SOUTHERN MELBOURNE INTEGRATED FAMILY VIOLENCE PARTNERSHIP
Submission to the Royal Commission into Victoria's Mental Health System

Introduction

The Southern Melbourne Integrated Family Violence Partnership (The Partnership) is one of 13 such bodies across the State responsible for delivering family violence reforms and the recommendations of the Victorian Royal Commission into Family Violence. The Partnership covers the Cities of Greater Dandenong, Casey and Cardinia Shire. It brings together representatives from specialist women's and men's family violence services, children and family services, homelessness and housing services, health and mental health services, Child Protection, Police, Magistrates Courts, Corrections, Department of Health and Human Services, legal services, alcohol and other drug services, culturally and linguistically diverse services, and indigenous services. The Partnership welcomes the Royal Commission into Victoria's Mental Health System and the opportunity to make this submission.

Family violence is a major mental health issue. The long-term mental health consequences of exposure to the chronic stress and trauma of family violence are well-established. Victims are more likely to experience mental illness over the course of their lifetimes including depression, anxiety, post-traumatic stress disorders, substance misuse and suicidal ideation and suicide. Children who are exposed to family violence have higher rates of depression, anxiety disorders, attachment issues, emotional problems, learning difficulties, and other trauma-related and extreme behaviours. Abuse in childhood increases the likelihood of being abused as an adult. Perpetrators of family violence can also have higher rates of depression anxiety, and post-traumatic stress disorders, substance abuse and personality disorders.

Whilst family violence occurs across all socioeconomic and demographic groups, certain groups in our community are more vulnerable to family violence and mental health risk factors. They may also experience barriers to accessing services and receiving appropriate responses. These include older people who experience elder abuse, Aboriginal and Torres Strait Islanders, LGBTIQ, immigrant (particularly refugees and those escaping trauma and war in their countries of origin), and people with a disability.

The Partnership estimates that mental health issues - including high anxiety, depression, panic attacks, severe stress, and post-traumatic stress disorders - are prevalent in approximately 80% of all family violence cases in the Southern Melbourne area.

The Partnership's responses to the Royal Commission's questions are set out below.

Question 1: What are your suggestions to improve the Victorian Community's understanding of mental illness and reduce stigma and discrimination?

1. Help the community to understand that: (a) mental illness is an illness and should be treated as such; (b) the different types of mental illness; (c) what is needed to support the individual; (d) people from diverse cultures view mental illness differently and may require different treatment. Educational programs such as Mental Health First Aid appears to be useful. Progress has been made in the community with understanding depression and anxiety, but more work needs to be done in areas such as schizophrenia.
2. Help the community to understand the causes of family violence and its effects on mental health; that mental health is not an excuse for condoning violence; and that men's capacity to address family violence is often affected by mental illness, cognitive impairment and acquired brain injury.
3. Help the community to recognise that social media, and trolling in particular, affect mental health. Technology-facilitated abuse has a profound impact on women who are already victim survivors and experiencing mental health issues.
4. Expose the community to more high-profile people with a mental illness in the media so that more people in the community can engage in mental health conversations and help reduce stigma and discrimination. Build on models such as Beyond Blue that already work well.

Question 2: What is working well and what can be done to better prevent mental illness and to support people to get early treatment and support?

1. Beyond Blue is widely admired and needs to continue.
2. Headspace has made commendable inroads into working with young people, but more needs to be done for young people with an identifiable mental illness.
3. Role models and ambassadors for mental health, such as AFL footballer Tom Boyd, play an important role in normalising mental illness. Role models need to go beyond AFL footballers, however, to attract a wider population of young girls and boys.
4. Schools are offering more wellbeing-type programs, but their quality, effectiveness and uptake can be variable. The new national platform "Be You" aimed at providing mental health literacy, has reportedly had a slow take-up. Designing and trialling interventions that target young children would be most beneficial in preventing mental illness and providing early treatment and support.
5. Mental Health Plans are working well, as is the capacity to extend them for some types of illness. GPs, however, are stretched for time, often ask poor and inconsistent questions and do not necessarily understand the mental health offer. Support could be widened through the involvement of other health and allied health professionals who can provide support in partnership with GPs.
6. Frontline services have a heightened awareness of mental illness and complex issues, but there is still a tendency to provide 'band aid' support when longitudinal support is generally what is required.
7. Greater flexibility is needed in the service system to recognise that people move in and out of episodes of care and to allow people time to recover and recognise that mental health issues will escalate at times of trauma.
8. The Forensicare Mental Health Assessment and Referral Service (MHARS) based in the Criminal Division of Magistrate Courts is working effectively, but there is a significant lack of crisis and acute care in the family violence, civil and family lists. Forensic Care Nurses should be extended to all Courts and lists.
9. Magistrates' Courts across Victoria would be better able to help people to get early treatment and support through: creating a triage and assessment function within Courts to better screen and refer people to the right supports at the earliest time; the expansion of diversionary options into community mental health supports; continuing to expand the Court Integrated Service Program (CISP) and to include CISP as an outreach capacity to be able to better service the needs of people in their communities; and the expansion of the specialist Assessment and Referral Court (ARC) to equitable access across Victoria.
10. The Forensic Mental Health in Community Health Project that is piloting wrap-around supports for people with low to medium needs appears to be very useful and should be extended.
11. The Specialist Family Violence Children's Counsellor role works very well, but there is only one role for the entire region and enormous waitlists. The numbers and capacity of the Counsellors needs to be increased.
12. Psychologists-in-residence within agencies can have a significant impact on client outcomes. In one of our agencies, the psychologist was employed to see people in complex situations of homelessness where family violence and mental health issues are almost always present. Despite the program having resulted in significantly better outcomes with substantial positive impacts for clients, it is no longer being funded.
13. Wrap-around services, where available, work very well to provide people with a holistic approach, including access to psychological support. Wrap-around services need to be adequately funded and co-case management should be encouraged.

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

1. Police welfare checks are usually effective and responsive. Police, however, do not always provide feedback to the relevant agencies, leaving them in the dark as to the suicide risk, and it is often an arduous task to track the information down.
2. RAMP for perpetrators works well at keeping eyes on the person when the services are connected. It is problematic, however, when the perpetrator of family violence is not connected to any agency.
3. Perpetrators often threaten to commit suicide, and many are successful. Services at the crisis end struggle with this reality as it is very difficult to get people into treatment. Agencies rely on CAT

teams, but they are limited in what they can do. Expanded treatment services and case management are urgently needed to prevent suicides by perpetrators.

4. Suicide risk is often at its highest when perpetrators of family violence are at Court and at their lowest ebb, facing homelessness, the loss of access to children and partners etc. Supports (beyond counselling) are needed at this crisis point to reduce the likelihood of self-harm or harm to others. Continuity of care also needs to be provided for an appropriate level of time. Often perpetrators of family violence are admitted to hospital for 2-3 days, then released into homelessness with no discharge planning or community supports, which places them at significant risk. Bed availability in Victoria is half the OECF average, which severely affects the duration for which a person receives care. It is a similar resource problem with refuges.
5. Capacity building is needed for practitioners and the family violence workforce to recognise the indicators of suicide risk and understand suicidal and homicidal behaviours (include adolescents, LGBTIQ persons and men aged over 75 years). The family violence services system also needs the ability and resources to respond, and the support of the mental health system to ensure sufficient resources are in place and continuity of care.
6. Resolving the tensions between people's rights, needs, self-authorisation, and capacity to make decisions.
7. It is difficult to "get a service" from CAT teams and these difficulties are dramatically increased when a person is homeless. Intensive teams, similar to what used to be undertaken by CAT teams, are needed to 'hold' people until a suitable response is found.
8. Addressing issues of worker safety as workers are unable to attend to people in their home when the risk to worker safety is too high. This in turn impacts on staff morale as staff feel hopeless and unable to help.
9. Address the significant gap that exists in the current service system for clients who do not have the capacity to care for themselves but who are not admitted to hospital. This includes people who should be eligible for the NDIS. These people go unassessed and undiagnosed, which sets them up to fail.

4. 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.

1. It is difficult for people experiencing family violence to have good mental health, therefore addressing family violence is paramount. Similarly, better funding of services and support for people suffering from significant mental illness will reduce the incidence of family violence.
2. The removal of men from their families leads to significant grief and loss which, combined with the lack of housing options for men, has a major impact on their ability to address their mental health and to engage effectively with services and family members. Greater holistic support and service continuity is needed. The Caldonian Model in Scotland, for example, provides men with 2 years of support to address their use of family violence. In Victoria, men receive 20 weeks. It also needs to be recognised that the removal of the perpetrator creates a new wave of potential mental health issues for the other family members. Safety for victims of family violence needs to be a priority.
3. Homelessness has an enormous compounding effect and is a significant issue in treating mental health across the network. There are simply not enough rooming houses or Resi-Rehabs offering a refuge model for mental health and substantial investment is required.
4. The loss of community mental health support services under the shift to the NDIS has had a dramatic impact the community. The NDIS' budget for 64 000 people with chronic mental illness fell dramatically short of the 700 000 people now requiring support. The NDIS needs to be properly funded to provide adequate supports to all eligible people with chronic mental illness.

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

1. Geographical and cultural isolation are major drivers behind some communities experiencing poorer mental health outcomes. The Sudanese community, for example, has a higher suicide rate than that of the wider population – its members feel marginalised, they may have language problems and

difficulties in feeling they belong in the wider community. They are keenly aware of the stigma attached to violent gangs etc.

2. Social determinants of health are another major driver – people with literacy and numeracy difficulties, people who misuse alcohol and other drugs, LGBTIQ persons and those who experience trauma or natural disasters.
3. Communities experiencing poorer mental health need, in the first instance, to have access to food, housing, medical and psychosocial care, and then the support to develop a sense of safety and belonging in their community. The wider community needs greater cultural literacy and community education in order to be more aware, inclusive and able to support people with poorer mental health outcomes.

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

1. The inadequacy of supports for family members and carers places them under considerable strain. Prime carers often become depressed themselves. Pregnancy, the birth of a child and other family developmental stages can also exacerbate issues. Families and carers need better access to counselling and support, including respite, as
2. Caring for someone with a mental illness in the context of family violence creates very complex dynamics for family members and carers. Family violence can in some cases be seen as "carer stress". It requires careful insight, understanding and appropriate responses from support services.
3. For families and carers from different cultures, there may be an added level of expectation and guilt. Arranged marriages, for example, create particular expectations on family members. For recent arrivals, there is often great stress in the first 2-3 months after arrival; they may have travelled with the perpetrator of family violence from where they have come from, and not have any access to income, supports, or Medicare. People on short-term visas can be even more vulnerable. Families and carers need nuanced, culturally sensitive supports.

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

1. Reduce the stigma around mental health in the community generally.
2. Create improved career pathways from school into universities to better attract people into careers in mental health.
3. Raise guidelines and standards for workers through Professional Associations.
4. Make mental health jobs more attractive through improved terms and conditions including flexible hours; job sharing; access to counselling; greater awareness of and support for workers' own mental health issues resulting from exposure to family violence, clients' mental health and complex trauma; setting minimum standards for supervision; improving training for supervisors; providing staff with the tools and adequate resources to do their jobs including use of technology to make easy referrals etc; providing health and wellbeing incentives.
5. Improve pay and conditions to assist the retention and attraction of casual staff. Staff are often trained by agencies then lost to other sectors where they receive better payrates and lower caseloads.
6. Create a service system that staff can have confidence in rather than carrying undue stress and anxiety when, for example, someone is discharged into less than satisfactory circumstances.

8. 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 realist these opportunities?

1. The NDIS presents an opportunity to provide people with greater support to connect to social and economic participation. To achieve this, however, NDIS needs to be properly funded for support coordination.

2. Addressing community barriers and stigma around mental illness will increase the capacity for people to job share, have flexible working environments etc. Not all people require support to participate, they may just need better understanding from the broader community.

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?

1. Housing and support including an interim refuge model (not all people with a mental illness need acute levels of care)
2. Fostering integration between the various parts of the system – this includes health, justice, police, education etc. Service system integration can be built on the recommendations of the Royal Commission into Family Violence
3. Design an appropriate crisis management system - people having to be voluntary creates a risk to the community.
4. Create an improved post-service response
5. Create a system for perpetrators of family violence admitted onto acute wards that doesn't put other patients at risk.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

1. Begin the recruitment of mental health workers to support enhanced service system responses.
2. Create better data systems.
3. Learn from the lessons of the Royal Commission into Family Violence and the Implementation Monitor's Reports.
4. Begin community awareness raising and education to normalise mental health and reduce stigma and discrimination.
5. Create an Information Sharing Scheme similar to that developed as part of the family violence reforms. Sufficient information needs to travel with people into vastly different parts of the system including custody, community, private practitioners, hospitals etc. Confidentiality issues will need to be addressed.
6. Ensure that recommendations include a strong focus on the comorbidity of mental health with family violence, and with substance abuse, as this is often missed.
7. Ensure that the voice of consumers is heard.

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