People diagnosed with 'mental illness' doing things for ourselves

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RESOURCE CENTRE FOR MENTAL HEALTH CONSUMERS

Contents

STOP PRESS: PEER ZONE IS COMING TO MELBOURNE!

On December 12th, Mary O'Hagan (internationally acclaimed consumer thinker, writer and former New Zealand Mental Health Commissioner) will be sharing PeerZone with Melbourne! This event will be held at the Victorian Mental Illness Awareness Council, Building 1, 22 Aintree Street, Brunswick East. Check out the back cover for more information, and check out www.peerzone.info for the scoop on what Peerzone is!

INTRODUCING ... *What is happening at the Seclusion Review that makes a difference? – a consumer led research study.*

In this edition, we introduce an important consumer-perspective piece of research, conducted by Bradley Foxelwin, into the success of the Seclusion and Restraint Review Meetings at the Canberra Hospital – this is the executive summary from the report. More information is available on the ACT mental health consumer network website: http://www.actmhcn.org.au/publications/research.html

This research pilot study has been conducted by people who have experience of mental health challenges and the mental health care system, and is focused specifically on the Psychiatric Services Unit, PSU, at the Canberra Hospital. The aim of the research was to explore, in collaboration with consumer representatives and clinical staff, what has occurred during the weekly Seclusion and Restraint Review Meetings (SRRM) that has led to the huge reduction in the use of seclusion at the PSU.

The SRRM closely examines every incident of seclusion, restraint and many 'near misses' to find out what happened, what could have been done differently, or what – in particular – is working to prevent seclusion.

The SRRM has developed a culture in which difficult situations can be discussed without blame, where every point of view is valued, every voice is heard and respected; where practices of exclusion, such as values that privilege staff over consumers, or beliefs that rob consumers of agency and dignity, are rigorously investigated. This is not always an easy process.

The SRRM [weekly Seclusion and Restraint Review Meeting] has developed a culture in which difficult situations can be discussed without blame, where every point of view is valued, every voice is heard and respected; where practices of exclusion, such as values that privilege staff over consumers, or beliefs that rob consumers of agency and dignity, are rigorously investigated. This is not always an easy process.

Nonetheless, in creating this culture, attitudes are challenged and changed, and the renewed energy passes 'downstairs' to the acute ward, maintaining systemic and cultural changes that enable all stakeholders to better support consumers.

This research study elicits and documents stories of these changes, told by consumers and clinicians in collaboration. The research takes the epistemological standpoint that change is enabled within social and relational domains and that individual identity development, both professionally and personally, is a consequence of engagement.

The research was proposed and conducted by an independent consumer researcher to reiterate the importance of including the consumer voice in implementing systems change.

The document utilizes quantitative data first collected for the Beacon Site Project, and now collected by ACT Health to support "the use of data to drive change" (Kipling, 2011, pers. com.), to set an historical context, and to provide a visual perspective on the significant reductions on the use of seclusion at the PSU. The data can be viewed on pages 8-25 of the research document, tracking the use of seclusion at the PSU from 2006 to 2012, and shows a dramatic drop in both episodes and hours of seclusion from 2009, when the SRRM was first established.

The document is also supported by literature reviews on both seclusion reduction and consumer led research (pages 26-30) and makes recommendations (pages 81-82) in regard to future research and the possible implications for Mental Health Services.

Two sites were researched: the SRRM members and the Consumer Reference Group, CRG. The CRG were consulted about the relevance and appropriateness of the research process, as key players in maintaining consumer perspectives. Focus groups, the CRG research method, were conducted on three occasions: at initiation, prior to submitting for ethics approval, and at report (advanced draft) stage. The results of the CRG consultations guided the proposal, the ethics application, the methodological approach and the final documentation, to ensure consumer perspectives were included at all stages of the research. The lived experience of the CRG and their embodied expertise as Consumer Representatives to the Mental Health care system provided both a relational base and a collective intuitive voice.

The SRRM research process, conducted on two separate occasions, included a focus group (Narrative Definitional Ceremony) followed by Collective Biography writing. SRRM data was analysed, firstly through the interaction of research participants, secondly through content analysis in collaboration with research participants and thirdly by a performative dialogic analysis.

Both methods took up a process of open inquiry around separate sets of questions. For the CRG these were focused on the research process itself and its resonance with consumers. The SRRM inquiry sought answers to the research question, “What happens at the Seclusion Review that makes a difference?” The Interview Schedule can be found in the appendix. (Appendix 1)

Following the consumers’ lead, staff members of the meeting were able to speak subjectively of their own experiences on the Ward. These stories enabled vulnerability, honesty, compassion and humanity to bring people together, joined in a common understanding that seclusion is a failure of care.

The research methods matched the intuitive process of the SRRM. Definitional Ceremony values relationships, respect, taking turns to ensure everyone’s voice is heard, keeping consumers’ lived experience at the centre, defining issues and themes as emergent outcomes. Collective Biography honours the community outcome agenda taken up by the SRRM.

The research document is a constructed research dialogue about the SRRM. It is drawn from collective research material positioned in such a way as to bring seclusion, and the ideas that underpin the practice of seclusion, to the fore as the very material that has informed the changing culture, personal and professional identities, and practices at the SRRM and the PSU.

The most significant factor was the inclusion of the consumer voice in the Meeting, allowing subjective stories of exclusion and emotional restraint that reflected seclusion practices on the acute ward to be part of the discussion. Following the consumers’ lead, staff members of the meeting were able to speak subjectively of their own experiences on the Ward. These stories enabled vulnerability, honesty, compassion and humanity to bring people together, joined in a common understanding that seclusion is a failure of care.

These stories appear in the research document (pages 42-62) within the themes of Consumer Voice, Diverse Shared Experiences, Inclusion and Exclusion, Inviting the Wardies, Othering and Mutuality, Relationships, Processes and Produce of SRRM, Contexts, Creativity, Practice / Reflective Practice / Reflexive Practice, Commitment, Contexts, Learning Community, The Journey, and Change.

Having reached the understanding that seclusion cannot be considered therapeutic, the meeting then searched for other means to care for people in acute distress. This gave rise to the Coping and Safety Tool, the Early Support and Intervention Team and staff training in Sensory Modulation, encouraging therapeutic relationships throughout the whole of nursing care.

Stories of these positive changes can be found between pages 50 and 70 of the research document, under the themes of The How-To in regard to Documents and Tools, Change, Trickle Down, Ripple Out, Ripple In, Produce / Outcomes.

Having reached the understanding that seclusion cannot be considered therapeutic, the meeting then searched for other means to care for people in acute distress.

It is not to be supposed that the cultural change achieved at the PSU happened easily and without obstacles. The research documents two years of work by the SRRM, during which time personal and professional identities were challenged. People’s stories of Challenges, Discomfort, Conflict, Benefit, Rewards, and Celebrations are told on pages 70-77.

Overall, research findings showed that the SRRM members considered consumer voice and the lived experience of both consumers and clinicians to be the central driver for cultural change in relation to seclusion reduction.

The meeting moved from allowing the consumer voice to privileging it, at the same time accepting affect and subjectivity into discussions. Much of what happened in the SRRM was based on negotiating changes of mind and heart.

The concept and practice of learning community, in which members were supported as they questioned the appropriateness of certain ways of working, enabled both personal and professional development. The role of challenge and discomfort was recognized as the precursor of cultural change.

The voices of consumers, clinicians and allied health workers, as heard in the stories collected by this research, are testimony to the value of including lived experience in professional discussions. Personal attitudes and attributes are not separate from professional identities. The SRRM gave permission for both consumers’ and other members’ lived experience to become part of the dialogue, leading to increased understanding and trust. As professional distance recedes, humanity and compassion comes to the fore.

At the day-to-day level of change and practice, the findings point to respect, relationship and awareness. Consumer/clinician collaboration is a key strategy for the implementation of any work related to systems change. All persons with a stake in the project need to be in attendance at the SRRM, and all voices need to be supported to equal value.

The research makes a clear case for the advancement of consumer led research as a means to understand the needs of mental health consumers in situations where the possibility of restrictive practices may be imminent. Continuing research would seek evidence in settings where collaboration, shared decision-making and the validation of struggle are central features.

FEATURED ARTICLE

Proposed changes to the Mental Health Act: what do they mean?

- Analysis by Isabell Collins, Director of the Victorian Mental Illness Awareness Council.

As many of you would know, Victoria has been undertaking a review of the Mental Health Act 1986. The review began under the Labor government and has continued under the Liberal Government. Recently the Mental Health Minister, the Hon. Mary Wooldridge, released a policy document entitled “A New Mental Health Act for Victoria - Summary of Proposed Reforms.”

While it needs to be stated that there is no guarantee about what the new Mental Health Act will look like when it finally becomes legislation, the policy document does demonstrate that the government has heard and responded positively to the many concerns of the consumer community about the flaws in the current Mental Health Act.

> *Put simply, the fact that the consumer may meet the criteria for involuntary treatment does not mean the person does not have the capacity to make decisions about his or her care and treatment.*

Basically, the policy document outlines the key reform objectives of the government under four main themes, namely:

- A recovery framework;
- Compulsory treatment orders;
- Safeguards; and
- Oversight and service improvement.

1. Recovery Oriented Framework

Under the Recovery Oriented Framework, legislation will provide for **supported decision making** which will include the presumption that **consumers have capacity** to make decisions about their treatment and care. ‘Capacity’ is a legal term, and in this instance, psychiatrists will be required to assess whether the consumer has the mental capacity to make decisions about his or her care and treatment. Put simply, the fact that the consumer may meet the criteria for involuntary treatment does not mean the person does not have the capacity to make decisions about his or her care and treatment. This is a positive change in that it should reduce the ability of clinicians to impose treatment and care on to a person against their will without good cause.

Consumers will also be able to **nominate a person** of their choice to provide assistance in regard to ensuring their views are taken into consideration and their rights are respected. The nominated person will also be able to receive information about care and treatment issues at key points of the interaction with mental health services.

Advance statements will also be introduced, enabling consumers to record their preferences for treatment and care in instances where they are so unwell that they require involuntary treatment and their metal capacity has been negatively affected.. The advance statements will allow consumers to document their “whole of life” needs while in hospital, including who is going to take care of the dog, pay the bills, etc.

It is the intention of the government to recognise that **carers and families** can play a significant role in the recovery of consumers and the new Mental Health Act will incorporate this role in the legislation.

The government has also agreed to provide funding for **advocacy and support** services to enable consumers to have someone independent of the service provide telephone assistance, advice and support as well as advocates who will be able to visit the mental health services and provide advocacy where consumers have concerns about the service they are receiving.

2. Compulsory Treatment Orders

While the current Mental Health Act 1986 provides for the least restrictive option for treatment and care, most consumers who have been made involuntary know that this does not work in practice. Therefore, the new proposals should go some way to restoring consumer confidence that involuntary treatment will only be used a last resort. For example, it is proposed that the framework for the new Mental Health Act is that voluntary treatment is the preferred option and if involuntary treatment is required it must be for a minimal period of time. In order to achieve this, the new legislation will encompass an Assessment Order, a 28-day Treatment Order and a Treatment order.

If a medical practitioner believes a consumer:

- **appears** to be mentally unwell;
- needs treatment to prevent serious harm to themselves or another person;
- is at risk of serious deterioration in regard to their physical or mental health; and
- there is no less restrictive option then an **Assessment Order** may be made.

An Assessment Order will last for 24 hours and can only be extended up to 72 hours under exceptional circumstances.

> *While the current Mental Health Act 1986 provides for the least restrictive option for treatment and care, most consumers who have been made involuntary know that this does not work in practice.*

The purpose of the Assessment Order is to provide the psychiatrist with an opportunity to make a clinical assessment of the consumer's mental state.

Following the assessment, if the psychiatrist decides that the consumer meets all of the criteria for compulsory treatment then he or she can make a 28-day **Treatment Order**. However, in order to do this, the consumer **must** have a mental illness as well as meet all of the other criteria outlined above.

The Mental Health **Tribunal** must review the Treatment Order to see if the consumer meets all of the criteria at the end of the **28 days.** If the Tribunal decides that the adult consumer does meet all of the criteria then they can make a 6 month Order for inpatient treatment or a 12 month Order for treatment in the community. If the consumer is less than 18 years of age then the Treatment Order can only be made for a 3 month period with options to extend for further 3 month periods. The authorised psychiatrist can vary the category of the order at any time if the person no longer meets the criteria for inpatient treatment, or alternatively the authorised psychiatrist can discharge the consumer from the Treatment Order if the criteria no longer apply.

3. Safeguards

It is the intent of the government to legislate to ensure there are safeguards to protect consumer rights. The safeguards will encompass new rules for conducting ETC and obtaining second psychiatric opinions, and a more active oversight of care and treatment with the introduction of a new Mental Health Tribunal. Tighter legislation will also be introduced in regard to the use of seclusion and restraint.

The new Mental Health Act will require that compulsory patients or anyone under the age of 18 cannot have **ECT** unless it has been approved by the Mental Health Tribunal, and only then if the person is determined to have capacity, and only if they give informed consent. In instances where the consumer does not have capacity the Mental Health Tribunal can only approve ECT if the procedure will benefit the person, giving consideration to the consumer's views and preferences along with a range of other factors not articulated in the policy document.

The Mental Health Review Board will be replaced with the **Mental Health Tribunal,** whose role will be expanded to include the requirement to assess whether a consumer meets all the criteria under the Mental Health Act to receive compulsory treatment. Put simply, the authorised psychiatrist can only authorise a Treatment Order for **28 days** and then it is up to a **3 person panel** of the Tribunal to assess whether the consumer meets all the criteria for a continuation of the Treatment Order. The 3 person panel will consist of a lawyer, a doctor (in most instances a psychiatrist) and a member of the community.

> *According to the policy document, the use of restrictive interventions such as physical restraint in addition to the current mechanical restraint and seclusion practices are to be regulated ...*

According to the policy document, the use of **restrictive interventions** such as physical restraint in addition to the current mechanical restraint and seclusion practices are to be **regulated** (laws to control their use) with increased accountability and oversight measures to ensure these restrictive practices are last resort measures.

Additionally, under the new Act, consumers (if the person meets criteria not articulated in the policy document) will be able to get a **second psychiatric opinion** from a private psychiatrist independent of the public mental health care system. While the consumer's treating psychiatrist is not required to change the course of treatment, they will be required to give consideration to the second opinion. The consumer will also be able to apply to the Chief Psychiatrist if dissatisfied with the authorised psychiatrist's lack of consideration of the second opinion. The Chief Psychiatrist will have the authority to direct the authorised psychiatrist to change the treatment strategy to that of the second opinion if they believe it is a better option for the consumer's treatment.

4. Oversight and Service Improvement

As many consumers would be aware, having a rights embedded in a Mental Health Act does not necessarily mean that your rights will be respected and protected. However, the new legislation will facilitate the establishment of a **Mental Health Complaints Commissioner**. The Commissioner will be provided with a range of powers including:

- Receiving, conciliating, investigating and resolving complaints regarding the public mental health sector;
- Investigating services and making recommendations;
- Issuing compliance notices for serious and flagrant breaches of legislation.

With the introduction of the new Act, the **Chief Psychiatrist** will no longer receive and investigate complaints. They will however:

- Provide clinical advice;
- Develop clinical guidelines;

- Deliver training and education;
- Analyse data;
- Undertake research;
- Publish reports;
- Monitor services;
- Conduct investigations; and
- Issue directions to the public mental health services.

> *... consumers who have accessed the public mental health care system know only too well that no matter what the legislation states, if the will of those in positions of decision making power is not about protecting consumer rights, then those rights will not be respected and protected.*

The role of **Community Visitors** will continue under the new legislation.

Codes of Practice will be developed to provide practical guidelines for all stakeholders regarding the new legislation. While the guidelines will not be legally enforceable, they will be able to be used to guide decision making by tribunals and courts to assist in the interpretation of the law and guide decision making.

Finally, the new legislation will allow for the **disclosure of health information** provided the consumer gives consent, or if it is needed for treatment purposes or to provide support or care and other reasons not yet articulated.

Summary

While the policy document does not provide prescriptive detail and there is no guarantee that all the proposals outlined in the document will make it through parliament (one hopes they will), there are some very positive projected changes. The introduction of Nominated Persons, Advance Statements, a Mental Health Complaints Commissioner, funding for independent advocates and limiting the time a consumer can be made involuntary without a review are all very positive. However, consumers who have accessed the public mental health care system know only too well that no matter what the legislation states, if the will of those in positions of decision making power is not about protecting consumer rights, then those rights will not be respected and protected. Nonetheless, the government does need to be congratulated for having heard the voice of consumers and others in the stakeholder consultations about the new Act; we need to wait to see what happens in everyday practice.

The Mental Health Act is SO IMPORTANT that we would love to hear more from our readers about these proposed changes. Do let us know if you have a particular interest, question or area of expertise! We want us all to be able to get our heads around this!

In the next edition, we will be including an article by Piers Gooding who is studying his PhD in the Centre for the Advancement of Law and Mental Health at Monash University. Piers will help explain what a capacity test actually means, what Australia's obligations are under international Human Rights laws … and other things too!

SOAP BOX

SINGING THE BIPOLAR BLUES: BOWELS COME FIRST!

By Ann Tullgren

My elderly surrogate mother is in a nursing home. On the whole it is a good establishment. She feels safe there. The staff is kind. No smell of stale urine, or worse, assaults my nose when I visit. In addition to numerous ailments that cause her much pain and distress, she also has bipolar. When I visited her recently I noticed that she wasn't firing on all cylinders and so I asked her if she was feeling down.

- Yes. Very.

- How long have you been feeling like this?

- About a week.

- Has the nurse given you the extra medication the doctor says you can have when things are bad?

- No.

- Do they know you're depressed?

- I don't think so?

At such times she really suffers with the malignant effluvium of bleakness, guilt and worthlessness. She thinks she has outlived her usefulness. This time she is experiencing bone-crushing tiredness and tells me that she wonders if she's finally dying. She asks if it is possible for someone to will herself into death. My mother is a former nun and these death-embracing thoughts heap further guilt onto her shoulders.

> *... you ask her about her bowels not expecting that she will become constipated or have diarrhoea. How can asking her about her mood cause her to become mentally ill?*

I seek out the nurse.

- You know how my mother has bipolar, well she's been feeling really down for a week and I wonder if you've given her the prescribed extra medication.

- I didn't know she has bipolar. I ask her every morning how she is and she says she's fine.

- You need to specifically ask her how her mood is. Perhaps when you ask about her bowels you could ask about her mood.

- I wouldn't do that. If I ask her if she's depressed she might imagine that she is; old people can be very suggestible.

- But you ask her about her bowels not expecting that she will become constipated or have diarrhoea. How can asking her about her mood cause her to become mentally ill?

It is usual for nurses everywhere to ask patients about their bowel habits each day. This often occurs when they greet the resident each day with a 'Good morning dear, how are we today?' to which the resident says 'Good thanks, how're you?' That's the way we Aussies usually greet each other, not, of course, expecting a detailed description of aches, pains and problems. That's why bowels require a specific question. Pain also merits attention. But mental illness appears to be a different kettle of fish.

I don’t want to blame individual nurses about the ways they support residents with mental health issues, but rather to question the appropriateness of staff training and the understanding of the organisations that run residential facilities and put in place policies, procedures and ‘care plans’. Equally, I want to question the silence of the mental health sector about the needs of consumers who age with a mental illness. Try searching the web sites of major mental health organisations for information about this. Currently, concern with dementia dominates this space.

This appears to be underpinned by an ageist assumption that [young people] are most amenable to treatment and that recovery is about social and economic participation in community life.

The consumer movement typically is young people’s territory as they champ at the bit held by older hands. This is not surprising as each generation has unique experiences of society and its institutions as they change, often radically. There is urgency about the concerns of the young. They have energy and commitment to drive social change. Mirroring this is the literature and professional practices surrounding the recovery paradigm that also seem to be concerned with youth and people of working age. This appears to be underpinned by an ageist assumption that they are most amenable to treatment and that recovery is about social and economic participation in community life.

If recovery is to become a robust paradigm underpinning treatment, intervention and hopes for a better future it needs to have salience – to be useful and applicable – across the lifespan. What does recovery mean for older consumers? How is it experienced by consumers with diseases of ageing where both symptoms of mental health disorders and medications cause/worsen those physical illnesses, specifically dental/oral disease, diabetes and vascular disease? As we become less agile and more home-bound and isolated, how do we live recovery? What role could mental health peer workers have in generic aged care community support services and aged care facilities? Or, does the recovery journey peter out by mid life? The gay, lesbian, transgender and intersex movement is developing both a research base and systemic advocacy to improve the experiences of their community as they age. The challenge is there for us.

What does recovery mean for older consumers? ... Or, does the recovery journey peter out by mid life?

* * *

‘The woods are lovely, dark and deep,
But I have promises to keep,
And miles to go before I sleep,
And miles to go before I sleep.’

Robert Frost

* * *

Mental Health in Australia: Collaborative Community Practice

Third edition, Eds. Graham Meadows, Margaret Grigg, John Farhall, Fiona McDermott, Ellie Fossey &Bruce Singh, Oxford University Press, 2012

–analysis by Merinda Epstein and Annd Olsen

The latest edition of this wide-ranging text book was recently published. From the beginning the consumer voice has proved difficult to nurture despite effort by consumers and editors. It is a huge volume labouring under the weight of a cast of a thousand separate authors: 82 to be exact.

Edition One: 2001

The first edition in 2001 included two consumer authors. Although there was intent on the part of the editors to include consumer perspective there was no mechanism for doing this with dignity. One consumer was on a pension and the other in a poorly remunerated job. What could be done to enable them to contribute? There is no tradition in health academia of paying people other than through commissioned work or royalties and the two consumers made it clear that that was inadequate. It was during the process of writing that the consumers needed income not royalties in the never-never.

The first edition in 2001 included two consumer authors. Although there was intent on the part of the editors to include consumer perspective there was no mechanism for doing this with dignity.

A deal was struck. Well salaried contributors agreed that they would take part in a scheme that would enable the non- and low-salaried consumers to write. A loan would be sourced from the University to pay the consumer contributors to be repaid with royalties that would be forgone by writers who were on middle to high salaries. Unfortunately, all these careful negotiations came unstuck when many contributors claimed that the actual writing took place during their 'own' time in the evenings and on weekends and therefore they declared themselves to be unwaged at the point of writing. On the basis of this the royalty agreement idea teetered and collapsed.

The Consumer Context: Edition Three

With the publication of the third edition, it is interesting to observe how things have changed. All but one of the consumer contributors are in full-time or significant part-time employment. Consumers are engaged in jobs that enable them, as consumers, to work on chapters in the text as part of their work. This is not to say that our pay is anything like that paid to many of the clinicians and academics but it is a start.

As in so many situations, the consumer voice in this text is described as central when in fact it is not. The consumer perspective constitutes a minority speaking position and the number of contributing consumer writers is tiny compared to the clinical and academic speaking positions. It is also interesting to note that several of the sub-headings use the term, 'Consumer-Perspective'; however, other perspectives are not flagged as Academic-Perspective, Psychologist-Perspective, GP-Perspective and so on. This is important because, for the reader, the other perspectives are positioned not as perspectives at all but as knowledge.

What is a textbook?

Textbooks, on the whole, are written by experts for the consumption of those would themselves become experts. Undergraduate and post graduate students constitute a great percentage of the target audience for this book. Textbooks are also often big, as is this one at 897 pages. They provide material divided up into discreet chapters, under different areas of interest and are punctuated by mechanisms designed to attract the interest of the desired readership. As a text, this book makes a gallant attempt to include consumer input; however, there are a few issues here worthy of reflection.

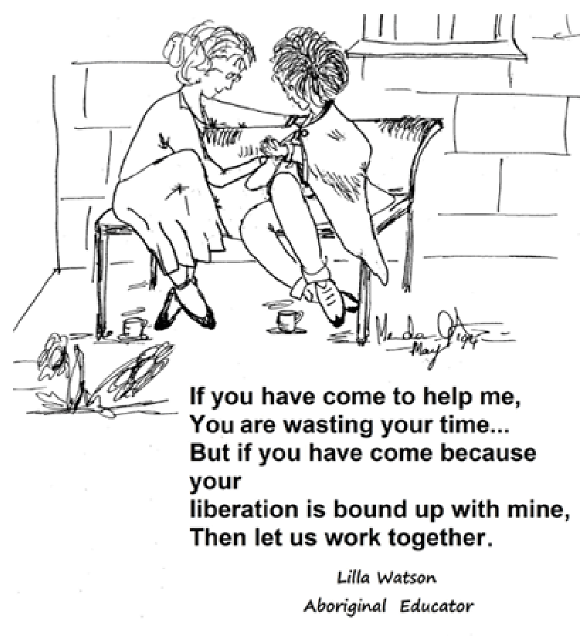
Firstly, textbooks are rarely read from cover to cover. They are cherry-picked by students: often as directed by university lecturers. Tertiary students quickly become attuned to what information is essential to their course in terms of either graduation or high marks. Unfortunately, unless identified by academic staff, the consumer discourse is not of immediate interest to those we most wish to influence. It is probable that many students will navigate through this text without reading very much at all written by consumer contributors. It is also probable that many of these students will come from the disciplines of psychiatry and psychology – the two disciplines in mental health that are yet to embrace the value and importance of the consumer word. Indeed, many have never heard a consumer speak, other than perhaps through personal narrative, and might be astonished by the mere term 'consumer', let alone the fact that 'their patients' and 'their clients' might want to be part of decision making with respect to their own care and in the sector more broadly.

How to Get the Sector to take the consumer voice seriously

Unfortunately, creating a place for consumer expertise in a text book is not enough, although it is something. Because of the way texts are used, two things are imperative:

1. consumer writing should be neither valorised nor neglected. It constitutes knowledge just like any other expertise in the text and students need direction in order to approach it with the tools of critique as well as with questions for further exploration facilitated by consumer expert educators;
2. consumer content must be included in courses across all disciplines as material that is part of the examination cycle and further reading must be made available for students who are encouraged to learn more from a consumer perspective.

Locating the consumer voice at the beginning of the text will do little to change prejudicial values held by clinicians unless specific emphasis is placed on this material by those who determine a pass or failure at the end of the year. Secondly, there is a tension around social status. Many students from privileged family backgrounds make their way into mental health particularly within the powerful clinical groups such as medicine and clinical psychology. A background of privilege often brings a sense of social responsiveness which defines 'responsibility' as an act of being a benefactor to 'the poor others'. If this is a student's world view, she or he may not understand that it is important to challenge this assumption. Such a view could mean that students feel threatened by anything characterising consumers as other than needy recipients of 'care'. To its credit, this text endeavours to challenge such perspectives.



Consumers and the text

It is important that active consumers read the parts of the text that have been written by consumers. It is sometimes very useful to use a quote or an argument from a text book. It shouldn't be this way but even if we know something by virtue of our 'lived experience' reference to a text book can give it an authority we could not give it on our own.

Critique

The inherent problem for a text with so many authors is that despite the best efforts of editors the different discourses will clash and clang with one another. There are hierarchies amongst the different clinical groups and some kinds of knowledge have ascendency over others. Many different aspects of clinical practice are captured by this very large volume. Compared to the first edition, the 2012 edition carries more consumer voices and a greater range of consumer interests. However, we are still a minority voice and not only small in volume but also the smallest in terms of social power and influence.It is, nonetheless, a bit more than we got last time and that was a bit more than we got the time before. There are changes that were not made despite our attempts. We are hoping these changes will be given an opportunity to influence the next edition if there is one. In the piece on Borderline Personality Disorder, Anne Olsen, a consumer, and her son Sven, also a consumer, have offered readers and potential writers a model for enhancing personal stories by presenting real people using their real names instead of vignettes in which the use of just first names continues to infantilise and disempower us. Case studies and vignettes are a clear target for the consumer assault if there is a fourth edition in a few years time.

> *... we are still a minority voice and not only small in volume but also the smallest in terms of social power and influence.*

Consumer Contributions

Glancing through the contents is a bit disheartening. The consumer input is tiny compared with the sheer numbers of 'other' contributors. In the next edition it is imperative that the consumer voice is heard in each of the chapters which identify and describe a particular set of 'clinical' experiences. For example, the writing about Bipolar Affective Disorder. This must include both a consumer-as-expert position and a self-written consumer-as-story position. These are discussions that **will** attract students and examiners including those we particularly want to influence in the disciplines of medicine and clinical psychology.

Structural Limitations to Consumer Authorship

There are other parts of the textbook which are reduced in sophistication because of a continuing lack of consumer input. However, there is a major structural problem here. We have one consumer academic in Victoria as compared to over a thousand academics teaching discipline specific courses. Consumers employed in other roles are generally underpaid and under-respected part time employees with hardly any time to breathe let alone write text books. The consumer voice is amongst other things controlled by the capacity of the system to increase the appropriate consumer workforce.

What's in the text from consumers?

The following (self-identified) consumers have contributed to this text book: Wanda Bennetts, Merinda Epstein, Flick Grey, Sandy Jeffs, Jon Kroschel, Irene Oliver, Anne Olsen, Sven Olsen, Cath Roper & Sandy Watson. Some of us collaborated with each other, others collaborated with clinicians and/or academics and others wrote separately and our pieces were threaded into the text by editors.

CONSUMER AUTHORS: *MENTAL HEALTH IN AUSTRALIA* 3rd edition (2012)

PART ONE: CONTEXT

Chapter One: Society, mental health and illness

- Mental Health Consumer Movement: Merinda Epstein and Anne Olsen, pages 7-8
- A Consumer Perspective on Mental Illness; Merinda Epstein and Anne Olsen, pp.12-13

Chapter Two: How Communities respond to mental distress: a consumer perspective

- How Communities Respond To Mental Distress**:** Merinda Epstein and Anne Olsen, pp. 12-30
- Community Awareness Campaigns: Flick Grey, p.23

Chapter Seven research in mental disorders and mental health practice

- Consumer Perspective Research: Flick Grey, pp.197-198
- Definitions of consumer and carer participation: written by people why identify as carers, p.234

Chapter Eight: Evaluation and the concept of quality in mental health practice

- Understanding and Involvement: Yoland Wadsworth [While Yoland Wadsworth doesn't identify as a consumer, the Understanding and Involvement project was a significant piece of consumer-perspective research], pp.213-214
- Consumer Driven Quality Improvement (QI): Jon Kroschel, pp.231-234

PART TWO: CLINICAL PRACTICE PRINCIPLES

Chapter Ten: The Active Participants in Mental Health

- The Consumer of Mental Health Services: Merinda Epstein and Anne Olsen, pp.279-281
- Two Hats: a cautionary tale: Irene Oliver, p.318

Chapter Eleven: Working Collaboratively

- Working Collaboratively with consumers as consultants, advisors and educators: Wanda Bennetts (with Ellie Fossey), pp.321-323

Chapter Twelve: Assessment: Essential Skills

- What consumers understand about assessment: by Anne Olsen and Merinda Epstein, pp.345-347

Chapter Fourteen: Case Management

- Consumer-Directed Recovery and Case Management: Sandy Watson (with Kath Thorburn), pp.432-434

Chapter Seventeen: Reporting recovery and Living Well

- Consumers in Control: Consumer-developed initiatives, consumer-developed recovery tools, self help and peer support: Flick Grey, pp.519-524

PART THREE: DISORDERS CONSIDERED IN THE CONTEXT OF THE LIFESPAN

Chapter Eighteen: Personality Disorders

- A poem: Flick Grey, p.531
- Our Experiences… Are you listening: Anne and Sven Olsen, pp.542-543

Chapter Twenty-eight: Schizophrenia

- The Experience of Schizophrenia: Sandy Jeffs, pp.751-752.

NEWS IN THE CONSUMER WORLD:

The Victorian Association of Mental Health Peer Specialists (AMHPS Vic)

A group of peer workers in the mental health sector have been meeting over the past few years for mutual support and reflection on their work. This forum has provided the context out of which has grown an increasing commitment to the formation of a professional association for people with a lived experience of mental ill health and recovery who declare that as part of their employment.

The group is now incorporated as the Victorian Association of Mental Health Peer Specialists – AMHPS Vic. The current aims of the Association are to provide a networking opportunity for Victorian mental health peer specialists, to be the peak body that represents Victorian mental health peer specialists and to provide a forum for reflective practice for Victorian mental health peer specialists.

The Association holds networking meetings once a month on either a Monday or Friday between 10:30am-12:30pm. The network meetings are an opportunity to discuss topics of special interest, raise issues, exchange ideas, learn and share from each other and conduct group reflective exercises.

We invite peer workers and consumer consultants who are interested in forwarding the agenda of a professional organisation for their mutual benefit to contact us by email at the following address: vmhpeers@gmail.com and one of the members of the network will then contact you to provide you with details of the meeting times and dates.

Information session on the new Mental Health Act

The Department of Health is pleased to invite you to attend an information session on the new mental health legislation. The session will provide information on the intended policy directions for the new legislation, including to promote recovery-oriented practice, minimise the duration of compulsory treatment, safeguard the rights and dignity of people with mental illness and enhance oversight while encouraging innovation and service improvement.

Date and time: Wednesday 21 November 2012, 1:30pm - 3:00pm
Venue: Department of Health, 50 Lonsdale Street, Melbourne, Room 1.01

If you wish to attend, please RSVP your name to Keir.Saltmarsh@health.vic.gov.au at the Department of Health by Monday 19 November 2012.

Consumers spreading the thinking behind our work

Louise Byrne (a QLD-based consumer academic) recently published a journal article called ‘‘Things you can’t learn from books’: Teaching recovery from a lived experience perspective’, co-authored by Louise, with Brenda Happell, Tony Welch and Lorna Jane Moxham, and published in the *International Journal of Mental Health Nursing* (2012). It’s exciting to see some of our thinking getting into the academic literature. Also, check out this interview that Louise did recently on ABC radio about what lived experience work is about – she articulates it so well!: http://blogs.abc.net.au/queensland/2012/10/louise-byrne-uses-lived-experience-to-teach-mental-health.html.

Flick Grey (team member at Our Consumer Place) was involved in a conversation on ABC Radio National, on coercive treatment in mental health. The interview is available here: http://www.abc.net.au/radionational/programs/lifematters/mental-health-laws3a-the-pros-and-cons-of-coercive-treatment/4363612

New publication on consumer participation in health

The Victorian government have recently put out a new publication on consumer participation in health. Check it out here: www.audit.vic.gov.au/publications/20121010-Consumer-Health/20121010-Consumer-Health.pdf).

Consumer educator position at Southern Health

A Part-time position has been created for a consumer educator at Southern health:

“Imagine the satisfaction of contributing to improving quality of life, building understanding of consumers whilst opening access to the consumer perspective across the Mental Health Program. Draw on your commitment to assist our workforce to manage and develop their capacity for working with consumers in today's Mental Health context. With a key responsibility of education you will also assist with promoting Mental Health Week. Supporting the creation of a welcoming environment for our consumers, you will coach our people to provide the respect and support required. This role has been developed in response to growing need for the inclusion of the consumer perspective in Education, Training and orientation activities. It will provide an avenue for the consumer perspective to be embedded across the Mental Health Program as a conduit for culture change. ...”

Closing date for applications is 19th November 2012. For more information, go to: https://southernhealth.mercury.com.au/ViewPosition.aspx?Id=10120&k=Educator&E=3&C=16&J=0&P=0&I=0#.UJpDtahhV0s.mailto

Legal, Community & Psychiatrist Members

Applications are invited for appointment of sessional members to the Mental Health Review Board. Closing date is 5.00pm, Friday 30 November.

The Mental Health Review Board is an independent tribunal established under the *Mental Health Act 1986.* The Board conducts reviews and hears appeals from involuntary and security patients under the Act. Hearings are held at approved mental health services and are conducted in an informal manner.

- **Legal members** must be Barristers and Solicitors of the Supreme Court of Victoria (or equivalent) of not less than 5 years standing.
- **Psychiatrist members** must be Fellows of the Royal Australian and New Zealand College of Psychiatrists or equivalent.
- **Community members** are appointed to represent the views and opinions of members of the community.

Members will be appointed by the Governor in Council from 10 June 2013 for a period of up to five years. Members may be paid sitting fees as determined by the Governor in Council. Existing members are eligible for re-appointment. An information kit and application form are available at the Board’s website: www.mhrb.vic.gov.au.

Feedback from a reader:

I would like to comment on the statement below you made in the October Consumer Place Issue.

> *3. THUMBS DOWN: to consumers on the Speaking Circuit who have turned themselves into a commodity, or who tell their stories in educational contexts for their own therapy.*

I found this statement unfair to those Consumers who work very hard and are dedicated Educators.

During 2011 I was trained as a Speaker where I talk about my lived experience with Bipolar using Biopsychosocial Model which includes my experience of dealing with Bipolar from my youth to today.

What I like best about this role is speaking to different groups, and getting the message across in a positive way.

I do not feel that the word 'commodity' is used correctly. I am a big fan of Education and always wanted to pass on my knowledge to others and that is what I feel my role is as Speakers Bureau Educator. For me the position is very rewarding not really 'therapy based' more self esteem based for me. The best part is when the audience asks questions and I have the opportunity to answer with my own words. I have even had individuals speak to me afterwards and praise the work I do, this to me validates that what I do as a Speaker/Educator.

Kind Regards,
Maria Dimopoulos, Mental Illness Fellowship Speakers Bureau [email printed with permission]

Ed: let's keep this conversation alive! We think these are interesting, complicated issues ...

THUMBS UP/THUMBS DOWN

1. THUMBS UP: to the amazing diversity of peer work and the showcasing and sharing of this work through the Centre for Excellence in Peer Support – we're all stronger when we network!
2. THUMBS DOWN: to services that are deeply embedded in a "them-and-us" (or, as Martin Buber would say, "I-it") way of looking at the world, as if workers and service users are fundamentally different.
3. THUMBS UP: to all those programs working hard to remain entirely free to participants, and valuing an abundance of time and community, so natural relationships can grow.
4. THUMBS UP: to workers who attend consumer-run educational sessions and who change their practice as a result (and then tell us 10 years later how influential the session was ...!)
5. THUMBS UP: to mental health workers (peer or non-peer) who are genuinely committed to power sharing (mutuality)!
6. THUMBS DOWN: to organisations who think it is ok to pay young peer support workers $30 for 2 hours of peer support work and to frame this as "reimbursement". This is deeply disrespectful of the value and skilfulness of peer support work (and the peer workforce)!!
7. THUMBS DOWN: to peer participation that is framed as "improving mental health literacy and promoting help seeking behaviours" like being allowed to choose the colour of pamphlets that someone else writes. We are capable of so much more!
8. THUMBS UP: to those non-consumer champions in our workplaces who do truly appreciate our work and who fight for us to have space and resources to do our work.
9. THUMBS DOWN: to the confusion around "supervision" of consumer/peer workers – we need spaces to reflect on our practice, spaces that aren't complicated by performance management relationships. But perhaps "supervision" is a hierarchical, clinically-owned term anyway ... how about "co-supervision" like in Intentional Peer Support or "consumervision" or "intervision" (which apparently the Dutch use) ...
10. THUMBS UP: to people who take the time, energy and thought to engage in dialogue.

VMIAC'S
CONSUMER WORKFORCE EDUCATION AND MUTUAL SUPPORT DAY

MEET INDIGO DAYA
"Voices Vic."

Wed 14 November 2012

11 am-3 pm Wednesday 14 Nov 2012

Guest Speaker:

Indigo Daya : Program Manager For Voices Vic. Prahran Mission.

Indigo Daya is the project manager of Voices Vic. Indigo has her own business as an independent speaker and trainer in consumer-oriented mental health practice, and delivers accredited and non-accredited courses. She will discuss her current work with Voices Vic.

AGENDA:
11:00 to 12:00 Indigo Daya.

Indigo Daya will discuss her current work with Voices Vic. Indigo has extensive experience within mental health as a facilitator, keyworker, arts program coordinator, peer worker, activist and manager. She is also a qualified trainer, and has spoken at conferences across Australia and overseas. Indigo also has almost 9 years of experience in the corporate sector in project management, human resources and marketing.

(This session is open to the entire consumer workforce, consumers, & consumers who are looking at joining the consumer workforce)

12:00 to 13:00 Lunch …..All Welcome.

13:00 to 15:00 Peer Support.
(This afternoon's session is open to Consumer Workers ONLY)
Please RSVP (for catering purposes) to 03 9380 3900 or email to: info@vmiac.org.au

WWW.VMIAC.ORG.AU

VMIAC Bldg 1, 22 Aintree Street, Brunswick East Tel 03 9380 3900 Fax 03 9388 1445

Free Introductory Day

Melbourne, Wednesday 12 December 2012

The PeerZone developers (Mary O'Hagan and Sara McCook Weir) are holding an introductory day for service providers and peers who are interested in providing or participating in PeerZone workshops. We will tell you all about PeerZone, give you an opportunity to sample what's in the workshops, and talk about how you might want to get involved.

Venue: VMIAC, Building 1, 22 Aintree Street, Brunswick East, 3057.
Times: 9.30 am to 4.30 pm on Wed 12 December.
Inquiries and RSVP: info@peerzone.info by Wed 5 December.

Visit our website www.peerzone.info to find out about PeerZone.

PeerZone thanks all the organizations that are sponsoring this event.