2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
"The Bouverie Centre, La Trobe University"

Name
Dr Brendan O'Hanlon

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
N/A

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
"The Bouverie Centre-The Context for Our Submission The Bouverie Centre, is an integrated practice research centre within La Trobe University that is a recognised leader in family inclusion and interventions in the mental health and related human service fields. The centre receives its core recurrent funding through the Mental Health Branch of DHHS and operates as a statewide specialist service as part of Victoria's public mental health system. The Bouverie Centre uniquely combines clinical family therapy, academic teaching, qualitative and quantitative research and workforce development in one integrated service. Our mission is to improve the lives of individuals and families through delivering a range of relationship focused services, our vision, healthy relationships in families, organisations and communities. The Bouverie Centre is uniquely placed to contribute to the Royal Commission because of our integrated roles in relation to the Victorian mental health system. We provide clinical family therapy services to families experiencing a range of mental health difficulties with a focus on families with a family member with a severe mental illness who is treated by publicly funded mental health services. Our workforce development role involves working with mental health services across the state to increase their capability to constructively include families in treatment and care. We are in contact with mental health services, through the provision of workforce training and through our unique Beacon projects where we work with mental health and drug and alcohol services intensively for 1- 2 years to implement family inclusive practices and evidenced based interventions. This engagement is strongest with adult mental health services but there is an increasing engagement with CAMHS/CYMHS and aged persons' mental health services. The Bouverie Centre co-ordinates Victoria's Families where a Parent has a Mental Illness (FaPMI) program which involves co-ordinating and facilitating local FaPMI co-ordinators in each of the 21 adult area mental health services in Victoria. In addition to our work with local co-ordinators we are also in contact with the managers in area mental health services. We host the mental health Carer Academic position which is strongly engaged with Tandem and with the Carer Lived Experience Workforce (CLEW). We provide advanced training in family therapy (including a two year practice-based Masters program) for the health and human services workforce that includes clinicians working in publicly funded mental health services. Our rapidly expanding research capacity addresses developing effective and efficient models of family-based practice and supervision as well as how to best implement these interventions in mental health services. Current Issues in Victorian Mental Health Services We identify several key issues in the delivery of mental health services in Victoria. Consumers and family members not infrequently experience their care as de-humanised with practitioners seen as unwelcoming and lacking in warmth. This is despite most mental health

clinicians being committed and caring professionals who do their best in difficult circumstances. This apparent contradiction might be understood in terms of mental health services being under heavy demand with inadequate resources for many years. Over time we believe this has contributed to the development of a defensive culture and practice that is overly risk focused and where practice rather than having a therapeutic orientation, is reduced to the three Ms of Medicate, Monitor and Manage. The contradiction that caring and committed practitioners are often experienced as unwelcoming and lacking in warmth can be further explained by the lack of non-blaming and non-judgemental models and interventions that identify and respond to underlying trauma experienced by consumers and by some of their family members. The rate of past trauma such as neglect, sexual abuse and violence in clinical mental health presentations are not reflected in the treatments provided by mental health services. Service delivery is very individualised with families and friends of the consumer often not properly identified, engaged or involved in ways that evidence indicates will deliver benefits for consumers and their families. This is most concerning for vulnerable groups such as dependent children and older carers who have less capacity or opportunity to give voice to their own needs. This results in the needs of family members not being recognised and opportunities for supporting these vital relationships being missed. Policy and funding arrangements reinforce the creation of self-reinforcing consumer, carer and clinician camps' which constrain the sharing of perspectives and experiences between these groups. Consumers and their families typically do not have access to evidence-based psychological and psychosocial interventions as recommended in treatment guidelines for conditions such as schizophrenia and bipolar affective disorder. This comes as a consequence of a mental health workforce that is not systematically trained and organisationally supported to use psychological and psychosocial interventions. The service system for people experiencing mental health difficulties and their families is complex and difficult to negotiate. In part, this reflects the development of specialist service responses to emerging needs, however the consequence is bolted on' services rather than integrated models of care. Variation in the way services are delivered across health networks may suggest local responsiveness, however it also adds additional complexity for those trying to navigate the system. The training of the existing mental health workforce appears ad hoc, lacking in a shared focus and delivered in a manner that is unlikely to achieve its intended aim of improving practice. There is little accountability in terms of practitioners using their newly acquired skills in practice and post training support for translation of training to practice is still the exception rather than the rule. A New Paradigm for Victorian Mental Health Services The Bouverie Centre believes the Royal Commission provides a once in a lifetime' opportunity for a paradigm shift in the delivery of mental health services in Victoria. While additional funding would of course be welcomed, there is a danger that providing more funding for the existing service arrangements will result in more of the same' rather than the transformation of mental health services that is needed. The key elements of a new paradigm are outlined here while the specific implications will be addressed in responses to the Commissions questions. Individual mental health is known to be associated with the quality of social relationships and poor mental health strongly associated with social isolation. In the context of adversity, positive family and social relationships can provide a buffer to the development of mental health difficulties. The nature of a person's family environment can have a significant bearing on the course of their mental health difficulties. Family-based interventions can address difficulties in families, support recovery and facilitate the coping and adaption of family members. If the significance of the role of family and other key relationships is truly appreciated, then this will inform the way mental health services are provided. Consumers are understood and offered treatment and support in a way that recognises the importance of their relationships with family and friends. Family members and other supporters should be included in the treatment and care of people experiencing mental

illness in a manner that is congruent with the consumers preferences. Recovery remains a useful and optimistic framework for understanding and informing how treatment and care is provided by mental health services. Understanding recovery as a fundamentally relational experience is likely to enhance its value to consumers by inviting greater inclusion of families as a resource for recovery and to provide support to family members who have their own recovery experience.
The role of trauma in the aetiology and exacerbation of mental illness and in the impact of mental illness on consumers and their family members should be acknowledged and responded to as key drivers of treatment. Services should be delivered in a manner that reflects the impact of both individual and relational trauma. There needs to be a sophisticated appreciation that interpersonal trauma may arise both inside or outside of the family, but that even if it arises within the family, relational trauma informed responses are likely to be most effective (e.g. engaging non-abuse members of the extended family). Consumers and families should receive services that are informed by available evidence for their effectiveness, are consistent with established treatment guidelines and are congruent with contemporary values underpinning mental health care. A focus on achieving meaningful practice change rather than simply delivering training is needed if the benefits of available psychological and psychosocial models of practice are to be realised. The sustainable implementation of trauma informed, family sensitive treatment is complex and costly, but the rewards to the health of mental health organisations and of their staff and consumers and families would provide good return for investment. What is already working well.... While we recognise the significance of the social determinants of mental health and the importance of intervening at this level, this is not an area in which we have specific knowledge and expertise. However, we would make the point that families feature prominently in individuals' pathways to treatment and support services and this should be considered in strategies for improving accessibility of services for people seeking treatment, especially people reluctant to seek help. Secondly, through our work in relation to FaPMI we are aware of the increased vulnerability of children whose parents have a mental illness to developing a range of social, emotional and mental health difficulties. The State Governments investment in the FaPMI program has the potential to reduce the inter-generational transmission of mental health difficulties by providing early identification and intervention for children who may be showing signs of distress or difficulty. Family based intervention for children and families where a parent with a mental illness are needed either through the development of new models or the adaption of existing models. Coordination of supports for these families is also important. The Village project in Austria aims to support children of parents with a mental illness and investigate how a whole community could be involved to identify vulnerable children and strengthen formal and informal supports around children whose parents have a mental illness. This novel and ambitious project is currently in development but could have relevance in Victoria given that it is being led by Victorian researchers. A number of mental health services have implemented accessible services based on the single session thinking. This approach derives from three research findings: 1. The most common number of sessions consumers of many therapeutic services have is one, followed by two, followed by three etc. 2. Consumers more commonly report the value of one session rather than seeing it as a failure. 3. It is not easy to determine who will attend one session and who will attend more sessions. Hence, single session thinking leads to treating the first session as if it is the last, whilst not putting any constraints on further support if consumers request it. The Alfred CYMHS, for example, have taken single session thinking to inform three family therapy teams, which have found that over 50% of families decide one session is sufficient. As a result, the Alfred CYMHS do not have a waiting list. Furthermore, clinicians using this approach are by necessity consumer led and responsive to consumer goals. "

What is already working well and what can be done better to prevent suicide?

"Families are frequently involved in seeking out assistance for their relatives who may be at risk of self-harm and at key points in the pathway of care including discharge from hospital. The role of families or rather the failure to include families has featured prominently in coronial and other inquiries in relation to mental health patients who have committed suicide. These inquiries have recommended increased family involvement in discharge planning and other points of care. These recommendations make good sense although the question of whether increased family involvement reduces the likelihood of suicide warrants further research. The development of Hope teams in emergency departments has been a positive attempt to address the alarmingly high rates of suicide attempts and completions. There needs to be continued support of those programs including provision for clinicians to have time and skills to include families in this work. Good practice requires a plan for how family and other supporters can be included in the recovery of the person at risk of suicide including what to do in the event of noticing warning signs. The use of apps' which have involved individuals at risk of self-harm could be expanded to involve family usage. Again, any of these interventions warrant careful evaluation to determine whether they are effective before they are introduced more widely. Within the Alfred CYMHS single session family therapy teams, there is some anecdotal evidence that family sessions post suicide attempt can have a powerful effect on addressing factors that have led to the suicidal attempt. The suicide attempt raises issues that may have been previously hidden and family members are prepared to make changes given the gravity of the situation. "

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

"It is still challenging for people to speak up about their mental health because of an ever-present fear of being judged. This means that opportunities for early treatment and support can be lost, leaving the person's supports (friends, family, colleagues) as those witnessing the challenges and sometimes trying to advocate for help. Seeking support can also be additionally challenging depending on age, demographic, family relationships, cultural background, and socio-economic status. Primary health care providers who are often the first port of call', such as GP's, are often not well equipped to respond to people presenting with significant mental health concerns. Community health and family services are also well placed to respond to people experiencing mental health challenges but again, have a workforce largely ill-equipped to respond. Publicly funded mental health services currently reflect a largely crisis driven system which is hard to access- a person must be in crisis or very unwell before meeting the criteria for this service. All this results in low levels of early intervention and support and many preventable mental health issues spiralling. The current range of services that constitute the mental health support system are not well integrated, well promoted, easily accessed, or routinely affordable. The fragmented nature of services means it is hard to someone who is vulnerable to navigate a path to getting the right treatment and support. Access to services in rural and remote parts of Victoria is especially limited by distance, challenges recruiting and maintaining the workforce, and access to transport. Aboriginal and Torres Strait Islander people are especially vulnerable where culturally appropriate services are not available or mainstream health services are not well equipped to respond. Whilst Aboriginal Community Controlled Health Organisations need to be further funded, mainstream services need support to build their cultural capacity to respond more effectively to Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander communities need choice and mainstream services need more Aboriginal staff members to drive cultural safety with these services. Opportunities for good mental health outcomes for children and young people are

routinely lost when adult focused services do not routinely and sensitively enquire about family well-being. Parents who may be vulnerable due to poor mental health and a range of other challenges that can be associated with mental ill health (e.g. family violence, substance use, homelessness, unemployment), often find themselves on a kind of merry-go-round of help seeking, trying to access multiple services that are not well connected. "

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

"Many factors can contribute to poor mental health outcomes. Social determinants - such as socioeconomic status, education, housing, social support networks and the physical environment - have a significant impact on health and wellbeing and are largely responsible for health inequities. Several studies illustrate that social isolation and poor family relationships have a greater impact on a person's mental health than other factors such as smoking or obesity. Populations and communities who are vulnerable to poorer mental health outcomes include Aboriginal and Torres Strait Islander peoples, people on very low incomes and who do not feel valued by society such as LGBTI people, families with intergenerational trauma and experiences of adversity, families where one or both parents have a mental illness and/or substance use, people living with limited access to social supports and networks. Families where a parent experiencing a mental health challenge or serious mental illness can be more vulnerable to poor outcomes and the children in those families are twice as likely to develop their own mental health disorder without early intervention and support. The often associated disadvantage for these families such as low income, isolation, stigma, the episodic nature of mental illness, means that they are a population that should be sensitively identified and offered a range of supports as early as possible. Communities need to work collaboratively (families, schools, support and health services etc) to offer a wrap-around, early intervention approach so that children do not fall between the gaps of a fragmented system of care. "

What are the needs of family members and carers and what can be done better to support them?

"The needs of parent carers of adults experiencing mental health difficulties have been thoroughly researched. However, the needs of children, partners and siblings requires further investigation given that, whilst they may not always be in caring roles, they are usually profoundly affected by their relative's mental health problems. Older carers are faced with increased vulnerability, particularly if they live alone with their relative as well as facing worry about the future care of their relative. The key question to be addressed is how families and carers can be better supported. As articulated at the beginning of this submission, we believe a family and relational focus to mental health care provides the best way of meeting the needs of both consumers and their family and friends, and provides a greater range of potential intervention points for practitioners. Active and assertive inclusion of family members at the point of entry to mental health services is key to setting the tone for future family involvement. While this needs to occur in a manner that keeps the consumer at the centre of care, families can be included in care in ways that respect the consumers autonomy and expressed wishes. The interests of consumers and their families are often similar but where tensions do arise these can usually be managed positively for both parties. In cases of intrafamilial abuse, a family perspective can help identify the abuse and create effective safety strategies. As such family inclusion could be adopted as the default position if there are clear opportunities for the consumer to express their preferences about who will be included, how and what information will be shared. As we have articulated in the attached

framework document, From Individuals to Families,' mental health services also need to develop a family sensitive and inclusive organisational culture where involving families is unremarkable and just what we do in this service.' In our experience, families most want to speak to and have ongoing contact with the clinicians directly involved in their relative's treatment. We would therefore advocate that all clinicians are encouraged, supported and trained to develop trusting relationships with the families of their clients whether this is through informal contact or more formal involvement. We believe that wherever possible, this engagement occurs with the consumer being central to the process. This consumer centred, family inclusive' approach provides the best opportunity for family members to be identified, engaged and have their needs addressed. Importantly engagement should extend beyond an identified single carer' to include other family members. This is especially important when it comes to responding to vulnerable family members (children or elderly parents) or those who have not previously be included in care. Once family members are identified, the treating clinician is well placed to help the family articulate their needs. At this point, they can directly address needs for information, practical advice and emotional support. The Single Session Family Consultation model developed by The Bouverie Centre provides a relatively simple and efficient framework for meeting with families to identify and respond to their needs. If the family needs more support than the clinician is equipped to provide (either in terms of capability or scope of practice) families can linked to other options in their service- peer support, carer crisis funding or specialised family interventions-or referral to other external services that might better address their needs. The development of strong working relationships with relevant external services such as family support services for families with young children, financial counselling services or family violence services is also critical. Developing these relationships is also important in counteracting the isolationist' culture and practice that has historically characterised mental health services. It is our experience that no one service response will meet all family's needs, as these differ according to broader family circumstances, (including cultural background, family composition, history) and according to families changing needs over time and stage of illness. This requires that mental health services can engage well but also as needed provide more intensive forms of intervention that are known to be effective in improving consumer and family outcomes. For example, Family Psychoeducational interventions such as Multiple Family Groups and Behavioural Family Therapy provide the type of interventions articulated in treatment guidelines for most serious mental illnesses. While recognising that there is a need for a range of responses to families, we do think that there should be an emphasis on building the capacity of the treating teams and clinicians to respond to family needs. The Bouverie Centre has demonstrated that if clinicians are given a clear scope of practice, adequate time and training, they can identify and respond well to many of the needs of families. Separate carer services and the lived experience workforce have a vital role to play in the provision of support to families. However, unless treating clinicians engage with and respond to families, many families will not receive any meaningful services at all. This is in part because families, especially in the early phase of treatment, are focussed on ensuring their relative gets treatment rather than considering their own needs. In addition, referrals to other services can create the sense that something has been offered' but there is a significant risk that families will not end up engaging with the referred service. The inclusion of consumers and family members in service governance structures already occurs in many mental health services. This should be further encouraged and supported as this provides a useful mechanism for helping to achieve the required shift in the culture of mental health services flagged earlier. We commend and further encourage the work of the Mental Health Tribunal in addressing the experience of families and carers in tribunal hearings. Families in this context find the experience of participating in hearings challenging as they balance maintaining their relationships with their relative, with their views of

their relatives needs and their own needs as family members. Our own research in relation to family violence in mental health indicates that this is a complex and disturbingly common problem in which family members and the consumer can be victims or perpetrators of violence. Family violence will compromise the recovery of individuals already experiencing mental illness and contribute to the poor mental health of family carers. The establishment of specialist family violence positions in mental health services is a welcome initiative although a great deal of work needs to be done in articulating effective practice for responding to this issue in the context of mental health care. Our work suggests that different terminology and frameworks are required to fully address family violence in a mental health context. "

What can be done to attract, retain and better support the mental health workforce, including peer support workers?

"Consumer and family experience of mental health care is largely mediated through their interaction with mental health clinicians. It is critical that this workforce is therefore well trained and organisationally supported to deliver effective treatment and care in a compassionate manner. We argue that training clinicians in effective, change oriented models of practice will contribute considerably to the attraction and retention of the workforce. In our engagement with clinicians in our workforce and implementation roles we observe that clinicians derive a sense of meaning and satisfaction from facilitating and witnessing change in their clients through the use of therapeutic practice models. Moreover, this greater intensity of involvement allows them to know' their clients and families more deeply and develop more trusting relationships that promote recovery. Although working in an effective and therapeutic way is what most clinicians aspired to when they enter the mental health field, their capacity to work in this way is often untapped and under-utilised. Instead their role is limited to monitoring their clients mental state and managing them through a treatment system heavily focussed on medication compliance. In summary, trauma informed, family sensitive models of practice naturally lead to non-blaming, non-judgemental, compassionate responses to the consumer and their families, which in turn leads to rewarding and meaningful experiences for practitioners and services. Creating a mental health service that utilises effective psychological and psycho-social intervention is challenging. It requires a strong organisational commitment to releasing staff for training, to providing post training support and to making changes to systems of care and work roles so that once trained, staff can practice what they have learned. Enabling co-working and providing supervision are critical to the uptake of family interventions. Ultimately however, this investment delivers for consumers, their family members and for clinicians. There are examples of services using evidenced-based interventions in the context of specialist roles but less commonly as part of routine care. The youth mental health services at Barwon Health have managed to provide the Multiple Family Group intervention for the last four years. The Inner West Area Mental Health Service of North Western Mental Health offers a suite of evidence based interventions and provides support for staff to develop their skills in an intervention offered by the service. This service has also been acknowledged by Tandem for its efforts in conducting a successful Multiple Family Group intervention for the last eight years. The Alfred CYMHS have used single session family therapy teams and consultation from Bouverie to train practitioners, including psychiatrists and psychiatric registrars trauma informed, family sensitive, accessible therapeutic approaches. Our recent experience in delivering clinical supervision training across the mental health and alcohol and other drug sectors highlighted that the availability and quality of supervision varied considerably. Clinical supervision is key to helping clinicians to reflect on and make meaning of their work, help support their self-care and deal with adversity and supporting their efforts to incorporate new ways of working into their practice. It is also likely to have appositive impact on clinician competence and their retention in mental health

services. Further investment has been made by Government to improve the quality of supervision provided in mental health. Additional resources will be needed to achieve sustained improvement in this area, particularly for inpatient nursing staff who work with the most confronting circumstances and typically have less access to supervision. The Lived Experience Workforce has developed rapidly in the last few years. Key challenges exist in defining and articulating the work role, providing relevant training and ensuring that these roles are both well supported and integrated into the wider mental health service. This will require a continuing investment in developing the lived experience workforce so that staff can be sustained in these roles. "

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias 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 bolstering of inpatient services so that they can better meet the high demand that currently exists. However, the long game' should be to build the capability and capacity of community-based services. This provides the best option for addressing the spirally demand for inpatient services. Properly trialling and carefully evaluating new models of care such as single session approaches in CYMHS offers the possibility of challenging existing models of care and opening up new ways of working. In adult mental health services, trialling the open dialogue practice model and framework for service delivery offers a welcome challenge and radical alternative to existing modes of care. Such trials will encourage a wider reflection on how to best deliver mental health services in Victoria. A level of experimenting and trialling new approaches more generally may be required before it becomes clear how mental health services should be re-designed. The state government can no longer afford to take a hands off' approach to shaping and influencing service development but rather must take a more active and directive role in reforming Victoria's mental health system. Though this is clearly counter to the broad direction of government in relation to health services, it will be necessary in the short term achieve the required level of change. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
N/A