

WITNESS STATEMENT OF MARIE PIU

I, Marie Piu, 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 that information to be true.

Please detail your background and experience.

- 1 I am a registered Psychologist and have worked in community and clinical mental health, union, police and management consulting sectors.

Please describe your current role and your responsibilities, specifically your role as CEO of Tandem

- 2 I am the CEO of Tandem which is a not for profit peak body with a sole focus on the needs and interests of mental health carers. I have responsibility for 12 staff across three main programs which are the Carer Support Fund, Advocacy and Engagement.
- 3 I also hold a variety of other roles such as the co-chair of The Lived Experience Advisory Group of the Mental Health Branch of DHHS, a member of the Eastern Primary Health Network Community Advisory Group, a member of the North West Melbourne Primary Health Network Mental Health Expert Advisory Group and have also recently been appointed to the Mental Health Ministerial Advisory Committee.

What is the role of Tandem?

- 4 Tandem is a trusted voice of mental health carers in Victoria. Tandem's role is to provide leadership, coordination and knowledge for the organisations and individuals who are working to improve outcomes for Victorian people living with mental health issues. Tandem is committed to ensuring that the importance of the contribution, expertise, experiences and needs of family, friends and other carers is recognised and addressed, and that they will be essential partners in treatment, service delivery, planning, research and evaluation.
- 5 Tandem has 59 organisational members and supports over 3000 carers a year across Victoria.
- 6 Tandem is involved in the following activities:
 - (a) advocacy for carer involvement in planning and care, participation in system change, and support for families and friends;

- (b) promoting and supporting the development of mental health carer workforce and leadership;
- (c) informing and empowering mental health carers to access the National Disability Insurance Scheme (NDIS);
- (d) promoting and collaborating on the delivery of training on family inclusive practices for mental health professionals;
- (e) providing information, education and training to mental health families, friends and supporters;
- (f) supporting and advocating for the diverse needs of families, friends and supporters of people living with mental health issues;
- (g) collaborating on research and policy development on matters relating to mental health carers; and
- (h) raising community awareness about the important role of families, friends and supporters in mental health recovery.

7 Tandem manages the Mental Health Carer Support Fund which provides up to \$1000 per year to each carer supporting someone in Victoria's 31 Area Mental Health Services. In 2018, the Mental Health Carer Support Fund aided 3,427 people. Tandem also manages the Tandem Victorian Mental Health Carer Register on behalf of the Mental Health Branch of DHHS. Additionally, Tandem supports the Carer Lived Experience Workforce.

What role are carers and families assuming in caring for the needs of people with mental health issues?

- 8 Unpaid mental health carers in Australia play an essential role in our society. Most people with mental health issues live in the community with family and friends supporting them. Mental health carers report that they provide care for the following reasons: *first*, because they believe they can provide better quality of care than they could otherwise afford, *secondly*, because of the bonds of family or friendship or *thirdly*, because no comparable or otherwise helpful service is available.
- 9 Research done in this area highlights that most of the support (67%) carers provide is emotional support.¹ However, carers often also find themselves having no option but to provide extensive social and practical support in the absence of support services. Additionally, more than a third of mental health carers find themselves responsible for providing over 40 hours of care each week and becoming defacto case managers and

¹ Diminic S, Hielscher E, Lee YY, Harris M, Schess J, Kealton J & Whiteford H. The economic value of informal mental health caring in Australia: summary report. Brisbane: The University of Queensland; 2016
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financial planners. This is often due to government support services being inappropriate, inaccessible, underfunded or unavailable.

- 10 A major study of subjective wellbeing of family carers in Australia undertaken in 2007 showed that carers had the lowest collective wellbeing score of any group sampled utilising the wellbeing scale. 56% of carers were found to have moderate depression, and carers reported stressors in employment, with over one third being concerned about job loss as a consequence of being in a carer role.²
- 11 Data from the economic value of caring commissioned by MIND Australia³ highlights the below:
- (a) 21.7% provide care to at least one other person with another disability type;
 - (b) 14.7% were young carers aged below 25 years;
 - (c) 49.1% had been caring for ten years or more;
 - (d) 38.4% of carers were not in the labour force;
 - (e) the care recipient was most commonly the spouse/partner (45.8%) or child (31.8%); and
 - (f) 25.3% of care recipients were aged between 1–24 years.

What currently happens when a person living with mental health issues does not have any family or carers to support them or if their carer is no longer able to provide support?

- 12 It is likely that without access to NDIS support or adequate services and housing options that many will fall into homelessness, end up in prison or worse, lose their lives.

How will changes to Victoria's population (such as ageing) impact on this?

- 13 I have observed that a huge fear of carers who are ageing grandparents, parents and siblings, is to who or what will fill the void when they are gone.
- 14 I have spoken to older carers who have explained this fear to me. One carer who is now 74 years of age, who began caring for her brother as a teenager said that she wanted to know that there were proper supports and plans in place for her brother after she is no longer around as a carer. Specifically, she wanted to know that someone would be available to check in on him and make sure he is okay.

² Cummins, R et al. Special Report 17.1. The Wellbeing of Australians – Carer Health and Wellbeing. Deakin University October 2007 p. vi–vii

³ Diminic 2016, op cit.

- 15 In my opinion, for those who do not have siblings or other family or friends to pick up the carer role, unless the person is able to access support through the NDIS, they will remain unsupported.

From your experiences at Tandem, what are the impacts on family members and carers caring for someone experiencing mental health issues?

- 16 The impacts on family members and carers caring for someone are profound and lifelong. However, these impacts can be improved with early and ongoing support.

- 17 A carer who has been a carer for the last thirty years, starting as a young carer in her 20's, said the below to me:

"My experience is one of intergenerational trauma, constantly battling with the mental health system to get myself and my family member's access to meaningful mental health support.

I have witnessed the changes from deinstitutionalisation to community care. It has been exhausting to navigate and the responsibility of care and support has always fallen to me when the system failed to support my family members. I have lost seven close family members and friends to suicide.

Both of my parents were diagnosed with severe mental illness when I was a child, which resulted in myself and my siblings being put into care. Both my brother and sister were diagnosed with a mental illness in their youth. My sister was only 21 years old when she suicided. Despite my best efforts as a 20 year old with a baby, my brother was unable to access proper mental health support. Despite regular, severe self-harm episodes spanning several years he was repeatedly discharged to me, his 20-year-old sister and a mother with a young child. There was no support for families to deal with this and my children were exposed to many violent episodes. We were told there was 'nowhere to send him' so they sent him home and he took his own life.

Now in my 50's, I have my own diagnosis of mental illness relating to my past traumas and I also care for my son who has recently been diagnosed with a mental illness. The cycle continues alongside the failings of the system."

What do families and carers of people living with mental health issues report they need to support their loved ones and themselves?

Lack of understanding of the caring role

- 18 Mental health carers consistently tell us that their primary relationship with the mental health consumer is relational: husband, wife, friend, daughter, son, sister etc. They do not want their relationship defined by the caring role; however, replace with the way

decisions are made about what services are funded effectively confines them to this limiting identity.

- 19 These carers could be children and young people who experience reduced educational and employment opportunities, with 71.4% of carers aged between 15-24 studying or in paid work, compared to 91.3% of their non-carer counterparts.⁴ Many of these carers are also parents and grandparents well into their twilight years with no support.

Lack of investment in carers

- 20 Without a significant cultural shift and strong leadership alongside a significant increase in investment in the mental health system, including a conscious specific investment supporting the contribution of carers, this vital network of support that carers provide and which has been estimated at \$3.3 billion based on the figure provided nationally⁵, is at risk.

- 21 If a carer is no longer able to provide ongoing support, the person with mental illness can become more at risk of hospitalisation, homelessness and suicide. These impacts in turn, flow on to the federal, state and territory governments with cost blow outs in health, justice, housing and homelessness, and addiction services.

Lack of adequate and appropriate supports

- 22 Mental health carers have been significantly impacted by major reforms to Commonwealth Government funded mental health services over the last few years. These reforms have seen services shift from targeted and specialist mental health support services towards generalist disability solutions. This trend is illustrated by two major reforms to the delivery of community-based mental health services: the NDIS and the Integrated Carer Support Service (ICSS). The restriction of discussion on projects and services in the early stages of review and rollout, mean that it is difficult to meaningfully discuss issues around the Integrated Carer Support Service and related carer supports/interventions that fail to meet the evaluations threshold as to their effectiveness and value for money. It is important for this Commission to be aware that it seems highly unlikely that the ICSS will be in any way able to replace the supports that have been removed to make way for the NDIS. This is particularly true of respite services.

⁴ Diminic S, Hielscher E, & Harris M. Understanding the factors associated with Australian mental health carers' employment: summary report. Brisbane: The University of Queensland; 2018.

⁵ Diminic 2016, op cit. The study states that "To calculate the annual replacement cost for mental health carers in Australia for the year 2015, we required estimates of: 1. the total number of mental health carers in Australia 2. the total hours of care provided by each mental health carer in a year 3. the cost per hour to replace this care with formal services 4. cost offsets for the estimated current annual government expenditure on mental health carers that might not be required if all informal care was replaced with paid formal care."

- 23 Without adequate and appropriate support, carers can see a reduction in their own health and wellbeing, with some becoming at risk of developing their own mental health conditions⁶. Not only does this lack of support have consequences for the carer, it can also have negative consequences for the person they care for, particularly if it results in the carer being no longer able to perform their caring role⁷
- 24 The financial support presently available such as the Carer Support Fund administered by Tandem is insufficient, particularly as the level of funding has not been reviewed over the 10 years it has been in place and has only been recently indexed.⁸

Lack of access to information about mental illness and carer support services

- 25 Carers continue to meet resistance when trying to access information vital to the carer relationship, and involvement in care planning and discharge. This must change.
- 26 In my opinion, these challenges cannot be met without much greater government acknowledgment and investment.

In what ways are current services and arrangements meeting or not meeting those needs and what could be done to better meet these needs?

- 27 There has been an acknowledgment of mental health carers (family and friends) as well as associated investments by the Victorian Government in the past year including the release of the *Victorian Carer Strategy*⁹ and updated Chief Psychiatrist Guideline *Working together with families and carers*.¹⁰ However, these are only guidelines and has only limited scope to change practices in relation to identifying, including and supporting the consumer and their family and friends or support network services on the ground.
- 28 Additionally, there has been no similar acknowledgment or investments by the Commonwealth Government. In the absence of adequate and appropriate support services, family members and friends are increasingly providing intensive and complex care for people with mental illness. Mental health carers often face different challenges to those faced by other carer cohorts, and consequently, have their own unique support needs. Mental illness has a younger age of onset than most physical health conditions such as cardiovascular, musculoskeletal and neurological disorders. Mental health carers also tend to provide high levels of emotional and behavioural support to the person they

⁶ Cummins, R et al. Special Report 17.1. The Wellbeing of Australians – Carer Health and Wellbeing. Deakin University October 2007 p. vi–vii

⁷ Shah, AJ., Wadoo, O. and Latoo, J. 2010. 'Psychological distress in carers of people with mental disorders'. British Journal of Medical Practitioners, 3:3.

⁸ https://www.tandemcarers.org.au/images/TandemPreBudgetSubmission_Jan2019.pdf

⁹ <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-carer-strategy-2018-2022>

¹⁰ <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/working-together-with-families-and-carers>

care for, making up on average 67.9% of their caring role.¹¹ Providing these supports, and a range of other day-to-day supports long-term can have a significant impact on their economic security, health and wellbeing and education.

- 29 There is a current tendency in policy design to focus on the individual consumer without sufficient regard to the relational context of a person's life. Research has shown that there are significant benefits associated with the move to individualised funding arrangements, but the presence of supportive interpersonal relationships is critically important to ensuring that people can access these benefits.

A new, fit for purpose system, based on compassion and contemporary thinking

- 30 Victoria's mental health system needs to be revamped into a new, fit for purpose system, based on compassion and contemporary thinking. This has been discussed in more detail in Tandem's submission to the Royal Commission, which has been predominantly informed by extensive consultation with Tandem members throughout the state who are either family or friends with experience of supporting someone living with a mental health issue, or who currently is, or has been engaged with the Victorian mental health system in the past (see Attachment 'MP - 1')

- 31 In order to fix Victoria's mental health system, we need to ensure all services are:
- (a) safe – we need to change the current, punitive, crisis driven system to one which has sufficient, dedicated, accessible and therapeutic services to provide a safe environment for all;
 - (b) inclusive - mental health services must include family and friends in recovery. These groups need to be recognised as a critical part of treatment and recovery teams;
 - (c) fair - everyone has the right to access services. The provision of mental health services must be fair. They need to treat everyone fairly, regardless of their location, gender, sexuality, cultural background, drug and alcohol issues, and economic status;
 - (d) funded - we need to change the culture of the mental health system. It needs sufficient funding to provide the compassionate care people require. We must ensure that the responsibility does not fall to families, police, and emergency departments.

¹¹ Diminic 2016, op cit.

Compassionate leadership

- 32 At present, services are crisis driven and transactional at best and destructive at worst. They do not actively support the practice of compassion with consumers or their families. Compassion is defined as¹²:
- (a) recognising suffering;
 - (b) understanding the universality of suffering in human experience;
 - (c) feeling for the person suffering and emotionally connecting with their distress;
 - (d) tolerating any uncomfortable feelings aroused (such as fear, disgust, distress, anger) so that we remain accepting and open to the person in their suffering; and
 - (e) acting or being motivated to act to alleviate the suffering.
- 33 In order to practice compassion, we need compassionate leadership. Compassionate leadership means creating the conditions – through consistently listening, understanding, empathising and helping – to make it possible to have tough conversations when needed. Staff indicate they only see their leaders when something goes wrong and that even if they do listen, nothing changes after the conversation. Compassionate leadership ensures a collective focus and a greater likelihood of collective responsibility for ensuring high-quality care.
- 34 Consequently, we need to actively support staff to identify and work with 'family' as part of this. 'Family' needs to be understood in its cultural context and can include biological and non-biological relatives, intimate partners, ex-partners, people in co-habitation, friends, those with kinship responsibilities, and others who play a significant role in the consumer's life.¹³
- 35 We also need to provide a multidisciplinary workforce including a significant increase in the number and distribution of family carer workforce members to work as part of recovery teams with consumers and their families/carers.
- 36 It is important to adopt a framework for family-focused care in services. It must be inclusive of children, and it must recognise the diverse roles consumers hold outside a sick role, including parenthood. The framework must recognise that mental illness, and indeed health and wellbeing, occur within families.
- 37 The intensity, stressful and all-consuming nature of mental health caring should not be overlooked and importantly not minimised by excluding families and friends who are

¹² Strauss, Lever Taylor, Gu, Kuyken, Baer, Jones, and Cavanagh (2016).

¹³ Department of Health & Human Services, Mental health lived experience engagement framework (2019)

providing care for someone with a mental health issue. Research indicates they are coping with intense and chronic isolation, grief, loss, guilt, devastation, fear, worries, and sense of responsibility. As a result, it is important that they are not only included, but that their challenges are also addressed

What impact do language and cultural barriers have on family members and carers looking after someone living with mental illness?

- 38 There are many cultural differences in understanding what 'mental illness' is which are based on many different explanatory models of illness. Stereotypes do not apply and there are no 'cookbooks' to look up how to approach or work with someone from Burundi or Italy. Time needs to be taken and the skill learnt to ask the right questions.
- 39 Using a Cultural Consultation approach and utilising a cultural formulation as per the DSM-V is critical in understanding what the person and their family think the problem is, when and why it started, what they think is causing it and what they think will help. Misdiagnosis is likely without the use of such tools alongside interpreters and/or trained bicultural workers. The implications are wrong medications or wrong doses which can have catastrophic impacts on people. The field of ethnopsychopharmacology provides guidelines about differences in the metabolic rates of people from different cultures which is critical to understand before prescribing medications.
- 40 The other difference that needs to be understood is how comfortable people are with speaking with a health care professional or someone perceived as having much more power than them or power distance. Power distance refers to the way in which 'power' is distributed and the extent to which the less powerful accept that 'power' is distributed unequally. Put simply, people in some cultures accept a higher degree of unequally distributed 'power' than do people in other cultures.¹⁴ It is also important to enquire and understand which member of the family is most appropriate to have as the primary spokesperson or contact as there may be cultural mores or practices to respect if the development of a therapeutic relationship is the aim.

What are your personal experiences of this?

- 41 See 'Attachment MP-2' for my personal experience of being a carer.

What is the impact of stigma and discrimination within some CALD communities that make it difficult for carers and families to support a person living with mental illness?

- 42 Culture applies on many levels – it applies to ethnographic categories of ethnicity and nationality, it applies to demographic categories of age, gender and place of residence, it

¹⁴ Geert Hofstede (2014)

applies to categories of educational, social, and economic status as well as a large number of formal and informal affiliations to family and it applies to values.

- 43 The stigma may be greater in some CALD communities because migrants already feel they need to prove they are worthy of being in Australia and they don't want their family to come under any extra scrutiny from others within or outside of their communities. The stigma may be of particular concern for communities where having someone with a mental illness can affect chances of marriage where they are arranged. In order to address this fear, we have reports that sometimes families send the one with an illness back to the country of origin to marry, hoping it might cure the illness or at the very least provide a carer for the person – usually a male.

How do mental health services provide culturally appropriate services? Do you have any examples of good practice?

- 44 I understand that in the public mental health system that this is mixed and dependent on individual clinicians and their commitment or understanding of the importance of doing so.
- 45 It also depends on the culture of the service – whether it is a service where compassion is at the core and demonstrated by service leadership and cultural diversity is acknowledged and valued, whether interpreters are budgeted for and whether translated information is provided to all consumers and families routinely. I understand from anecdotal information that this has deteriorated significantly in the last decade, whilst there has been an increase of (to 24.6%) of Victorians who speak a language other than English at home.
- 46 I am aware of a few examples of good practice. The Cultural Portfolio Holder Network supported by Victorian Transcultural Mental Health functions as a community of practice and is open to individuals working in mental health/community agencies that provide mental health services, who are currently undertaking a role to promote culturally responsive practice within their respective agencies. Similarly, Foundation House provides an excellent and tailored service to refugees and asylum seekers who have experienced torture and trauma. This service is compassionate, culturally safe and holistic.

From your experiences, including at Tandem, what are some of the additional challenges and circumstances that young carers may face? What are your recommendations for how young carers could be better supported, including to ensure their own mental health and wellbeing?

- 47 Young carers are not routinely identified where there is a parent or sibling with a mental health issue and therefore are not included or informed about what is happening, what

- they can do to help and therefore not provided with support. We particularly hear this where there is family breakdown and children are living with the parent without the mental health issue, they are excluded and remain unsupported even though they are living with all the anxieties and fears that accompany this experience.
- 48 A young carer said:
- "My dad first attempted suicide when I was 4 years old. Soon after, my parents divorced and I lived part time with each. My dad had almost a dozen more attempts throughout my childhood and teenage years. I remember visiting him in hospital after a suicidal overdose and being told he was just 'feeling sick'. In all this time no service, worker or teacher ever bothered to check in with me or explain to me what was happening, dad just kept disappearing and I'd stay with mum more often until he was back. It wasn't until I was 16 years old my dad told me he had a severe mental illness. It was a relief to final know what the problem was and that it wasn't me. But I wish someone would have taken the time to explain what was happening far earlier than this. As a kid growing up with a parent with a severe mental illness it is so confusing. You end up being a carer without even realising it or with anyone supporting you in your caring role."*
- 49 Families are a hub of caregiving in mental health. Given the life span of mental illness, children play an important role. There are issues across the lifespan if we fail to engage and support children of families affected by a parental mental illness.
- 50 Where adults experience mental illness and they are also parents it is not uncommon for their children to be undertaking some form of caring responsibility. The likelihood that children will be undertaking long term caring that is disproportionate to their age or level of maturity increases where parents with mental illness are also lone parents, experience poverty, low income, or the impacts of social exclusion.
- 51 When parents have serious mental health problems, the child may provide high levels of emotional care and nursing-type responsibilities such as administering medication, as well as participating in household tasks.
- 52 Children can experience adverse consequences of long-term caring. These include poor educational attainment, low self-esteem, difficult transitions into adulthood as well as developing their own experiences of mental health issues. The nature and extent of children's caring responsibilities when parents have mental illness fluctuates depending on parents' changing mental state. For example, children may feel they need to take on more household duties and care of siblings if and when parents are unwell. Tandem finds it is also common for them to report exclusion from services during hospital admissions or discharges. This is incredibly undermining and potentially life changing for these

children and young people who struggle to understand what is happening around them without any support being offered.

- 53 Children also worry a great deal about their parents' health and these anxieties can affect their school work, concentration levels and attendance at school. This was definitely my experience personally, however I did not understand that was what was happening.
- 54 It is the responsibility of services to support children in these contexts, both with the emotional consequences of living with a parent with mental illness and with their caring roles and experiences.
- 55 Research studies have revealed consistent patterns of need among young carers ¹⁵When children care for parents with mental illness they require both family support and dedicated services to address their needs as carers. Young carers need recognition for their caring roles and access to age appropriate information, particularly relating to mental health conditions and to information about support services and benefits. Young carers also need someone they can talk to about their own emotional needs, their family circumstances and their caring responsibilities. Parents with mental health issues may also require parenting support. They also need services and professionals to recognise and encourage the family relationship outside of their caring role.
- 56 A critical factor in helping young carers access support services is to ensure that their caring contributions are recognised. In the UK, the needs of young carers have been addressed by including them in health and social care policy and in guidance for professionals working with vulnerable children. Young carers can be assessed as children in need which means that local authorities have a duty to make a formal assessment of young carers' needs and those of their families. There are also now more than 140 young carers' projects in the UK that offer a range of dedicated services to children, including befriending support, homework clubs and respite services.¹⁶
- 57 In Victoria we have the FaPMI program which has the mandate to work with the parent with a mental health issue and support the family as a whole. This is an invaluable service that has been expanded across Victoria.
- 58 Tandem also believes it is essential to work across sectors to include schools, maternal health nurses and other related services to maximise the opportunity to identify those children and young people supporting a parent or a sibling with mental health issues and ensure they are validated in their role and supported appropriately.

¹⁵ Diminic, S op cit

¹⁶ <http://www.copmi.net.au/professionals-organisations/what-works/research-summaries-gems/gems-edition2>

Why is it important to support young carers and what could be gained in helping young carers?

- 59 It is critical that young carers are identified, provided with information on what is happening and how they can be helped and supported so they are able to continue to enjoy age appropriate activities, form healthy relationships, complete their education and/or gain employment.
- 60 It is also important that we support them and don't automatically pathologize them so that they are able to identify themselves by virtue of their relationship rather than the support they provide to their parent or sibling with mental health issues. Where a child or young person is from a culturally diverse background, staff must not assume that individualism is the best approach for the child - interdependence is normal for much of the world's population and definitely for kids from Aboriginal and multicultural homes in Victoria. In my experience, trying to force or push individualism only puts pressure on relationships and causes harm. People are living within a social context and attention to this is as important if not more so than medication and other interventions. We have to stop being so myopic in our approach.
- 61 We have heard from carers throughout this Royal Commission process who are now identified as "aging carers", but consultation with them reveals that their caring roles began as young carers for siblings more than 60 years ago. They have watched their parents die young from the impacts of caring, and as such have given up their careers, lost friends and experienced family breakdowns, to ensure they are able to care and support their siblings. For today's young carers, they are aware that this is likely to be their life for many years to come. Young carers need support so that this cycle does not continue and they are not left to pick up the pieces from this fragmented system.

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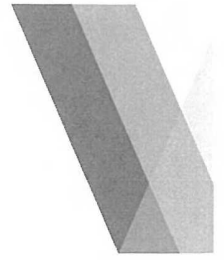
print name Marie Piu

date

17/7/19



Royal Commission into
Victoria's Mental Health System



ATTACHMENT MP-1

This is the attachment marked 'MP - 1' referred to in the witness statement of Marie Piu dated 17 July 2019.

Submission to the Royal Commission into Victoria's Mental Health System

Royal Commission into Victoria's Mental Health System
 PO Box 12079, A'Beckett Street, Victoria 8006
 And by online submission
 July 2019

Tandem Inc.
 Representing Victoria's mental health carers

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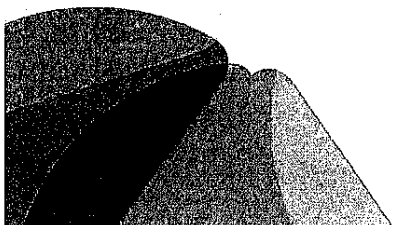
About Tandem

Who we are

Tandem is the Victorian peak body representing mental health carers of people living with mental health issues.

What we do

- We advocate for carer involvement in planning and care, participation in system change, and support for families and friends.
- We promote and support the development of the mental health carer workforce and leadership.
- We inform and empower mental health carers to access the National Disability Insurance Scheme (NDIS).
- We promote and collaborate on the delivery of training on family inclusive practices for mental health professionals.
- We provide information, education and training to mental health families, friends and supporters.
- We support and advocate for the diverse needs of families, friends and supporters of people living with mental health issues.
- We collaborate on research and policy development on matters relating to mental health carers.
- We raise community awareness about the important role of families, friends and supporters in mental health recovery.
- We administer the Carer Support Fund which provides financial assistance to families, friends and supporters of people registered with Area Mental Health Services in Victoria.



tandem  representing Victorian
 mental health carers

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Glossary of Terms

Carer	<p>A carer may be, and will continue to be, primarily the person's wife, husband, partner, son, daughter, parent, neighbour, friend, ... their child or children. It doesn't matter how many hours are spent each week providing support. Carers may live with the person they are caring for, providing assistance with daily needs, or may visit the person regularly. Carers are people who invest time, energy and support, generally in an unpaid capacity. However, some may receive Centrelink benefits to enable them to continue in their caring role. Carers are often hidden. Children who become carers face particular difficulties in being recognised and having their needs met. In culturally diverse communities, care may involve the entire community and may provide additional challenges during the process of identifying who is a carer.</p> <p><i>Adapted from A Practical Guide for Working with Carers of People with a Mental Illness, p.6</i></p>
Co-design	<p>Co-design is a creative process to actively involve all stakeholders (e.g. services, consumers, carers) in a collaborative design and re-design process to help ensure the result meets their needs and is usable.</p>
Compassion	<ol style="list-style-type: none"> 1. Recognising suffering 2. Understanding the universality of suffering in human experience 3. Feeling for the person suffering and emotionally connecting with their distress 4. Tolerating any uncomfortable feelings aroused (such as fear, disgust, distress, anger) so that we remain accepting and open to the person in their suffering and 5. Acting or being motivated to act to alleviate the suffering. <p><i>Strauss, Lever Taylor, Gu, Kuyken, Baer, Jones, and Cavanagh (2016).</i></p>
Compassionate leadership	<p>Compassionate leadership means creating the conditions – through consistently listening, understanding, empathising and helping – to make it possible to have tough performance management and tough conversations when needed. Staff indicate they only see their leaders when something goes wrong and that even if they do listen, nothing changes after the conversation. Compassionate leadership ensures a collective focus and a greater likelihood of collective responsibility for ensuring high-quality care.</p> <p><i>Adapted from: https://www.kingsfund.org.uk/audio-video/michael-west-collaborative-compassionate-leadership</i></p>
Family	<p>Family is culturally grounded; for example, Australian Aboriginal nations each have rich, complex and nuanced kinship and family structures which prescribe relationships and responsibilities people have to each other and the land. Family includes the consumer and those with a significant personal relationship with the consumer. This includes biological relatives and non-biological relatives, intimate partners, ex-partners, people in co-habitation, friends, those with kinship responsibilities, and others who play a significant role in the consumer's life. Some family members may identify themselves as a "carer" in a consumer's life, others will identify more so with the characteristic of their relationship (for example: parent, child, partner, and sibling).</p> <p><i>Department of Health & Human Services, Mental health lived experience engagement framework (2019)</i></p>
Family carer Workforce	<p>Family carer workforce is a collective term for family carer workers in a range of roles. Family carer workers provide support and connection for people who are in a consumer's family, some of whom may identify as a carer.</p> <p>Family carer workers may do this directly through providing peer support, or indirectly through leadership, advocacy, education, and research. Lived experience as a carer is an essential part of the selection criteria, with other skills and knowledge required depending on the role.</p> <p><i>Strategy for the Family Carer Mental Health Workforce in Victoria CMHL (2019), p.3.</i></p>
Relational recovery	<p>Relational recovery is a model which emphasises the interpersonal aspects of recovery, recognising that people's lives and experiences cannot be separated from the social contexts in which they are embedded.</p> <p><i>Adapted from Price-Robertson, Obradovic, & Morgan. (2016). Relational recovery: Beyond individualism in the recovery approach. Advances in Mental Health, 15.</i></p>



Tandem's key asks:

Victoria's mental health system is broken. To fix this system we need to ensure all services are:

Safe: Change the current punitive, crisis driven system to one which has sufficient, dedicated, accessible and therapeutic services to provide a safe environment for all.

Inclusive: Mental health services must include family and friends in recovery. These groups need to be recognised as a critical part of treatment and recovery teams.

Fair: Everyone has the right to access services. The provision of mental health services must be fair. They need to treat everyone fairly, regardless of their location, gender, sexuality, cultural background, drug and alcohol issues, and economic status.

Funded: We need to change the culture of the mental health system. It needs sufficient funding to provide the compassionate care people require. We must ensure that the responsibility does not fall to families, police, and emergency departments.



Executive Summary

Tandem, the peak body for mental health carers in Victoria, welcomes this Royal Commission into the Mental Health System in Victoria as an urgent opportunity to change the system to one which is properly resourced and demonstrates compassion for all in need. We urge the Commission to be bold, and make recommendations to truly transform the system as it is. This is a once in a generation opportunity.

Our members and supporters, both individual carers and organisations, have told us, through consultations – inclusive of urban, regional and rural members – that the mental health system in Victoria is in many ways broken. It currently only operates in crisis. When it does operate, it is largely experienced as unsafe and not inclusive of families and friends who care for people with mental health issues, poorly funded, and unfair.

For people experiencing acute mental distress and their carers, the system is deeply flawed. It relies on police, ambulance and emergency departments. The system communicates poorly with carers and family. It is underfunded and experienced by many as uncaring. It leaves people behind, unable to access the few beds, in a bed-based system. At best, it is transactional. At its worst, it is experienced as destructive.

The impacts of the failed system ripple through our community, our courts and our hospitals. Victorian's need a mental health system which has responsive, compassionate, and accessible services, available everywhere, when people need it.

Carers, the family and friends of those with mental health issues, are predominantly women, and often face substantial impacts in every part of their lives, including their own mental health. The system fails carers, when it fails those they care for.

Victoria can potentially have a world class mental health system. This system must be safe, inclusive, fair and well-funded. It must challenge the stigma that those with mental health issues and their carers face. It must have the resources to address all people's issues and to ensure that families and friends are seen as a critical part of the team that treat and manage mental health issues.

Unless we address these issues with real funding and a change of culture, they will continue to ripple through our community, damaging people and their families and supporters. Ultimately, failing to ensure people's right to a decent quality of life is upheld.



Introduction

"Families are at the end of their tether with this broken system." – Aunt & carer, 64 years of age

Tandem, the peak body for mental health carers in Victoria, welcomes the decision by the Premier Daniel Andrews and Minister Martin Foley to call a Royal Commission into the broken system that is also out of date in terms of international innovative best practice in mental health care. This is a once in a lifetime opportunity for reform to ensure Victorians get the services they need, when they need them. We need a new, fit for purpose system, based on compassion and contemporary thinking.

This submission to the Royal Commission into Victoria's mental health system is predominantly informed by extensive consultation with Tandem members throughout the state who are either family¹ or friends (mental health carers²) with experience of supporting someone living with a mental health issue, or who currently is, or has been engaged with, the Victorian mental health system in the past.

It includes those supporting people at risk of suicide, or who have tragically lost family or friends, to suicide. For every death by suicide, it is estimated that as many as 30 people attempt to end their lives. In Victoria, this means 65,000 suicide attempts every year³. After a suicide attempt, its family and friends who have the most contact with the person. If they are properly informed and resourced, they can play a major role in suicide prevention. Provision of information, education and support to families and carers post discharge has the potential to be a major suicide prevention strategy.⁴

"Despite regular, severe self-harm episodes spanning several years my brother was repeatedly discharged to either me, his sister, a 23-year-old mother with young children, or to his wife who was at home with their 6-week-old baby. It's idiotic. There was no support for families to deal with this and our children were exposed to many violent episodes. We were told there was 'nowhere to send him' so they sent him home and he took his own life."

– Sister, carer & consumer, 45 years of age

"My life has literally been in a state of depression so much, that at times it would be easier to simply not be on earth. This is not an option, but sounds easier than constantly dealing with my lot."

– Mother & carer, 53 years of age

Tandem has also contributed and supports a number of other organisational submissions including those by:

- Mental Health Victoria
- Victorian Council of Social Services
- Council for Homeless Persons.

Tandem also acknowledges the assistance of Dr Melissa Petrakis⁵.

¹ See Glossary

² *ibid*

³ Lifeline, 2015

⁴ Victorian suicide prevention framework 2016–25

⁵ Petrakis, 2019, A Systematic Literature Review: Family and Carer Interventions



Culture of the mental health system in Victoria

Tandem believes that in order to fix our broken system we must acknowledge that we currently have a service delivery culture which is doing harm. It is, at best, transactional rather than compassionate.⁶

We suggest, that for mental health services to be fixed, they need to become safe havens of therapeutic healing, inclusive and fair. For that to occur, we must insist on a substantial increase in funding, alongside fundamental cultural change, and compassionate leadership. Without both, our system will continue to do harm.

Compassionate leadership means creating the conditions – through consistently listening, understanding, empathising, and helping – to make it possible to have tough performance management and tough conversations when needed. Compassionate leadership ensures a collective focus and a greater likelihood of collective responsibility for ensuring high-quality care:

“Compassionate leadership requires courage. The courage to listen to tough messages from those we serve and lead. The courage to explore their understanding of the challenges they face and to have our own interpretations challenged and rejected. And the courage to accept that practicing compassionate leadership will first and foremost address the most apparently intractable workplace challenges such as excessive workload, staff shortages and ever-increasing demand. Putting such leadership into action demonstrates not the myths, but the magic of compassionate leadership.”⁷

Our mental health workforce, including the consumer and family carer workforce⁸ is arguably amongst the most motivated and skilled in Victoria. However, we impose on them a dominant command and control style that has the effect of silencing their voices, suppressing their ideas for new and better ways of delivering care and suffocating their intrinsic motivation and fundamental altruism. Released, their motivation and creativity can ensure commitment to purpose and performance. Their voices are needed alongside consumers and their family and friends, to tell us how care can best be improved.

As commissioners you have witnessed many testimonies around the state. You will have heard stories of a Catch 22, when the only option available to people exacerbates the issues it is seeking to address. Families experience chaos as they try to find the right door, in fact any door, which will lead to support. They then report challenges in dealing with police, ambulance and other service providers who are clearly under resourced, and struggling to deal with the impact of our broken mental health system. People spend hours waiting in overcrowded and stressful emergency departments, only to be discharged, sometimes without the knowledge of their family, on powerful medication. Often, the process repeats over and over, with the person's condition continuing to deteriorate.

It is the view of Tandem that this is a service based culture, which is punitive, chaotic and most importantly, one which exacerbates the acute issues people are facing. It isn't compassionate. It's often brutal. This is in part caused by underfunding and under-resourcing, but also a culture of transaction and process over people's experience.

⁶ See Glossary

⁷ Don Berwick, Prerana Issar, Sam Allen, Sussex Partnership Trust, King's Fund webinar, May 2019.

⁸ See Glossary



But it's not working for our members or consumers. It places huge stresses, and mental health impacts, on police, ambulance, those who work in the Emergency Departments and the mental health clinicians. It ostracises families and friends, and causes tremendous further pain and anxiety for the consumer.

People with mental health issues need care, they need people to take the time to understand their condition, and otherwise they're unable to heal.

Family and friends are in despair. They recount examples of staff who did their best and were compassionate, but that sadly, these experiences are the exception.

Families and friends almost universally report being denied basic information, which would aid them to care, build stronger relationships, or just understand what's going on. On the ground, this means people being discharged from hospitals in the middle of the night, sometimes hundreds of kilometres away from their only family support or any shelter, without even a phone call to that family.

Tandem believes that Victoria deserves a world class mental health system. One in which we can expect the same compassionate therapeutic care that wraps around its clients and their families when services are treating cancer. Services in which mental health issues are identified early, treatment options are carefully explored and support is offered to the whole family. A world in which public awareness campaigns around the spectre of mental illness and its prevention are rolled out, and a broad suite of bio-psychosocial supports and therapies contribute to the highest quality of care.

Extensive worldwide evidence exists that indicates that shared understandings of recovery, developed in a social context in partnership with consumers, carers, and clinicians, improve results. Investigating new ways of working to increase staff contact time with service users and carers to improve a focus on relational recovery⁹ is key to a compassionate Safe Inclusive, Fair and Funded mental health system going forward.

Our system must be transformed from the crisis driven one that we currently have to one with:

- Compassion at its core and compassionate leadership at the helm
- No wrong door to accessing care
- A system that recognises that family and friends are a critical part of the recovery journey and consequently are entitled to respect, kindness, information and support

⁹ See Glossary



SAFE

Tandem members have told us that to be SAFE services must provide:

Compassionate care for all: change the current punitive, crisis based system to one which has sufficient, dedicated, accessible and therapeutic services to provide care for all. This includes:

- Limiting the use of police, and emergency departments to fill the gaps, using seclusion and restraint as a last resort, and eradicating sexual assault within facilities of care.
- Ensuring that there is a full complement of consistent, caring professionals always available, including where possible, those with a lived experience, who are able to provide care for those experiencing mental health distress and their families, friends and carers. Ensure these workers understand the history of the consumer, and are encouraged to consult the family regarding this history.
- Actively reshaping of the culture of mental health services, to ensure that staff have compassionate leadership and have the resources, training and support to care for people with mental health issues appropriately.
- Providing women only wards, and wards which ensure cultural safety to people from culturally diverse and Aboriginal communities
- Ensuring there are adequate beds available and remove wait lists for accessing services. Remove the incentives hospitals have to discharge early, without consulting families and carers. Create environments which are conducive to healing, not sites of further distress and anxiety.
- Supporting staff and carers. Ensuring that there's sufficient care and support for staff and carers including children and young people to cope with difficult environments.
- Tailoring treatment plans responding to individual bio-psycho-socio-cultural factors (Aboriginal, Multicultural, LGBTQ+, faith, disability, Drug and Alcohol, rural and regional)
- Providing whole-of-person treatment - Physical, social and emotional issues addressed together.



INCLUSIVE

Family and friends frequently report exclusion from care planning, information relating to discharge and report a lack of compassion in the system and feeling like adversaries rather than partners in recovery.

Tandem recognises that some services and staff in the mental health system already seek to deliver compassionate family inclusive practice. These services must be universal, and the practices that they have pioneered need to be showcased, incentivised and supported. Moving from a crisis driven, and transactional system, to a compassionate culture, with appropriate multidisciplinary staffing levels, and addressing resource shortfalls is essential if we are to facilitate holistic and inclusive practice.

The literature notes that it is important to adopt a framework for family-focused care in services. It must be inclusive of children, and it must recognise the diverse roles consumers hold outside a sick role, including parenthood. Recognising that mental illness, and indeed health and wellbeing, occur within families. Even a single-session intervention can make a very impactful contribution⁹

Families are a hub of caregiving in mental health. The majority of this care is provided by women, with a large proportion of these being single mothers. Given the life span of mental illness, children also play an important role. There are also issues across the lifespan if we fail to engage and support children of families affected by a parental mental illness¹⁰

The intensity, stressful and all-consuming nature of mental health caring should not be overlooked and importantly not minimised by excluding families and friends who are providing care for someone with a mental health issue. Research indicates they are coping with intense and chronic, isolation, grief, loss, guilt, devastation, fear, worries, and sense of responsibility. As a result, it is important that they are not only included, but that their challenges are also addressed¹¹

"Time and time again, I have been sucked in by services to be involved. Then they spit me out when I demand too much for my daughter, complain too much or when they think they've got it under control. But all of a sudden when it is too hard for them, they throw her back to me without support."

– Mother & carer, 67 years of age

"There is a need for more family inclusive services that include carers in the treatment process. I was never included in my brother's treatment, yet I was expected to pick up the pieces when they discharged him to me."

– Sister & carer, 35 years of age

"Families need to be valued and supported. There used to be funding for carer support workers, for education, for trips away where you could learn as well as meet other people with shared experiences of caring. We need these programs back so families can get information and feel respected."

– Mother & carer, 40 years of age



In an acute inpatient setting, families particularly need – yet do not routinely receive – evidence-based therapeutic conversation interventions¹⁰ their inclusion is critical though at this time, phase of illness and stage of care and diagnosis, and contact with services¹¹

Effective models exist and must be rolled out across the state. An inclusive model which has been designed to respond to acute crisis by holding meetings involving the person in distress their family, other natural supports and multidisciplinary team members is Open Dialogue. This model has been partially trialled at Alfred Health – Headspace. This model, has the client at the centre and therapeutic relationships are developed where the client feels safe, understood, valued and respected. Family and friends are engaged, involved and supported and viewed as sustainable networks¹²

Family continue to tell us that they feel locked out of the system and marginalised in decision making processes that directly and indirectly affect them. Involving family in all aspects of service planning has multiple benefits, including reducing stress and anxiety and improving the skills and knowledge of carers in providing support to the mental health consumer in their everyday life outside the clinical/therapeutic setting. Where 'family' members are LGBTIQ we have heard accounts of additional difficulties in being provided with information and support which can lead to trauma and PTSD for both the consumer and the person supporting them. This has also been reported by those who have English as a second language.

Further to this our consultations have uncovered that many in the workforce feel ill-equipped, overstretched and not supported to deliver compassionate care and services that include family and friends in a meaningful and helpful way. This then leads to negative outcomes for all concerned. This must change.

Carers continually report issues regarding the privacy provisions of the Mental Health Act, and we urge the Commission to review this legislation, and its implementation in the culture of mental health services. Families consistently report being told that they do not have any rights to basic information around the patient. They report this as incredibly disempowering, and preventing recovery, and often making difficult situations worse. This extends to all aspects of care, whether it is mental health tribunals, admission and discharging in hospitals, challenges with the legal sector and the medication provided. The Mental Health Act currently holds an exemption that families can [italics - emphasis] be communicated with, but all too often, they are not.

Tandem members have told us that to be INCLUSIVE services:

Must include family and friends in recovery. Family and friends need to be recognised as a critical part of recovery teams. This can be achieved by:

- Consulting on, informing and discussing important decisions, including changes in treatment and medication, admission and discharge into hospital, long term treatment and management plans and mental health tribunal hearings
- Addressing the culture of exclusion within some mental health services for friends and family carers.
- Acknowledging family and friend carers as a critical part of the treatment team.
- Providing contemporary therapeutic and support options in all services
- Providing consistent services across the state regardless of postcode, socioeconomic status, culture or gender
- Providing outreach services, and consult with family and friend carers, as standard practice on discharge.
- Providing more services in the community for people with mental health issues, friends and family carers.
- Not punishing people for having mental health issues

¹⁰ Sveinbjarnardóttir, Eydis Kristín, Svavarsdóttir, Erla Kolbrún & Wright, Lorraine M. (2013). What are the benefits of a short therapeutic conversation intervention with acute psychiatric patients and their families? A controlled before and after study. *International Journal of Nursing Studies*, 50, 593-602. doi:10.1016/j.ijnurstu.2012.10.009

¹¹ Taylor, Rumina, Mellotte, Harriet, Griffiths, Maria, Compton, Agnes & Velsraj, Koravangattu. (2016). Carers matter: Promoting the inclusion of families within acute inpatient settings. *Journal of Psychiatric Intensive Care*, 12, 69-77. doi:10.20299/jpi.2016.014

¹² Swann, World Social Work Day 2018



FAIR

Everyone has the right to access services. The provision of mental health services must be fair. They need to be accessible by everyone, regardless of their location, gender, sexuality, cultural background, drug and alcohol issues, and economic status, fairly.

"We live in a rural area, with no services. My son keeps pleading with me to get him help. He tells me that he doesn't want to die, saying "you don't know how hard I am trying to not do something, I'm really fighting it". I have nowhere else to turn, I am trying everything but there is no help available. It's just not right we can't get help."

– Mother & carer, 46 years of age

Tandem members have told us that to be FAIR services must:

- Be accessible to all Victorians regardless of age, socio-economic status or postcode
- Tailor recovery plans respecting psycho-sociocultural factors, the wishes the consumer and their family and friends.
- Treat the whole person – physical and emotional
- Provide supportive environments, not punitive ones.
- Provide appropriate levels of funding and resources to meet demand for mental health system support
- Ensure General Practitioners have adequate mental health and family inclusive practice training
- Ensure there are high quality, integrated and accessible services in regional and rural areas
- Guarantee culturally safe services for Aboriginal and Torres Strait Islander people and those from other marginalised groups
- Expand the Family carer workforce across the state, and across programs including dedicated positions to address particular cohorts in response to local population data such as Aboriginal, Multicultural, LGBTIQ
- Address cultural disadvantage by incentivizing and mandating use of interpreters, supporting bi cultural staff and expanding the Family Carer workforce



FUNDED

“More funding is needed to allow workers to do their jobs properly and make sure the services are there and are accessible. If consumers had better access to these supports, the family wouldn’t experience so much stress and hardship”

– Aunt & carer, 63 years of age

“Carers themselves bear immense and cumulative stress that must affect their own mental and physical health. The cost of this to our health system must be enormous. It makes good economic sense to support carers more and give them more support and education and help and recognize their central role in mental health care.”

– Mother & carer, 56 years of age

“As a result of the overloaded and under resourced workforce, clinicians often give up and discharge consumers from their service before even giving them the chance to build rapport. Unfortunately, this means that the only way to get any proper access to and support from services is through a treatment order, because if there is an order in place they have to help.”

– Mother & carer, 83 years of age

The most glaring problem with the mental health system is the lack of funding. To fix the broken system, we need to:

- Urgently address the shortfall in inpatient mental health beds. Victoria currently has less than half of the international standard for adequate care.
- Reduce wait times in hospitals. Redesign and resource Emergency Departments to provide respectful, culturally appropriate and compassionate responses to people in mental health crisis and their family and friends.
- End inappropriately early discharges from hospitals by an investment in facilities that are comparable to Victoria’s best practice general health facilities. Ensure that services are resourced to provide high-care discharge processes that include family and carers where appropriate. End the discharge to homelessness and housing insecurity.
- Mandate investment in workforce, in staff training and staff support so that consumers, families and carers receive therapeutic and compassionate care.
- Mandate investment in a range of contemporary family inclusive therapeutic models including Single session family therapy and open dialogue across Victoria
- Mandate Investment in a range of Psychological therapies such as cognitive approaches to relapse prevention with families
- Mandate Investment in Family psycho-education non-judgmental information provision & support Investment in Family support groups - peer support with some agency co-facilitation assistance
- Mandate Investment in Peer support group peer-led and peer-delivered intentional support groups Investment in stage of life appropriate supports for consumers and family tailored to: child, adolescent, young adult, adult, aged
- Mandate Investment in a range of Cultural, spiritual or religious groups supporting and exploring shared understanding of mental illness and health



- Mandate investment in Community Care Units. Appropriate supported facilities for high needs patients/consumers, and those who need long term care.
- Invest in Housing: Provide secure shelter for people who require on-going psychiatric support and rehabilitation. The current 'supported accommodation' options are grossly inadequate
- Expand investment in the PARC (Prevention and Recovery Care Centres) these centres need to have a culture of compassion and focus on increasing access, family inclusion and therapeutic step up and step-down options available. Women only, youth PARCS and culture specific PARCs need further support and investment.
- Secure Investment in a consistent state-wide model of Hospital Outreach Post-suicidal Engagement (HOPE) initiative which assists consumers and their family and friends
- Secure investment in PACER, CATT and outreach teams 24 hours a day 7 days a week across Victoria
- Mandate Investment in the support and complementary and ancillary services that are needed for compassionate, whole person approach.
- Mandate a significant investment in Family Carer workers across Victoria as part of holistic multidisciplinary teams. Currently, the Family Carer workforce is grossly over extended and under resourced to meet demand
- Support Investment in evidence based family interventions for example Multiple family group
- Support Investment in Individualised psychoeducation and support
- Support investment in services that support family with the maintenance of their own emotional and physical wellbeing. These include respite, peer support, psychosocial education, assessment, planning and direct service to assist carers in identifying their own support needs, particularly mutual support and self-help services.

"We also need accessible supports for siblings, as care and attention often goes to the unwell child. Siblings need support too."

– Mother & carer, 47 years of age

"My experience is one of intergenerational trauma, constantly battling with the mental health system to get myself and my family member's access to meaningful mental health support."

– Sister & carer, 65 years of age

"The impact of trying to get my daughter help all these years has been immense and I have gone through so much trauma. She has worn me down, even my personality, my attitude. I just don't feel like myself anymore."

– Mother & carer, 74 years of age

"My experience has been one of frustration at trying to navigate Victoria's overburdened and 'broken' mental health system."

– Mother & carer, 43 years of age

"The carer, is usually the middle person between all the intersecting services. As a carer you end up case managing your own family member to the best of your abilities and it becomes you (unpaid) job to follow up appointments, take medications and make sure services are coordinating their treatment approach... Families need education and support"

– Aunt & carer, 40 years of age



Conclusion

"I love my daughter and I want the best for her. Before the mental illness then drugs took over, we had a good relationship. I miss that person. I have lost someone important in my life, because the supports weren't there when we asked again and again for help."

– Mother & carer, 68 years of age

We encourage and support you, the commissioners, to make recommendations ensuring the mental health and wellbeing needs of Victorian consumers and their family and friends are heard. We ask you to have the courage to be bold and embrace this opportunity.

Unless a solid and contemporary investment is made in the mental health service system based on cultural transformation and a shift from crisis driven brief encounters to compassionate, and therapeutic engagement with consumers and their family and friends, we will continue to see the carnage of human suffering which is a feature of our current mental health system. We are better than that.

A safe, inclusive, fair and appropriately funded contemporary world leading mental health system for Victoria is possible.

"Having to monitor his medication compliance created significant conflict in our relationship. Once my son was back in clinical care, it was such a relief. I did not have to continue the role of medication monitoring and I was able to be a mother again."

– Mother & carer, 72 years of age



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