Formal Submission to the Royal Commission into Victoria's Mental Health System from the Centre for Psychiatric Nursing (CPN), School of Health Sciences, University of Melbourne.

This document addresses the formal submission **question 9:** ***Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?***

The aim of the CPN is to advance mental health nursing practice in Victoria, through research, education, training and consultation. The CPN team consists of mental health nurse academics and consumer perspective academics; we are known for our co-productive skills, practices and outcomes.

The CPN team is invested in reforms that matter most to consumers, the people with the highest stake in the service under consideration. Four top issues are: enabling mental health work as relational; recognising and redressing the harms when we override human rights though coercive practices in mental health care; innovating models of care that are respectful and attractive to consumers; and building practitioner skills for supported decision making, as the usual practice in mental health services. Many of the points made are underpinned by our own research.

1. Give first priority to enabling relational work in public mental health services

Relational work is core to mental health care. In other areas of healthcare, relationship is the means through which good treatment is provided, but in mental health care, good relationship **is itself** a key mode of treatment. People in need of mental health care, whether briefly or over time, value systems that makes it possible to form good person-to-person relationship (Eldal et al 2019).

Quality relational practice has been mixed in Victoria's history, but is currently eroded across public sector services. From first contact, many consumers and families experience being deflected rather than engaged with, via a mental health triage service (Healthtalk Aus. 2015). People in crisis are directed to present to an emergency department, a setting not designed for therapeutic conversation (Thomas et al 2018). Episodes of care in community mental health settings are much briefer than they were 10-15 years ago. Even specialist service Orygen has reduced engagement to 18 months for people and families coming to grips with the derailment of a first episode of psychosis, though strongest evidence shows the need for outreaching community care (Bond & Drake 2015). Across our system, the short-sighted focus is on medication adherence and symptom management, not on growth and experience of recovery.

Quality and continuity of relationship is a very high priority for consumers and carers (Fletcher, Hamilton et al 2019, Fletcher, Buchanan et al 2019, Farhall et al 2019). Reform in Victoria will hit the mark only if it structurally prioritises relationships of skilled support, through service design decisions about: time, location, outreach, responsiveness, continuity, staff perspective and training and clinical supervision in services.

2. Drive down reliance on involuntary treatment

Concerted attention must be given to redressing the damaging impact of human rights breaches, ie involuntary detention, medication without consent, community treatment orders seclusion and

restraint. The high rates of these practices in Victoria (AIHW 2018, 2019) is the clearest evidence of system failure.

The claimed short-term gain of 'safety' is not born out in an experience of safety for the person, rather coercion leads to long term harms of trauma, demoralisation, disengagement, and damage to family relationships (Brophy et al 2016). Many instances of coercion can be averted/replaced every day with intensive engaging work, including offers of treatment and support that match what people do want. Trauma informed approaches are also needed to prevent further harms that follow experiences of coercion.

3. Invest in models of care that are respectful and attractive to consumers

Consumers seek out and affirm a range of services, some of which are already available in Victoria. These include: innovations such as community based Open Dialogue (Buus et al 2019), PARC (Harvey et al 2019), coaching for mental & physical health, humanistic therapy, narrative therapy, individual and family peer support (Farhall et al 2019). Consumers value community-based services that are accessible, flexible, strengths-focused and outreaching (Hamilton et al, 2012). Some consumers welcome a range of psychological therapies, including specialist interventions to address trauma (Sweeney et al 2018).

Some consumers seek and appreciate psychiatric treatments including psychoactive medicines or ECT. Contrary to stereotypes that exist about people with experience as consumers of public services, most people actively seek assistance (Salomon et al 2014). They want to be well-informed about possible help and to choose.

4. Build workforce capability in enabling supported decision making

Given the ongoing use of hospitalization and community treatment without consent via mental health law, it is very concerning that there is currently a poor level of knowledge among our workforce of the principle of supported decision making (SDM) that underpins the MHA Vic 2014, or of its application using the tools of advanced statements, nominated persons, etc (Maylea et al 2019). Whereas clinicians frequently confuse SDM with *shared* decision making and favor the latter (Healthtalk 2018), peer workers are committed in principle and more skilled in enabling SDM. At the CPN we currently offer nursing and consumer co-designed training about SDM, the associated instruments and the important set of practices for clinicians.

We sincerely urge that recommendations from the Royal Commission feature these four priorities.

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