attendance in 'mental health emergencies'.

What was the outcome in terms of 'felt safety' of people present?

Who decided to call the police?

Was there definitely a need for the police presence at that time?

Can you imagine any other useful responses in that situation?

Have you encountered police alongside mental health services?
Victoria’s Royal Commission into mental health says system “catastrophically failed”

The Victorian Mental Illness Awareness Council (VMIAC) biennial conference took place amid a huge momentum in mental health reform – with draft reports being published by the Productivity Commission inquiry into mental health, Royal Commission into aged care, and the interim report from Victoria’s Royal Commission into the state’s mental health system.

Our final report for #VMIAC2019 wraps the major recommendations from and responses to the Royal Commission, which will be of interest nationally as Australia considers wide-ranging reform proposals to provide better mental health care.

Marie McInerney writes:

Victoria is set to introduce a mental health ‘tax’, create a new community controlled focus on social and emotional wellbeing for Aboriginal Victorians, establish the state’s first residential mental health service designed and run by people with lived experience and greatly expand the consumer and carer workforce.
These steps are among nine urgent recommendations in the interim report of the Royal Commission into Victoria’s Mental Health System that was tabled in State Parliament after nine months of consultations, roundtables, public hearings, surveys, and more than 3,200 submissions.

In its 680-page report (read a 28-page summary here), the Royal Commission found that Victoria’s mental health system, which it said was once admired as the most progressive in the nation, has “catastrophically failed to live up to expectations” and is “woefully unprepared” for current and future challenges.

It quoted one person’s view that it said resonated with all its hearings:

“In an often-repeated explanation is that the system has ‘cracks’ and that people will fall through them. I don’t know if [we were] just unlucky to continually step on those cracks, or if the cracks are so wide that you cannot avoid them.”

The report outlines in detail a system that is failing and in crisis: one key figure points out that Victoria Police had in 2017–18 attended about 43,000 events relating to a ‘psychiatric crisis’ or ‘suicide attempt or threat’, “amounting to a mental health callout about every 12 minutes”.

Commission chair Penny Armytage said in a statement:

1. “There is no question that the status quo must change.
2. One thing we have heard very clearly is that we are in the midst of a mental health crisis, that the system is failing and not meeting the needs of those who need it most. This must change.”

The Royal Commission’s interim recommendations are for:

1. A new approach to funding, comprising a new revenue mechanism (a “tax or levy”) to enable substantially increased investment in mental health which would facilitate delivery of the reforms required to establish “a contemporary and enduring mental health system”. Victoria has previously had a fire levy in the wake of the 2009 Black Saturday bushfires.

2. The creation of the Victorian Collaborative Centre for Mental Health and Wellbeing to bring together expertise in lived experience, research and clinical and nonclinical care, disseminating the practice of evidence-informed treatment, care and support across the state. This might have a similar role as the Peter MacCallum Cancer Centre.

3. An additional 170 acute mental health beds for young people and adults in areas of need.

4. All area mental health services to offer the Hospital Outreach Post-suicidal Engagement (HOPE) program to expand follow-up care and support for people after a suicide attempt, along with the creation, delivery and evaluation of the first phase of a new assertive outreach and follow-up care service for children and young people who have self-harmed or who are at risk of suicide.

5. The creation of an Aboriginal Social and Emotional Wellbeing Centre, developed and hosted by the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and the establishment of social and emotional wellbeing teams in Aboriginal communities throughout the state to support appropriate models of care.

6. The establishment of a residential mental health service designed and delivered by people with lived experience of mental illness, the first ever in Victoria and believed to be one of only a few in Australia.
7. The development and implementation of supports and structures to “enhance and expand” consumer and family-carer lived experience workforces in the mental health system.

8. Addressing workforce shortages and preparing for reform including through the provision of more training and recruitment pathways to boost the number of graduate nurses and allied health professionals in public mental health services – including funded graduate positions, postgraduate scholarships and psychiatry rotations, supported overseas recruitment, leadership development and improved data.

9. Establishing a Mental Health Implementation Office to start work delivering these recommendations.

“Transformational change needed”

But the Royal Commission has made clear there is much more to come in its final report due in October next year, saying that “transformational change is needed”. It said:

“Our initial recommendations…do not fully describe the systemic changes that are needed. Instead, we have taken the opportunity of developing this report to recommend changes aimed at redressing urgent problems and preparing the ground for further reform.

Although the Commission is in the early stages of its reform work, what we can say is that well-resourced community mental health services—based on collaborative, multidisciplinary models of care—will be at the centre of a redesigned system.”

Premier Daniel Andrews promised to hold the Royal Commission into Victoria’s “broken” mental health system in the leadup to the 2018 election and said the interim report “shines a powerful light on the failings of a system that has let down Victorians and their families for far too long”.

His Government promised from the start it would implement “each and every one” of the recommendations – as it did with the Royal Commission into Family Violence.

It reconfirmed that, while acknowledging there’s some work to be done on what type of tax or levy it will apply.

Both the Premier and mental health leader Professor Patrick McGorry, executive director of Orygen, who has played a key role in setting up the Royal Commission in Victoria, flagged the possibility of a national levy, including as something the ongoing Productivity Commission inquiry into mental health could or should be considering.

The Royal Commission report follows hot on the heels of the Productivity Commission’s draft report.

The tax/levy proposal also raised concerns for groups like the Victorian Council of Social Service (VCOSS) that the toll shouldn’t be felt more heavily by lower income Victorians, who are also more likely to be experiencing mental health pressures.

There’s also a question mark over whether the State Opposition will try to block the levy in the Upper House, where the government would rely on cross bench support.
Disappointment on housing

While there is much reading to be done of the hefty Royal Commission report, the initial response has been warm from most stakeholders, except for deep disappointment from housing and homelessness groups that it makes no recommendation to address “the tragedy of the revolving door” for people exiting acute care, into homelessness, and back into acute care.

The state’s peak body, the Council to Homeless Persons, had urged the Royal Commission to acknowledge the critical role of housing in mental health, and to identify how much social housing and long term supported housing is needed to provide proper care to people recovering from mental illness.

It said the Royal Commission had revealed that more than one in six people who use public mental health services also access homelessness services.

“If we want to deliver high quality community mental health services, we need to ensure people have safe places to live,” said CEO Jenny Smith.

There’s also criticism from the newly established Women’s Mental Health Alliance that the “gender-neutral report” means the mental health of women and girls “is still largely invisible”.

But other groups commended the direction of the Royal Commission’s work, including the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), which will play a key role in the creation and ongoing management of the new Aboriginal Social and Emotional Wellbeing Centre.

The report opens with an acknowledgement of the Aboriginal peoples of Victoria and the importance of Aboriginal leadership in improving outcomes, but also of “the devastating impacts and the accumulation of trauma resulting from colonisation, genocide, the dispossession of land and children, discrimination and racism”. It says:

“The Royal Commission is conscious that its work is taking place concurrently with renewed efforts to achieve constitutional recognition of Aboriginal peoples and treaty processes that are underway in Victoria.

We commit to building on this momentum and to ensuring our work is shaped by the voice of Aboriginal people.”

In a statement, VACCHO says the Royal Commission has produced a report that “finally reflects and recognises the challenges faced by the Aboriginal community and our tireless work to support and care for our community with at times very limited resources and infrastructure”.

VACCHO’s Acting CEO Trevor Pearce said:

“The report recognises what the Aboriginal community has been saying and fighting for over a very long time.

Putting Aboriginal mental health into Aboriginal hands and recognising Aboriginal values of healing and caring for Community is key to Aboriginal health and wellbeing.”
Consumers “encouraged”

First scan of the @RCMentalHealth interim report:

—Some wonderful recommendations re peer work & a service run by & for peers

—Acknowledgement of system harms

—Acknowledgement of serious gaps re trauma

But lots that concerns me too—eg. more beds.

Will take time to digest.

The peak consumer body, the Victorian Mental Illness Awareness Council (VMIAC), also says the interim report “has delivered welcome news”, despite early concerns that none of the four Commissioners had lived experience.

VMIAC has welcomed three recommendations in particular: social and emotional wellbeing support for Aboriginal Victorians; the residential service designed and delivered by people with lived experience of mental and emotional health issues, and the Lived Experience Workforce recommendation around improving career pathways, including learning and development processes in leadership positions.

Its CEO Maggie Toko said:

“The Interim Report validates what we’ve been saying and campaigning for over a long period of time.”

Watch this VMIAC video:

The carers peak body Tandem also said it was “thrilled” with the many innovative recommendations, “with specific recognition of the importance of supporting consumer and family lived experience workforce and providing alternative care options”.

Victoria's Royal Commission into mental health says system “catastrophically failed”

#VMIAC2019
Other responses

The Royal Australian and New Zealand College of Psychiatrists was also “encouraged” by the report, welcoming new investment in mental health, immediate funding of more inpatient beds, an expansion of suicide prevention services and a greater focus on Aboriginal social and emotional wellbeing.

“We are particularly supportive of the focus on an enhanced role for people with lived experience in the co-production of service design and delivery, which acknowledges their central role in establishing a more contemporary, humane, and fit for purpose mental health system,” it said in a statement.

The RANZCP Victorian Branch said psychiatrists were also pleased the report highlights the shortage and maldistribution of psychiatrists in the mental health workforce, particularly in rural and regional areas, the deficits in inpatients beds for people with complex needs, and the lack of treatment options for the ‘missing middle’ who do not meet the threshold for public mental health services.

But it warned that psychiatrists are exiting the public system “at alarming rates” due to broader problems within the system.

Mental Health Victoria welcomed the interim report and its emphasis on consumers, families and carers being at the centre of the design process for new services.

It echoed other stakeholders, including the Premier, in saying that “while the costs to transform our mental health system will be high, we know they will be an investment that delivers large economic returns to the state”.

The Australian Nursing and Midwifery Federation (Victorian Branch) welcomed the report as “game-changing”, in particular the boost to mental health funding and additional 170 adult and youth acute mental health beds within two years.

It said recommendations to increase the number of mental health nurses will be "a great start" and include an additional annual 140 fully-funded postgraduate mental health nursing scholarships, which will more than double existing scholarships. There is also a recommendation to fund an extra 120 mental health graduate placements each year.

Orygen said it strongly supports the Commission’s analysis of the depth of the problems across Victoria’s mental health system and was pleased with its recommendation of a Victorian Collaborative Centre for Mental Health and Wellbeing, which has been “influenced by the ambition of the Orygen clinical model and the attention it has achieved nationally and internationally”.

Professor McGorry said the interim report placed significant emphasis on the value of interdisciplinary translational research to the development of the new models of care, service design and delivery that would be required to achieve the Commission’s recommended redesign of the mental health system in Victoria.

cohealth says the interim report shows the Commission is “on the right track for delivering real reform to a fundamentally broken system”. Chief Executive, Nicole Bartholomeusz welcomed the recommendation for a new mental health tax and said: “Bolstering the system via a new revenue stream will reduce the burden on emergency departments, police, the courts and social support services, and save taxpayers money in the long-run.”

Victoria’s Royal Commission into mental health says system “catastrophically failed”

#VMiAC2019
She said more needs to be done integrate mental health care with multidisciplinary physical health care and social support services, a model such as that delivered within community health centres, and hoped this would be evidenced in the final report.

And via Twitter

@RCMentalHealth's Interim Report puts Aboriginal mental health into Aboriginal hands and recognises that Aboriginal values of healing and caring for Communities are key to Aboriginal health and wellbeing. bit.ly/37JTIC2

We are thrilled with the many innovative recommendations put forward in the Royal Commission’s interim report, with specific recognition of the importance of supporting consumer and family lived experience workforce and providing alternative care options.

#RCVMHS #mentalhealth
"We need to see a generational change. An attitudinal change ... This is a very ambitious commission, which is looking to redesign a whole system of care in a way that I don't think has been done before."

Simon Stafrace, Head of Psychiatry at Alfred, on #RCMentalHealth

Although not yet highlighted in the recommendations, good to hear the #RCMentalHealth talk about prevention. Hopefully the next report makes this a key plank of the way forward.

At the briefing of the Interim report :: Royal Commission into Victoria's Mental Health System. A great start! Next steps - making sure that migrant and refugee women's needs are integrated into system design, not an add-on. #RCMentalHealth

"Variability in environmental factors—such as climate change, extreme weather events and natural disasters—can play a role in shaping mental health, particularly for people living in rural and regional areas" (RC Vic Mental Health) #RCMentalHealth #ClimateEmergency #ClimateChange
You can track Croakey’s coverage of the conference here.

MHLC looks forward to supporting the ongoing work of the Commission in “examining the relationship with the justice, housing and other health and social systems to identify ways in which consumers, families and carers might be better supported across systems”.

#RCMentalHealth

Laura Vidal
@lauraemilyvidal

The Victorian Royal Commission into Mental Health has handed down its interim report; whilst #gender has been acknowledged as a determinant of mental health no specific reform has been recommended for women and girls. @SquireSarah summarises below 👇

👇 #RCMentalHealth

Women’s Policy Au @policyforwomen · 17h
New analysis - Nine months of the RCMentalHealth but women and girls’ mentalhealth is still largely invisible @SquireSarah @GoodAdvocacy powertopersuade.org.au/blog/nine-mont...

VC OSS
@VC OSS

Great to hear @CHPVic on ABC News making the point we can’t really fix our mental health system without addressing housing and homelessness.

After all, 1 in 6 people people receiving public mental healthcare also use homelessness services.

The issues are linked.

Marie Mcinerney @mariemcinerney · 22h
Thanks @Dpeters1977 for heads-up: #RCMentalHealth interim report is now published rvc.hhs.vic.gov.au/download_file/... cc @MelissaSweetDr @VMIA C @Mental-healthVic @IndigoDaya @timheffo @SimonStafrace @johno0910

Tim Heffernan
@timheffo

Replying to @mariemcinerney @Dpeters1977 and 6 others

Thank you @mariemcinerney. Combined with the @ozprodcom report we have a forest of reform now!
Victoria’s Royal Commission into mental health says system “catastrophically failed”

#VMIAC2019 analytics

According to Symplur analytics, 171 Twitter accounts sent 1,835 tweets using the conference hashtag, creating more than 14 million impressions (during the period from 29th October to 26th November).

#VMIAC2019 Participants
Watch all our video interviews

Watch this playlist of 10 interviews at #VMIAC2019, including with keynote speakers Matt Ball, Dr Daniel Fisher, and Elvis Martin, presenters Indigo Daya and Dave Peters, VMIAC leaders Maggie Toko and Tricia Szirom and from the newly formed National Consumer Peak Alliance. By 29 November, there were 2,312 views for the eight interviews broadcast live via the Periscope app.

Croakey Conference News Service

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