Royal Commission into
Victoria's Mental Health System

# WITNESS STATEMENT OF JULIE ANDERSON

I, Julie Anderson, Senior Consumer Advisor in the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist in Victoria, of 50 Lonsdale Street Melbourne in the State of Victoria, say as follows:

1    I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2    I am giving evidence to the Royal Commission in my personal capacity and not on behalf of any employer or organisation. I give this statement from both my personal experience and my knowledge of the mental health system. I have married my knowledge of the mental health system with my personal experience to say what I feel has worked for me and what I feel will work for other people.

## Professional Background

3    I am currently the Senior Consumer Advisor in the Office of the Chief Mental Health Nurse and the Office of the Chief Psychiatrist in Victoria. The responsibilities of this role include to:

(a)    attend, participate and advise from a consumer perspective at Statutory Committees on Electroconvulsive Therapy **(ECT),** restrictive interventions, mortality and morbidity;

(b)    attend, participate and advise at project meetings of the office;

(c)    attend, participate and advise at senior nurses' forums;

(d)    conduct service visits to ensure quality and safety of services and advise on recommended changes;

(e)    conduct ECT audits and advise on outcomes;

(f)    lead human rights projects to support the Chief Psychiatrist to take up his statutory role to support the human rights of people with mental Illness;

(g)    provide expert and authoritative advice, reasoned recommendations and innovative program options and solutions to complex and sensitive issues;

(h)    ensure operational and practice initiatives meet the strategic directions for managing and delivering high-quality clinical services;

(i)      formulate compliance and evaluation strategies to address specific issues related to the effective provision and implementation of required outcomes;

(j)      undertake high-level research and investigations into service delivery issues, risks and trends impacting on achieving key business objectives, policy initiatives and operational imperatives; and

(k)      monitor and analyse the implementation and delivery of practical and policy initiatives.

4      I am also a member of the Mental Health Australia National Register of consumer advocates and was on the Board of Directors for Forensicare from November 2013 to November 2019.

5      I have lived experience of recovery and lived experience expertise in working in clinical and Mental Health Community Support Services around recovery systems and participation.

6      Between November 2016 and May 2017, I was the Executive Officer of the Women's Mental Health Network Victoria. Between October 2013 and November 2016, I was the Manager of Consumer Participation Strategy at Neami National (**Neami**).

7      Between 2000-2011, I was the President of the Board of Directors of Neami National and Vice President from 2011-2013.

8      In 2015, I sat on the expert reference group for the Federal Government's response to the National Mental Health Commission's review of mental health services and on the writers' group for the Fifth National Mental Health Plan.

9      I have completed the National Mental Health Commission's Future Leaders in Mental Health Program and the Australian Company Directors Course.

Attached to this statement and marked 'JA-1 is a copy of my current curriculum vitae.

**Lived experience**

10      I was what is called a 'revolving door consumer.' I was in and out of hospital. I had various diagnoses, but over the long term my diagnosis was schizoaffective disorder.

11      During the time that I was a 'revolving door consumer' I had two young children. The hospital had told my ex-husband that I was non-compliant with medication. He said he was going to sue me for custody of the children. I went to the Mental Health Legal Centre (**MHLC**) and they suggested to me that my ex-husband would win custody of the children because of my mental health issues. I decided that a judge wasn't going to tell me when and where I could see my children.

12      With MHLC's advice, I turned custody over to my ex-husband under certain agreed conditions, including being able to see my children every school holiday. He lived inter-state and would send my children down to me in Melbourne. I was able to include in my conditions of custody that my children were to go to private schools that my ex-husband could afford, have private health insurance and do after school activities, and things like that. While this was an extremely hard time for me, in the long run, it was the best thing for my family.

13      One day, my mother went to a citizens' advice bureau and got the name of the community mental health organisation, Neami. She said to me, "Ring these people. They may be able to help you because we can't."

14      I rang Neami at about six o'clock at night thinking nobody would answer. But, the manager did answer and asked, "What's going on with you?" That was the first time someone had asked what was going on with me without talking about my case, my diagnosis or my medication.  Because of that, I decided to engage in psychosocial rehabilitation support from Neami and they supported me on a recovery journey.

15      Neami gave me support from a recovery-oriented view. It wasn't just about providing services, like house cleaning or shopping, but actually working to my strengths and empowering me to take charge of my life. I had problems with budgeting and the community support worker suggested how I could do my budget. We sat down and did our budgets together. She did her budget while I did mine and we had a discussion about it. I think being personal when supporting people on their recovery journey makes a lot of difference.

16      I later started to volunteer with Neami and I started to tell them things that they should be doing differently. Eventually, they said that they had a position on their committee of management that they wanted me to join. I was there for two years and they made me President of Neami and I held that position for 11 years.

PANEL QUESTIONS

DESIGNING A GRADUATED SYSTEM OF MENTAL HEALTH AND SERVICES AND SUPPORTS FOR DIFFERENT LEVELS OF NEED

Question 1: What is needed to support people to self-manage their mental illness (where appropriate) in the community?

17      The first thing that people need to self-manage their mental illness in the community is a home. They also need:

(a)      an income stream;

(b)     contact with a community support worker who can provide psychosocial support. This is not just psychosocial services, but psychosocial rehabilitation support. The support has to work with a recovery framework, such as CHIME, which stands for Connectedness, Hope and optimism, Identity, Meaning and Empowerment. It works from a strength-based framework.

(c)     ongoing contact with a peer support worker who can support physical health initiatives, as well as mental health;

(d)     a nominated person and if they don't have a nominated person in their life, then people should be allocated a mental health advocate;

(e)     an ongoing relationship with a General Practitioner **(GP)**; and

(f)     an ongoing relationship with a psychiatrist.

18      It is the quality of the relationships mentioned in paragraphs 17(b) to 17(f) that makes the difference.

### Question 2: What is needed to make specialist mental health expertise available to general practitioners and other service providers?

19      In order to make specialist mental health expertise available to general practitioners and service providers, community mental health nurses and peer support workers need to be attached to both GP clinics and community organisations. There should also be a pool of clinical advisors and peer support workers who can advise GPs and community organisations. For example, when a clinical adviser is attached to the Office of the Chief Psychiatrist. The same model could be transferred in a GP practice. This works well because GPs would then be able to contact an outside source for information. It gives GPs a point of information that is otherwise missing. However, obviously to make this available and accessible to GPs would require resourcing.

### Question 3: The Commission's Interim Report defines community-based clinical mental health services as 'services that are made available to people outside hospital settings—often in their own homes, in community facilities or by phone'. These include specialist mental health services and psychosocial supports.

(a)     Considering a future mental health system (10 years into the future), what types of care, treatment and support should most appropriately occur:

i.      in hospitals?

20      I don't believe mental health should be treated in hospital settings at all. More thought should be given around the care type and not just containment. This is important

because containment is based on restricting and containing. A person's care is around discussing what a person's needs and strengths are from a caring, healing and compassionate perspective. In my view, the only time hospital treatment is appropriate is when a person's physical health is compromised.

### ii.     in the community?

21      My view is that, instead of a hospital environment, there should be more homelike environments for people with mental health issues, such as Prevention and Recovery Care Services **(PARCs)** that enable people to step-up or step-down with the amount of support they need.

22      There should be a special sensory area within those homelike environments. A sensory area is where there are tools to engage the senses. This has been important to me as it has redirected my emotional turmoil into being in touch with my senses and created a more calming feeling.

23      Importantly, these homelike environments should be staffed by multidisciplinary teams, including peer workers. It is important to tap into a multidisciplinary team to access professionals in psychology, social work and occupational therapy, so the varying needs of a person can be addressed. Peer workers are essential to recovery as they support empowerment and assist in changing a person's worldview by utilising their own experiences. They are able to do this because they understand the thoughts and feelings around being diagnosed with a mental illness.

## STREAMING

*Question 4: Considering how the mental health system might be designed around streams of care for people with different types needs and characteristics:*

*(a)     Should there be different streams of care (e.g. for age, severity, diagnostic group, stage of care, gender)?*

*i)      If so, along what criteria and why?*

24      My view is that there should be holistic care for the person through different streams of care around gender and youth. There should be age appropriate services for youth and young people, for adults and aged people. There should also be services that meet the needs of gender diversity. There should be diversity in how we offer to care for people such as peer support services and peer run services.

25      The stage of care should be determined and offered, no matter what the environment is. The environment is secondary to the care type the person needs. People should get the care they need, and the stage of care they need, regardless of the environment they are

in. For example, a person needing mental health intensive care should get that care whether they are at home, in a residential service or in a hospital.

26      At every stage of care, multidisciplinary teams need to be available to people to meet a person's needs in order to provide a holistic service offering. Everybody should have access to multidisciplinary teams that follow them wherever they are in the system. The multidisciplinary teams should have small caseloads, so the care plan is more personalised. The decision regarding a person's care should be based on a person's needs, and a result of a discussion between the consumer, the nominated person or carer and the clinician. The discussion of appropriate care should reflect what the consumer says their needs are.

**b)      What are the alternatives to streaming (e.g. individualised packages)?**

27      I think individualised packages should be built around the needs of the person, not about what resources or money is available. An individualised package should also be supported by a care plan. The disadvantages of streaming are that the service controls the resources and mental health often is not as resourced as it should be. Alternatively, with individualised packages people are empowered with choice and control of care and resources.

**(c)      What are the strengths and weaknesses of these alternatives?**

28      The strength of individualised packages is that they are targeted to the needs of the person, which makes them more effective in delivering care, and gives the person more choice and control. The weakness of individualised packages is that people other than the consumer can determine whether a person needs what they request in a package and whether they should receive it.

## CATCHMENTS

**Question 5: Should mental health services in Victoria continue to be delivered on a geographic catchment basis?**

**(a)      What are the advantages and disadvantages of catchments?**

29      My overall vision is that catchments should be smaller. They should be local government based. By having smaller catchment areas, the local community can have a say in how to support people with their needs, and design community supports appropriately.

30      Multidisciplinary teams should support the person within their catchment, and work with the person towards their needs, as self-identified by the person. Specialty services – for example the HOPE Support Services, Children of Parents with Mental Illness and the

Safewards Service – should be available to all, no matter which catchment a person is in.

31      Specialty services being open to all would be one advantage of smaller local government area catchments. Another advantage would be a more personalised service - the large catchment size makes services more institutionalised, meaning, a person has to fit in to the service system instead of the service wrapping around a person.

32      As a personal example, when I was acutely ill and I wanted some information for my children to understand what I was going through, I had to make my children consumers of services in order to get them information. Whereas if I had lived in a different catchment, my children could have accessed the Family and Parents with a Mental Illness program **(FAPMI).** But, that was not possible because FAPMI wasn't in my catchment.

*(b)      Could these advantages be achieved through alternatives to catchments?*

33      My view is that the advantages of catchments could not be achieved through any alternatives to catchments, but, there should be smaller catchments as discussed at paragraph 29.

*(c)      What are the risks of abolishing catchments for mental health services?*

34      The risk of abolishing catchments is that it may become unclear who is responsible for taking clinical governance for the care of the person and meeting their needs.

*Question 6: If catchments are to remain an element of the mental health system, how should they be configured?*

*(a)      What are the risks and benefits associated with larger regional catchments such as the Primary Health Network (PHN) catchments?*

35      In my view, the benefits of larger regional catchments are resourcing benefits, such as access to worker wellbeing and education programs, a medical hospital when needed and resourcing for new programs and initiatives. I do not think there are benefits to people; it is too complicated for people. A more personalised service is much more conducive to recovery. The risk of larger catchments is that the services become dehumanised.

*(b)*      *What are the risks and benefits associated with only using catchments for planning and resources allocation (i.e. similar to the broader health system), rather than for determining consumer eligibility for services?*

36       The risk with only using large catchments for planning is that the services may not be tailored and relevant to an individual's needs and the community's needs. Co-production should be used in all planning. The benefits of resourcing through larger catchments is that there would be the capacity to attract large workforces, have workforce support programs and policies and procedures would not need to be duplicated.

*SERVICE PROVIDERS AND DELIVERY MODELS*

*Question 7: In service 'hubs' a range of services are co-located in the same geographical area. What are the strengths and limitations of service 'hubs'?*

37       The strength of a service hub is that you only have to attend one place. The limitation is that it can become what I term a 'psychopolis', which can be stigmatising. By 'psychopolis,' I mean when all mental health services are in one place. It can be stigmatising as people will have to attend a place known for people with challenges to their mental health.

38       My view is that services should surround the person, rather than the person attend the hub. I think it is better that social services are accessed by people in the community as anyone else would access those services in the community, because of the importance of community ownership and accountability. "Community accountability" means that just because we have a mental health issue, it doesn't mean that we should be excluded from the community. We should be able to access generic services as a citizen of the community. It may be more difficult at times but that is where people from a multi-disciplinary team (depending on your needs), as well as family and friends, come in to support empowerment so you can be part of the community.

39       However, if there was a hub, there should be services other than mental health services within that hub. For example, it would need to be a hub for all people who need assistance with employment or financial counselling.

40       Stable housing is essential to establishing community relationships. Staying connected is a principle of recovery, therefore, a person may get what they need from a community hub while maintaining a local community connection through volunteering with the local council, being connected with neighbours, local gyms and sporting clubs.

41       From my personal experience as a consumer, what helped me with housing was a community housing cooperative. I sourced housing through a community housing

cooperative and that was extremely successful. It allowed me to keep my rent at a level in line with my income and also allowed me to do volunteer work. My rent only increased later when I had paid work. This eventually supported me to move out of that community housing into my own housing. This experience was an example of community accountability as this co-operative was not specific to people with mental health issues. I accessed a generic service as a member of the community and with the right support, I was empowered to be part of the community.

## Question 8: How should services within the mental health system be coordinated?

### (a) To what extent should consumer choice determine the nature and volume of care received?

42    Consumer choice is essential, but I think that when people suffer mental health issues, they are disempowered. This makes it hard to make those choices. Therefore, support that is centred around consumer choice, from a nominated person or an advocate about making those choices, is vital. Clinicians often argue that people don't have capacity, but I have never met a person who has not been able to say what they want or need, even when they have mental health issues.

43    A supported decision-making environment is important. For example, when I wanted to refuse treatment, it was an honest conversation with me saying, "these are the alternatives and this is what my family thinks." A supported decision-making environment helped me make a decision. While I wasn't happy with the choice I had, I was still able to make the decision with all the information presented to me.

### (b) What are the merits and challenges of a 'single care plan' approach to coordinating services?

44    I think a single care plan is a good idea. But, I think there should be provisions in legislation that the care plan is reviewed with the person and their nominated person regularly and reviewed by an outside team regularly so that there are fresh eyes looking at the single care plan. In such a system, the outside team would make sure that the consumer views have been incorporated and give suggestions of more up to date treatments relevant to the persons choices and wishes, that are recovery focussed and informed by all the principles of person driven mental health options. This is needed because one of the challenges with single care plans is that the same plan is 'cut and pasted' or repeated time after time without any thought given to support a person's recovery or assisting a person to form a new world view.

*INDIVIDUAL QUESTIONS*

*LIVED EXPERIENCE ENGAGEMENT AND CO-DESIGN*

***Mechanisms that ensure people with lived experience have a meaningful and enduring voice in decision-making at all levels of system design and service delivery***

45      In my view, there are many levels of participation.

46      *"Co-production: Putting principles into practice in mental health contexts"* by Cath Roper, Emma Cadogen and Flick Grey[1] outlines the spectrum of consumer participation through "Arstein's ladder (1969) – degrees of citizen participation.[2]" The various levels on the ladder are:

(a)      Non-participation: Manipulation (level 1) and therapy (level 2)

(b)      Tokenism: Informing (level 3), consultation (level 4) and placation (level 5)

(c)      Citizen Control: Partnership (level 6), delegation (level 7) and citizen control (level 8)

47      Roper, Cadogen and Grey put forward the view that co-production sits within partnership (level 6) or delegation (level 7) of Arnstein's ladder. I would agree with this view.

48      The Mental Health and Drugs Branch have also developed a lived experience engagement framework that outlines the International Association for Public Participation **(IAP2)** spectrum of participation and how to engage with consumer and carers. Engaging with peak bodies such as VMIAC and Tandem is a way of engaging with their membership. The use of social media in engagement is underutilised as a mechanism to ensure people with lived experience have a meaningful and enduring voice at all levels of system design and delivery.

49      A way to think of engagement in the design of services is to take an example of the National Health Service, UK experience-based co-design toolkit[3] that put people and their stories at the centre of the design of services.

**The barriers and enablers**

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[1] Roper, C, Cadogen, E and Grey, F *"Co-production: Putting principles into practice in mental health contexts,"* University of Melbourne, 2018 <https://recoverylibrary.unimelb.edu.au/__data/assets/pdf_file/0010/2659969/Coproduction_putting-principles-into-practice.pdf>
[2] *As above* at page 4
[3]      <https://www.pointofcarefoundation.org.uk/resource/experience-based-co-design-ebcd-toolkit/step-by-step-guide/1-experience-based-co-design/>

50      One of the barriers is that listening to people with lived experience can be tokenistic because it is not meaningful participation. This can include the situation where a mental health service, hospital staff, doctors or a professional body have already decided what decision they are going to make or what direction they are going to go in, but they need to ask people with lived experience for the sake of being seen to have asked. There have also been instances when government has funded a service system and made a model of care without consulting consumers. At the time they consulted consumers on the model of care, they had already decided on what the model of care was going to be so the consultation was tokenistic and was not meaningful participation.

51      Further, the scope of peer support work has not been fully addressed. I think people see the lived experience workforce in the clinical setting or hospital setting. It is a relatively new workforce and the structures are still being developed. There needs to be better structure around peer workers in terms of lived experience supervision, and in terms of understanding what peer work is. The lived experience workforce needs to be seen as an equal member of the team and lived experience expertise needs to be seen as equal to a discipline such as social work or psychology. I don't think that it is recognised by the other disciplines as a specific and valuable discipline.

52      The enablers to participation are support, training and education, and a willingness to share the power balance.  As an example of individual participation in my own health care, I wouldn't leave the house when I had challenges to my mental health, but my community support worker identified my interests and went with me to a few groups that I was interested in going to. After receiving that support, I was able to go by myself. Therefore, a supported decision-making framework empowered me in my decision making. Individual support is an enabler of empowerment for people. Peer support workers have a big role to play in providing support because they have travelled the path before.

*Best practice models*

53      A good practice model is a codesign and a co-production process. That means that there is co-evaluation, co-design and co-production. A best practice model is outlined in the *"Mental health lived experience engagement framework"[4]*.

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[4] State of Victoria and the Department of Health and Human Services, *Mental health lived experience engagement framework,* June 2019 <https://www.dhhs.vic.gov.au/publications/mental-health-lived-experience-engagement-framework>

## LIVED EXPERIENCE WORKFORCE

### The importance and current roles of the lived experience workforce across the mental health system

54      It is essential to have the lived experience workforce participating in different roles in the mental health sector. This includes peer workers, consumer consultants and advisors, consumer researchers and consumer academics. It is important because it grounds the work in the experience of people, making it more relevant and meaningful.

55      The support currently given to lived experience advisors is variable across different roles. My role as a lived experience advisor in the Office of the Chief Psychiatrist and Office of the Chief Mental Health Nurse is supported very well. I get external supervision from another lived experience worker and line management supervision. We act as a team and have team huddles, which are 15-minute informal catch-ups of the team. I am also supported to work from home.

56      However, I know that consumer consultants are quite isolated in their roles. There are not many who offer lived experience supervision for them to tap into and often supervision is not supported by their services. Further, consumer consultants are often part-time roles, but they are asked to work more than part time because their workload is higher than their part-time capacity to do that work. Consumer consultants are supported to attend high level meetings but not renumerated at the same level, as other attendees such as doctors, nurses and quality managers for their expertise at those high-level meetings.

### Support for lived experience workers

57      There needs to be more lived experience workers across organisations to ensure that lived experience workers are not isolated positions. For example, when a position comes up in a service, that service should consider filling that position with an experienced lived experience worker (even though it might not be a dedicated lived experience position) already working within the service and then employ another person with lived experience to fill the original lived experience position. Increasing the number of people with lived experience employed in an organisation in this way, would increase the amount of lived experience support available to each worker. Often, only one lived experience worker is employed within organisations which is very isolating.

58      There also needs to be more appropriate workloads to the type of position to better support lived experience workers. As stated in paragraph 56, most part-time lived experience workers would say their workload is far more that their part-time hours.

59      Lived experience workers also need to be remunerated at a level in which their expertise is valued if they attend high level strategic meetings or are providing peer support, remuneration should be at the level of other disciplines as discussed in paragraph 57.

## *Training and development for lived-experience workforces to prepare them for roles in service planning, design, delivery and governance*

60      There needs to be more training in supervision of lived experience workers. This is important because lived experience workers automatically disclose that they have a mental illness as part of their role. Lived experience supervision allows people to maintain the lived experience perspective and stay safe within the role.

61      In my view, governance is a difficult hat for a person with lived experience to wear. This is because you are not just part of the governance team for your lived experience, but you have equal responsibility with other directors and committee of management members for the operation of the service. Lived experience workers who are in governance roles should have access to the company directors' course, have specific training around that organisation and be mentored by another board member.

62      Service planning should be facilitated by a lived experience worker with consumers and a manager from the service. Training for such service planning is available at the Health Issues Centre and should be provided to lived experience workers.

63      In relation to service design, the Health Issue Centre also offers very good courses that services should take up in order to prepare lived experience workers to undertake service design roles. These courses are effective because they tailor training around the needs of the group.

## *Effective strategies for the retention of the lived experience workforce*

64      I think whether strategies are effective in retaining the lived experience workforce depends on how organisations work and are structured. The discipline of lived experience is not hierarchical and services work in a hierarchical way. Therefore, the flatter the structure around lived experienced workers, the better.

## *CONSUMER CONSULTANTS*

## *The role of consumer consultants in mental health services*

65      Consumer consultants bring lived experience to the operations side of a service. The work of consumer consultants essentially involves supporting the quality of services, for example through gathering people's experience of a service to improve the quality of

the service. However, in my experience, the position of consumer consultant varies from service to service.

66      The engagement team of the Mental Health and Drugs Branch and myself as senior consumer advisor have been working with the consumer consultants to try and get a generic position description to present to services around what their work is. It is important to develop the positions of consumer consultants as a discipline of work across the State to ensure consumer consultants are remunerated appropriately and have adequate supports in place.

## *The importance of consumer consultants*

67      Consumer consultants are important because they speak up for consumers in areas that consumers of the services do not have the opportunity to directly influence. For example, consumer consultants gather the experience of a service and bring it to quality, risk and culture meetings. Consumer consultants are the conduit between consumers who access the service and those who can improve the quality of the service.

## *The outcomes achieved by consumer consultants*

68      In my experience, consumer consultants are overstretched. They are achieving very high outcomes in terms of supporting the service, understanding the YES Survey, (the Your Experience of Service survey), supporting consumer advisory groups of the service and attending quality meetings and clinical meetings.

69      Consumer consultants are also quite isolated in their roles. There is usually a group of peer support workers in the inpatient services, not just one. But in mental health services, there is only one consumer consultant or two that share a part-time role. The implications of this are discussed in paragraph 56 and in my experience these lead to issues in retention of the lived experience workforce.

## *MODEL FOR COMMUNITY-BASED CARE*

## *The ideal role, over the longer-term of community-based and bed-based mental health services in providing support*

*People at-risk of developing mental illness or people experiencing early signs of mental illness*

70      I think the step-up/step-down program in PARC is really good because people can identify early signs of mental illness and get some early intervention. In the PARC program, people who are at risk of going to a hospital can go and stay in a residential,

homelike service to avoid a hospital stay. Also, people coming out of hospital can go to this homelike residential service to help integration into community, rather than going straight from hospital to home.

71      Therefore, community based mental health services have more of a role for people at risk of developing mental illness or people experiencing early signs of mental illness than the bed based mental health services.

*People experiencing suicidal ideation or following a suicide attempt*

72      I think it is really important that there are ways for people to connect when they have suicidal ideation. People need to connect to a service, such as Lifeline or the Suicide Help Line. But there should be a way that people with suicide ideation can talk about their situation without people panicking that they are going to suicide, while still taking it seriously. These services need to be non-reactionary.

73      I myself experience suicide ideation and the best thing for me is to be able to talk to somebody about it. It is about being able to say, "I need to tell you this, this is what is going through my head, but it's okay, you don't need to do anything about it." Or, "I need to tell you when I'm at real risk of doing something about it and I need some help."

74      Based on my experience, services such as Lifeline, the Suicide Help Line and psychological services are very helpful services to deal with this group.

*People experiencing mild, moderate illnesses and severe mental illness*

75      I think people need more support in the community. Everyone who feels they need an assessment around mental health should be able to access an assessment and then develop a plan with the person, their carer and a team nominated by the person, whether they are mild, moderate or severe in their illness

*Families and carers*

76      I don't think that there should be separate services set up for family and carers, their needs should simply be addressed together with the person with the mental illness.

*Supporting people to self-manage their mental illness in the community*

77      Peer support and education for the community around mental health is needed to support people to self-manage their mental illness in the community. I think there is a real fear in the community of mental illness, even though I don't think there are many families who have not been touched by mental illness. I think that when you mention 'mental illness,' people naturally think about the people who commit murder, when in fact, more violence is directed towards people with mental illness than people admit. So

it is both a misunderstanding of people with mental illness by the community and discrimination against them.

78      An example of support I had that was empowering and educational was that I needed to self-manage my mental illness was around budgeting and housing. I needed someone suggesting things like having the same PIN number for everything because I couldn't remember numbers and access my bank account. I also needed to be taught how to streamline or how to make a weekly menu because I couldn't think of what I would cook.

79      Therefore, what is needed is psychosocial supports or psychosocial rehabilitation support, which is supporting people to do things for themselves.

## ACCESS AND SERVICE ENTRY

### Mechanisms to improve people's ability to identify and navigate to the right mental health care, treatment and support for their needs

80      Mechanisms that would improve people's ability to identify and navigate to the right mental health care, treatment and support for their needs include:

(a)     access to a social worker;

(b)     online access to services (and assistance with how to use those services);

(c)     empowering people with lived experience to actually make comment about their experience of the service;

(d)     strengthening relationships with GPs to assist a person navigate to the right health care; and

(e)     support for family and friends.

### Benefits and risks of centralising screening and triage services

81      My view is that the risk of centralising screening and triage services over large areas is that the system becomes non-personalised. A formula triage function follows and your personal aspects can get lost in that system. For example, I could be triaged to Northern Health when I might have been to Northern Health before and been sexually assaulted. But because that's my local catchment and my local service, I would just be triaged there without my personal circumstances being taken into account.

82      The benefits of centralising screening and triage services over large areas are around clinical governance - there is a clear line of clinical decision making in that sort of process.

*The strengths and limitations of screening and triage functions being performed over the telephone or online*

83      The strengths of this kind of technology are that there are multiple strategies for people to talk online or on the telephone. This promotes choice and control for the person to decide on where, when and how they may wish to engage.

*The mitigation of risks*

84      There is sometimes a stigma that comes through with people working in mental health services. The stigma comes through their voice, and comes through their actions. I think this can be addressed with basic customer service training.

*The benefits and risks of having screening and triage functions run separately from on-the-ground providers*

85      I think that the fact that a person needs to be screened should be self-determined by the person, or their nominated person or advocate. I always think it is more beneficial to have on the ground providers. It is more personalised and has more meaning for the person. The person with a mental illness has lost meaning and they need someone to say that they are important, that "we're talking to you as a person because you're important, even though you don't feel it at the moment."

86      I suppose in some instances, the person could be a risk to safety to on-the-ground providers. There would have to be an overlay of safety for all. There needs to be an understanding that the person has to be involved in that discussion.

*Priority access to service providers for mental health assessment for clients without having to go through a screening or triage function*

87      I think priority access to mental health assessment without a screening/triage function should be given to people who have been recommended by a GP, a psychiatrist, a peer worker or a family member.

*INTERSECT BETWEEN PHYSICAL ILLNESS AND MENTAL ILLNESS*

*Ensuring the person receives holistic care*

88      How mental health services can ensure that holistic care is given to a person is addressed in the *"Equally Well in Victoria: Physical health framework for specialist*

*mental health services"* by the Department of Health & Human Services **(Equally Well)**.[5]

89      *Equally Well* also addresses the particular challenges of when patients are in inpatient environments, as well as best practice examples of holistic care.

## Enablers to strengthening supported decision-making on the physical health side effects of mental health medications

90      Often conversations around the physical health side effects of medication are played down by mental health services, so that people take medication. There needs to be honest conversations around what all the risks and benefits of taking the medication are, and the person with mental health challenges needs to make the decision.

91      All the issues around medication should be communicated openly by mental health services to allow informed decisions to be made by the person.

## The barriers and enablers to strengthening supported decision making on the physical health side effects of mental health medications

92      One of the barriers to people making informed decisions is that not all the information is given to the consumer. For example, if I ask, "I'm on this medication for 20 years – what is the outlook for my liver or my kidneys in 20 years time?" If they don't know the answer, the mental health service should say, "we don't know, but in the short term, this is what you can expect to happen."

93      My experience of these conversations is that a decision regarding medication has already been made by the mental health service. Often, honest conversations don't happen between the mental health service and the consumer. It is just seen as clinically appropriate to give this type of medication and the person goes away on that medication. In order to prevent this, more medication reviews should take place than what currently happens.

94      For these reasons, I don't think that the person is looked at holistically by mental health services, with both their physical and mental health. Instead, the physical and mental health is separated.
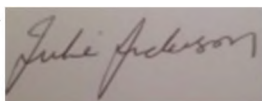
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[5] https://www2.health.vic.gov.au/about/publications/policiesandguidelines/equally-well-in-victoria-physical-health-framework-for-specialist-mental-health-services

## DIGITAL TECHNOLOGY AND INNOVATION

*Digital approaches that can help improve young people's ability to access information on mental health and the services available to them and easily access mental health services in a timely way*

95    I think digital approaches are helpful for young people and people generally who are working in this digital age. For me personally, because I work, it is easy for me to get online or to look up something up. I don't have a lot of time to attend appointments and things like that, so online is really great and allows me to easily access information on mental health and mental health services in a timely way. It is also private and people around me don't need to know what I'm doing. Sometimes at work when I'm a bit overwhelmed, I'll just call my support person and say, "I'm struggling at the moment. I just need to hear your voice, or I just need to check in with you to reassure me that someone's there for me."

96    Therefore, digital approaches are particularly good to support people with mental illness in employment and for young people. However, I am not able to comment on what digital approaches would be most effective for a young person, that would be best answered by a young person.

*sign here* ▶  *Julie Anderson*

*print name*  Julie Anderson

*date*  28 May 2020

**Royal Commission** into
Victoria's Mental Health System

# ATTACHMENT JA-1

This is the attachment marked 'JA-1' referred to in the witness statement of Julie Anderson dated 28 May 2020.

## *CURRICULUM VITAE*

## *Julie Anderson*

**CAREER SUMMARY**

I have an acclaimed career in the mental health sector as an experienced consumer leader with lived experience of recovery. I have a strong track record in internal and external advocacy and I am highly skilled in developing strong relationships to influence systems change. I'm experienced in providing advice to Federal and State Governments on mental health issues.

**WORK HISTORY**

**Feb 2018 – Current  Senior Consumer Advisor**

**Office of the Chief Psychiatrist  Office of the Chief Mental Health Nurse**

In this role I work with the OCP and OCMHN to provide access to expert understanding of diverse consumer experiences and perspectives related to the clinical mental health sector and mental health related human rights to inform the work of the Offices.

- Attend, participate and advise from a consumer perspective at clinical advisors meetings to review peoples situations;
- Attend, participate and advise from a consumer perspective at Statutory Committees on ECT, restrictive interventions, mortality and morbidity;
- Attend, participate and advise at project meetings of the office;
- Attend, participate and advise at senior nurses' forums;
- Conduct service visits to ensure quality and safety of services and advise on recommended changes
- Conduct ECT Audits and advise on outcomes.
- Lead Human Rights Project to support the Chief psychiatrist to take up his statutory role to support the human rights of people with mental Illness
- Provide expert and authoritative advice, reasoned recommendations and innovative program options and solutions to complex and sensitive issues.
- Ensure operational and practice initiatives meet the strategic directions for managing and delivering high-quality clinical services.

*Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.*                    20

- Formulate compliance and evaluation strategies to address specific issues related to the effective provision and implementation of required outcomes.
- Undertake high-level research and investigations into service delivery issues, risks and trends impacting on achieving key business objectives, policy initiatives and operational imperatives.

Monitor and analyse the implementation and delivery of practical and policy initiatives

**Oct 2016 – May 2017 Executive Officer                    Women's Mental Health Network**

In this role, I successfully instigated a process to produce a strategic plan for the network, I presented governance policies to the Committee of Management, ran forums for members on the issues of mental illness and women and applied for funding applications. I left to take up a full time caring role for an elderly parent.

- Resource the committee of management and working groups;
- Pursue funding opportunities to support network priorities; inclusive of longer-term sustainability opportunity;
- Work in collaboration with women with lived experience to raise awareness of women's issues in mental health services through training, presentations, conferences, forums and the media;
- Maintain collaborative relationships with relevant organisations, government departments and mental health services;
- Day-to-day management of staff and volunteers;
- Promote membership of the network;
- Day to day administrative role- budget, meeting all legislative, funding and statutory requirements;
- Undertake other tasks as directed by the committee of management.

**Oct 2013 – Oct 2016: Manager Consumer Participation Strategy          Neami National**

In this role I successfully worked with the National Leadership Team to research and co design a consumer participation framework and develop an overarching structure to guide planning, resourcing and development of consumer participation within Neami National using a co-production approach.

- Develop and maintain links with State and Federal governments and consumer bodies to ensure Neami is aware of the development of best practice in consumer participation.
- Advise State and Federal government, Mental Health Commissions and other social services on matters relating to social exclusion for people with mental illness.
- Provide advice to consumers, staff and managers to support the development of skills and knowledge to support inclusive participation in planning and decision making.
- Research the social context of participation and the implications to social inclusion.
- Provide advice to the research committee on co designing research and assist in developing Neami's research priorities.

- Gather and synthesize the views of the various stakeholders within the organization in relation to the development and implementation of the Consumer Participation Framework.
- Develop a range of strategies to promote the Consumer Participation Framework.
- Provide support to the State Leadership Teams in the development and implementation component of state plans.
- Provide practice development to four interstate consumer leaders.

**2009– 2013: Consultant Consumer Participation Services - Mental Illness Fellowship Victoria**

. I led the development consumer participation strategies, developed a peer worker framework and successfully managed the national roll out of a peer education program.

- Consult with internally and externally on the issues that people with mental illness deal with daily.
- Development of an experience based design survey delivered to current consumers who access MI Fellowship
- Convening MI Fellowship's consumer advisory group "Consumer Connections".
- Working as part of the Quality and Service Development leadership team and Rehabilitation Managers team to contribute to the development of organsiational policies, strategic goals and action plans of MI Fellowship.
- Contributing to the development and delivery of staff training and orientation.
- Reviewing and editing and delivering peer facilitator training for MI Recovery.
- Development of strategic relationships with other organizations and key consumer leaders.
- Providing leadership to the consumer participation team consisting of four consumer workers.
- Consumer Consultant and investigator in a MIRF lead by Swinburne University on bringing SMART technologies online to people with mental illness.
- Keeping up to date with latest research in recovery, consumer participation and peer work.

**2006– 2009:  Mental Health Project Worker          Mental Illness Fellowship Victoria**

In this position I worked to bring the lived experience of people with a mental illness to projects at MI Fellowship
- Program design, development and evaluation of peer consumer education program (MI Recovery)
- Associate Researcher on DHS research grant on Consumer Consultants in Victoria conducted by Wanda Bennetts
- Presenting sessions on consumer rights, duty of care and the Psychiatric Disability Support Sector (PDRS) in orientation sessions with new staff.
- Mentoring other consumers in different positions in the organization.
- Supervising volunteers.
- Facilitating MI Fellowship psycho education courses.
- Development and support of a speaker's bureau of people with mental illness to deliver community education.

**2000 – 2005:  Information Officer/Advocate - Victorian Mental Illness Awareness Council**

- Answering information calls to the service and advocating for people with a mental illness on their instructions and supporting self-advocacy.
- Supervising consumer volunteers and students.
- Facilitating training sessions for consumer consultants.
- Public Speaking and presentations to interested groups.
- Attending policy meetings and information sessions on issues to do with mental health.

**EXTERNAL CONSULTANCIES**

**Jan – March 2017**

- Worked as a consultant to undertake work on a mental health briefing paper for the newly formed Board of Uniting Care Agencies Vic and Tas. Contributing to discussion, writing and model development.

**May 2016**

- Review of Well Being assertive outreach program for Logan Beaudesert Mental Health Services, Qld with the objective of reporting to Queensland Health who extend funding on the basis of the report.

**Feb- March 2016**

- Member of an audit team engaged by North West Mental Health, Clinical Governance Committee to analysis reports and investigate cases of people who suicided in 2014-2015 to gain an understanding of system and service improvements that would support a reduction in suicide rates.

**Previous Consultancies**
- Auditor General Victoria.
- South East Primary Care Partnership.
- Eastern Region Mental Health Association.

**SYSTEMIC ADVOCACY, COMMITTEE AND COMMUNITY INVOLVEMENT**

I have extensive involvement in the mental health community since 2000. Here are some examples, including my most recent and current involvements:

**April 2020 – Current:  Member of Forensicare COVID -19 ethics committee**

**March 2016 – June 2017: Member of the Writers Development Group for the 5th National Mental Health and Suicide Prevention Plan.**
- Development of the 5th National Mental Health Plan that aims to redresses systemic imbalance, ensuring language and concepts align with community expectation and Ministerial approval.

**August 2016 – May 2017: Co-design leaders group to develop the new Mental Health Digital Gateway, Head to Health**

- Working to support the development of a digital gateway that will address the mental health needs for all Australian by understanding the drivers and the barriers to using digital mental health.

**2014 – May 2017: Member of NDIA National Mental Health Sector Reference Group**

- Represent a consumer perspective and mental health sector views in the development of the NDIS.

**March 2016 - May 2016: Member National Mental Health Services Planning Framework (NMHSPF) Reference Group**

- Revise and review initial work done on the NMSPF
- Discuss changes that need to be implemented to support a tool that is workable.

**May 2015 – November 2015: Member of Expert Working Group to Respond to the National Mental Health Commissions Report on Mental Health Services – DoHA**

- Contribute advice to support the government response to the National Mental Health Commissions review of mental health services.

**Nov 2013 – Nov 2019: Member of the Board of Directors Forensic Mental Health Council of Victoria (Forensicare)**

- Working with other Council members to have responsibility for the governance of Forensic Mental Health Services in Victoria including: finance, risk management; and setting the strategic directions.
- Subcommittee member of the Quality and clinical governance subcommittee of the Board
- Subcommittee member of the Research committee of the Board

**2012 –December 2016: Member Victorian DoH Mental Health and Drugs Division Victoria Partnership Forum**

- Provide advice to Government on issues relating to consumers and consumer workforce.

**2007 - Current: Member of MHA National Register of Consumer and Carer Advocates**

- Be available to consult on mental health issues, locally, at State Level and Nationally.

**2013 – 2014: National Consumer & Carer Peer Work Qualification Reference Group**
**2013- 2014: Co Chair of the Northern Melbourne Mental Health Community Collaborative (MHCC)**
**2000 –2011:  President of Board of Directors NEAMI NATIONAL**

**2011-2013: Vice President Board of Directors NEAMI NATIONAL**

**AWARDS**

2013                    The MHS Gold Achievement Award for Well Ways MI Recovery Program

**PAPERS PRESENTED**

I have presented at state, national and international conferences on the field of consumer participation in mental health services over 15 years. My more recent presentations include:

2019                    TheMHS Conference

                         Promotion of Human Rights

                         Snapshot of Survey Results                                   Brisbane

2019                    Office of the Public Advocate

                         Advocates Conference

                         Office of the Chief Mental Health Nurse

                         Workplan                                                     Melbourne

2019                    Mental health Tribunal

                         Professional Development Day

                         Promoting Consumer Rights                                    Melbourne

2019                    Equally Well Symposium

                         Keynote with Chief Mental Health Nurse Anna Love

                         on Lived experience Perspective on

                         Mental health and Physical health                           Melbourne

2019                    Centre for Psychiatric Nursing                               Melbourne

                         Collaborative Conference

Building Health Communities –

Stories of Hope and Resilience

| | | |
|---|---|---|
| 2018 | Western Cluster EN Nurses Forum | Melbourne |
| | History of the Consumer Movement | |

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|---|---|---|
| 2018 | TheMHS Conference | Adelaide |
| | Mental Health Intensive Care symposium | |
| | Mental Health Intensive Care Co-design | |
| | Promoting Consumer Rights | |

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| 2018 | CPN Mental health Nurse collaborative. | |
| | Keynote with Chief Mental Health Nurse Anna love on | |
| | the three "C"s consumer carer and clinician collaborative | Melbourne |

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| 2016 | Innovation Seminar - ReGen | Melbourne |
| | **Title:** Innovation in consumer | |
| | Participation practice at Neami. | |

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|---|---|---|
| 2015 | The Mental Health Services Conference (TheMHS) | Canberra |
| | **Title**: Consumer Participation Leadership | |
| | from Rhetoric to Reality. | |

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|---|---|---|
| 2012 | Psychiatric Disability Services of Victoria (Vicserv) | Melbourne |
| | **Title**: Peer to Peer not Pillar to Post. | |

| | | |
|---|---|---|
| 2012 | The Mental Health Services Conference (TheMHS) | Cairns |
| | **Title**: Peer to Peer, Not Pillar to Post: Why Authentic Inclusion of the Peer Workforce is a Citizenship Matter. | |
| | **Title**: Rediscovering Citizenship in the Recovery Domain; A Discussion About the MI Recovery Program. | |
| | **Title**: Consumer Participation as a process to claim citizenship. | |
| 2010 | Refocus on Recovery Kings College | London |
| | **Title**: Consumer Participation and Leadership. | |
| 2010 | Psychiatric Disability Services of Victoria (Vicserv) | Melbourne |
| | **Title**: Unfinished Business – Peer Services. | |
| 2009 | QLD Alliance Conference | Brisbane |
| | Jenny Brockie SBS hosted panel | |
| | **Title**: Reforming the system. | |
| 2009 | Spirituality and Mental health Conference. | Melbourne |
| 2008- 2009 | The Mental Health Services Conference (TheMHS) | New Zealand Perth |

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|---|---|---|
| 2007 | TheMHS Australia/New Zealand. | |
| 2008 | IIMHL Exchange. | Brisbane |
| 2007 | IIMHL Canadian exchange at the | |
| | Centre Mental Health and Addiction. | Canada |
| | QLD Alliance Conference | Brisbane |
| | **Title:** MI Recovery Journey Peer consumer education. | |
| 2005 | Absolutely Women's Health | Melbourne |
| | **Title:** Mothering and Madness. | |

**Journal Articles Written**

| | |
|---|---|
| 2016 | McKay, R., Coombs, T., & Anderson, J. (in press).Mental health and addictions workforce development in Australia. *Workforce Development Theory and Practice in the Mental Health Sector* |
| 2012 | Oades, L., Deane, F. P., & Anderson, J. Peer support in a mental health service context. In R. King, C. Lloyd, T. Meehan, F. P. Deane & D. Kavanagh (Eds.), *Handbook of Psychosocial Rehabilitation: Practitioner Toolbox.* Oxford, UK: Wiley. |
| 2012 | Oades, L.G., & Anderson, J. Recovery in Australia: Marshalling strengths and living values. *International Review of Psychiatry, 24(1), 5–10* |
| 2012 | Journal: New Paradigm, Winter 2012 Special Conference edition |
| | Title: Peer to peer, not pillar to post: a framework for supporting and expanding on the lived experience workforce and consumer leadership |

| 2009 | Journal: Synergy, addition 3 | |
| | Title: Well Ways MI Recovery | |
| | Journal: New Paradigm | |
| 2007 | Title:  Consumer Leadership in the PDRS Sector | |

## QUALIFICATIONS/TRAINING

| 2015 | National Mental Health Commission | NMHC |
| | Future Leaders Program. | |
| 2011 | Graduate of Company Directors | AICD |
| | Course. | |
| 2010 | Study tour of mental health services. | London |
| 2006 | Leadership training | NEAMI NATIONAL |
| | Developed with NEAMI and NMIT. | |
| 2005 | Graduate of Leadership Plus | RMIT & Leadership Plus |
| | Including RMIT Units in the | |
| | RMIT Community Education Course. | |
| 2000 | 1st semester Diploma of | Kangan batmen TAFE |
| | Community Development. | Broadmeadows |

1982     Certificate of Business Studies.                Collingwood College