Individual submission to Mental Health Royal commission

1. What are your suggestions to improve Victorian community's understanding of mental illness and reduce stigma and discrimination?

Education and awareness campaigns to be undertaken by social and community service organisations. Media including print, TV, radio and online social media can play a big role in improving community's understanding of mental illness or mental health issues, and can reduce stigma and discrimination in the society. Advertisement also can play a major role in this. Education and awareness among mental health and social sector professionals themselves and among other professionals is an important task. A significant number of professionals in the social sector themselves suffer from mental health issues such as anxiety, depression, PTSD etc. Stigma prevents them from seeking help initially or for longer periods of time. Many a time staff are discriminated based on their mental health issues and labelled as not fit for this work. There needs to be very comprehensive and unbiased strategy for them to receive support and continue to do their work with support from the service.

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

Adoption of the Mental Health Act 2014 with emphasis on recovery model of practice (clinical recovery and personal recovery), OCP guidelines for working with carers and families, and early interventions programs for families and children with the launch of FaPMI strategy in 2007, and the strategy becoming a full fledged program in 2016, with all 21 Area Mental Health Services (AMHS) employing full time FaPMI coordinators, myself being one among them. However, even after 12 years of its launch, the program is not well accepted by most of the AMHSs. Recovery model of practice is still a myth, and the mental health interventions are predominantly medical model based. Public mental health system is still operating on a crisis driven model.

There are major resource issues and significant staff turn over due to burn out and lack of support for their mental health and well-being. There is also bureaucratic and bullying culture prevailing in services. There needs to be innovative strategies to support staff and maintain staff retention. Besides, there is a work culture that doesn't allow new ideas or change to occur. There is stiff resistance to family focused approach being embedded into the clinician's practice. Clinicians maintain that it is not their core business. Having been in my role as FaPMI coordinator for 30 months now, I have been quite disappointed and frustrated about not being able to implement the FaPMI program in spite of my best efforts.

It's an excellent program and it needs to be driven by the leadership of services. The Dept needs to come up with some strict implementation plans and services need to be made accountable for its implementation on the ground. Collaboration with network partners and community service organisations (third objective of FaPMI strategy) is to be strengthened. This will help early identification and support. FaPMI program has a major role to play in this space, and hence this program needs to be enhanced and strengthened.

Stigma is a huge issue. Confidentiality and privacy issues come in the way for services to intervene early and help those who need support to seek support. As stated earlier collaborative practice is the key. The mental health branch of the DHHS needs to be more pro-active, and should develop policies and directives to make AMHSs more accountable. Lack of collaboration among different services is impacting on the quality of services consumers and their families receive.

11. Is there anything else you would like to share with the Royal Commission?

I am a professional social worker with 28 years' experience in the social sector including 10 years in statutory child protection (with SA and VIC Govt Departments) and over 7 years in mental health (5 yrs in India). I have a Master's Degree in Social Work, an MPhil Degree (post Masters-clinical) in Psychiatric Social Work, and a Doctorate Degree in Mental Health Social Work from Monash University, Melbourne (2018).
I joined in my current role as FaPMI (Families where a parent has a mental illness) Coordinator in February 2017.

The FaPMI program is a DHHS directly funded program being implemented in all 21 Area Mental Health Services (AMHSs) in the state since 2007 to enhance the outcomes for consumers, carers and their family members including children. It is an early intervention strategy and it takes a whole of community approach to achieve the best possible outcomes. The overall aim of the FaPMI program is to reduce the impact of parental mental illness/mental health issues on all family members, especially dependent children. My role as FaPMI Coordinator is a stand-alone position in the MHS division. My key responsibilities include providing education, training and consultations to specialist MH clinicians and network agency practitioners to build their capacity to work with families where a parent has a mental illness or mental health issues. This involves family focused approach being embedded in their practice, and working collaboratively to help consumers/clients in their recovery journey.

I also provide family consultations to consumers and their families and support service delivery via strengthening networking with other community service organisations and coordination of resources. Although I am based in a bigger regional office, I travel to other regional locations and spend at least one day a month in these offices and provide consultations and support to the clinical staff. I also undertake additional travels to these locations based on needs. A copy of the job description of FaPMI coordinator is attached for your reference, and highlighted some key roles of the position.
There could be staff in MHS, who have had traumatic childhood and later on experiencing mental health issues, especially in a work context like MHS and child protection. It is a hard job and can have impact on our life-vicarious traumatisation. The mangers need to be aware and be supportive in looking after the well-being of the staff. I consider myself as a 'person with lived experience in the workforce. I am happy to share my experiences with professionals as I think it is a very powerful tools to support/motivate/strengthen the workforce. I had endured significant family violence, emotional trauma, and all forms of abuse in my childhood. I also have been experiencing mental health issues (anxiety, panic

attacks, depression and physical symptoms of lethargy) specifically due to work place issues (discrimination, harassment and bullying) for the last three years, and have been on medications and counselling.

I have been trying very hard for the last over two years to orient the workforce (both MHS and community service organisations) about FaPMI the program, and initiated quite a few strategies to influence the workforce, but it hasn't been received well across the division. I have taken up with the MHS leadership my concerns and suggestions. Unfortunately, my line managers responsible for supporting me and driving this program in the service didn't fully understand and imbibe this program. However, I have been very proactive and passionate about implementing this program as a person with lived experience. I believe there needs to be accountability towards the consumers and families (it is their right to receive family support), the Department and the Govt.

There have been some significant work happening in the FaPMI space across the state in the last two years following the expansion of the FaPMI strategy into a program in 2016. There are 21 AMHSs and 28 FaPMI coordinators across the state. We have been assigned to different working groups (about 10) state-wide, based on portfolios such as Practice Standards, Research, Monitoring & Evaluation, Lived Experience, professional development, Knowledge management, NDIS, Family Violence, Networking & collaborations etc. I have been part of 3 groups (practice standards, M&E and knowledge management). We have been able to develop, trial and finalise two important tools-FaPMI practice standards audit tool and M&E tool. There have been discussions with the Department in this regard on a regular basis. There was a review of FaPMI coordination by Bouverie for the last 12 years by an external consultant commissioned by the Department. There have been some recommendations in the review report, one being Bouverie getting an additional recurrent fund of $200,000 per financial year for supporting the program. This is to employ an additional state-wide project officer plus supporting training needs in implementing the programs. Based on the review report, a FaPMI Strategic Priorities statement 2019-21 has been developed incorporating five work domains (pillars) i.e. systems and procedures development, workforce development, support interagency collaboration, support service delivery and knowledge development. FaPMI state coordinator, Rose Cuff had undertaken consultations with all AMHs in the state last year with a draft, and a final document is prepared.

Another work that is happening is, that a Senior Advisor in the mental health branch has held two workshops (state-wide) to commence discussions to develop a Victorian Implementation Plan (Supporting the implementation of the working together with families and carers-the chief psychiatrist guidelines). There were invitations to all FaPMI coordinators. I have attended both workshops via video link. I have individually provided feedback/suggestions to the Advisor. This consultation working group also emphasises on family focused approach, and improving sharing of information among services to provide best service to the consumers and their families and achieve best outcomes. Lastly, our service have had a model of care review, and I provided an extensive feedback and suggestions for implementation of the FaPMI strategy and involvement of family for improving care that we provide to our consumers and families. Everyone agreed in our

discussions that we need to work with families to implement the recovery model of practice. I have done a presentation on FaPMI (a way forward) in an academic program of the service in March this year.

Since I started in this role I have been I have been discussing with and requesting teams to have a baseline data of our FaPMI families. I developed a spreadsheet in this regard and passed on to the teams. This is the first step I believe to identify consumers who are parents (not only those who have dependent children at home, but those in out of home care) and offer family consultations to identify their needs and plan interventions/referrals. Ideally all families in a clinician's caseload should be offered FaPMI programs (Family consultations, Let's talk about children method, peer support groups and brokerage fund). However, I haven't been successful yet. The FaPMI coordinator can keep a division wide spreadsheet compiling data from all teams. This can stay as an active data base, and newly registered cases can be added on to the sheet. This would also help in selecting cases for FaPMI file audit, identifying clients (even after closure) and offering them opportunities to participate in peer support groups when they are planned, and also track readmissions.

I have had a situation recently (a few client families in the past in similar situation). A CAMHS clinician sought a secondary consultation re a child and asked if I could have a session with the family (mother and child) and talk about FaPMI programs. The clinician organised a family session. I read the child's file to have an understanding about the family. I have noticed in the child's file there is mention about both parents having mental health issues. Naturally, I searched for parents' history, if any, in Mastercare (local electronic client file system and state-wide Client file system (CMI) In this case, I have found that both parents are our registered clients, father not currently managed (but was briefly serviced by a regional team in the past as the family lives there, but mother being currently managed by our Primary Mental Health team. Interestingly, CAMHS clinician, is not aware of this, nor the PMHT clinician vice versa. I could find from Mo's file that PMHT clinician was going to have a session with the mother, prior to my family consultation session a few days later. I communicated with the PMHT clinician and CAMHS clinician. To my surprise I am advised that clinicians within the service do not communicate with each other if they are dealing with multiple consumers from within one family. This would mean there is no collaborative approach among clinicians and hence no collective outcome is not possible within the family unit. The reason given to me was confidentiality of individual consumers. If family is not open to collaborative support, we cannot provide any meaningful service. To me this family needs ongoing support, and my focus is to minimise the impact of parental mental illness on the children (four children between the ages of 8 and 3 yrs). I can offer different FaPMI programs such as family consultations, let's talk method, attending peer support groups, and brokerage fund for children's social inclusion activities

Confidentiality is a huge barrier in implementing the FaPMI program. How does confidentiality applies in the case of the above mentioned family when we have to work with the same family unit. Why do we need consent from parents/carers/children as we are from within the service? To address the consent/confidentiality issue, my suggestion is that

the clinicians will need to adopt family inclusive practice from the beginning, reach a good level of engagement, provide psycho-education to the parents, help them to acknowledge they have a mental health issue and its impact on their parenting, children's development etc. (I cover all these in my orientation including myths about parents talking to children about their mental health issues), and can explore/assess if anyone else in the family is affected and receiving service. My inference is if the parents of children attending CAMHS are not disclosing their MH issues, if any, (I would think most of them have either MH issues, substance abuse issues, family violence etc.) or PMHT or Adult consumers are not talking about their children's issues, then the clinicians haven't reached a comfortable level of engagement with them. The whole idea of FaPMI is to reduce the stigma around MH issues, and intervene early. Confidentiality issues come in when parents want to keep it as a secret due to stigma, but not within the family unit though. The clinicians need to encourage parents to talk about their children (using Let's talk method). I think there needs to be a practice change, policy and procedure change, and information sharing within the service, if required, is to be enabled provided the parents are educated and advised that their family information will be shared with other clinicians if they are working with other family members. How do we achieve the best outcome for this particular family if three clinicians work in isolation? If the parents are not open to it, then we can't force. But we will need to try. There needs to be Department direction/guidelines around this issue. The leadership of various AMHSs in consultation with the DHHS need to review policies around access to client information and current practice.

We FaPMI coordinators are all working at a senior clinician level, and we do some clinical work, like family consultation sessions (primary consultation). We cannot facilitate a family consultation unless we know the psycho-pathology and other dynamics within the family and its impact on other family members. So we need to have access to the files of consumers. When a clinician is referring a family to a FaPMI Coordinator they will need to advise the consumer/family that the FaPMI coordinator would have access to their files. We cannot identify the needs of the family and offer/suggest family interventions, unless clinicians engage with parent consumers well and bust this 'secrecy/stigma/confidentiality'.

Another issue I have come across is re registering an unregistered client in local client file system or CMI: to create a Screening Register with name and DOB, when we have secondary consultations with community service partners such as accessing a FaPMI brokerage fund. I think it would be a good practice as the information will be recorded (like utilising a FaPMI brokerage fund) in their file, and if they happen to access service in future, the information would be useful. It also provides data re early interventions attempted/impact of the program. I know there is a confidentiality issue here as well. But this needs to be explained to the client. They are providing consent/signing the application. If they don't, they cannot access the fund as it is for clients who acknowledge they have a mental health issue and it has impact on the children, and the fund is for their social inclusion activities.

Your contribution

Should you wish to make a formal submission, please consider the questions below, noting that you do not have to respond to all of the questions, instead you may choose to respond to only some of them.

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

- Education and awareness programmes to be undertaken by health & community service organisation.
- Media - Print, TV, online social media can play a big role in reducing stigma
- lived experience workforce can play a big role by sharing their experiences
- celebrities who have experienced mental health could play a role by sharing their experiences. *Additional sheet*

2. 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?

- Adoption of MHA 2014 - Recovery model of practice (clinical recovery + personal recovery)
- OCP guidelines for working with carers + families
- FaPMI program - early intervention pgms for family and children.
- this program needs to be strengthened
- Huge resource issues and staff turnover strategies to look after mental health and wellbeing of staff - support them + retain them *Additional sheet*

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

People с trauma background and experiencing anxiety + depression be shown empathy + compassion.
- Awareness programs
- Early intervention strategies - early warning signs and seeking help
- working с schools - awareness and picking up EWS.
- Support programs - GPs and community service organisations can detect early and refer to appropriate services. - Enhancing family and social support.

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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.

MHS linkage ē network partners and community service agencies have been an issue. There has been no close collaboration between the two, most of the time working in isolation. This has got a cultural baggage. networking and collaboration needs to be strengthened.

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

- Isolation
- Poverty
- Stigma
- Reluctance to seek help
- Substance abuse
- minimal outreach services due to lack of resources & time constraints

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

- The family members and carers need information and understanding about the consumer's mental health issues and need to be part of care planning. They need support themselves by way of respite and other forms of help. The children need to have age-appropriate understanding of the parent's MH issues.

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

There are significant resource issues and frequent staff turnover due to burn out and lack of support for their mental health and well being. There is also bureacratic and bullying culture prevailing in MH services. There is also a work culture that doesn't inhibit new ideas or change to occur. There is staff resistance to family focused approach being embedded into the clinical practice.

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 realise these opportunities?

- With the adoption of the recovery model of practice, persons living c̄ mental health issues can engage in gainful employment, to start c̄ in a controlled environment. Functional mobility can strengthen treatment outcomes, which in turn can improve social and economic participation.

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?

- There needs to structural changes and also model of care.
- MH services need to have dedicated family support teams to work with families as the current model is not working, with clinicians not having resources and time to work c̄ families. One stop shop

MHS divisions may be carved out of hospitals and be brought under the

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

There needs to be thorough revamp of the current structure and fit in with a model of care that is comprehensive and encompass all levels of care with checks and balances at each phase of intervention. FaPMI can monitor this continuously evaluate outcome. Orange door is a good idea.

11. Is there anything else you would like to share with the Royal Commission?

I am a professional social worker with 28 years experience in the social sector including 10 years in statutory child protection and over 7 years in mental health. I have a masters Degree, MPhil degree clinical psychiatric social work) and a phD degree in MH social work from Monash University. I joined in my currently role as FaPMI coordinator in Feb 2017. The FaPMI program aims to enhance the outcomes for consumers, carers and their family members especially children. It is an early intervention strategy and it takes a whole community approach to achieve but only.

| Privacy acknowledgement | I understand that the Royal Commission works with the assistance of its advisers and service providers. I agree that personal information about me and provided by me will be handled as described on the Privacy Page. ☑Yes ☐ No |

— additional sheet —