Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR BRENDAN O'HANLON

I, Dr Brendan O'Hanlon PhD, Mental Health Program Manager, of 8 Gardiner St, Brunswick in the State of Victoria, say as follows:

1 I 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 such information to be true.

2 I am giving evidence to the Royal Commission in my professional capacity as the Mental Health Program Manager of the Bouverie Centre (**Bouverie Centre**), La Trobe University.

Professional Background

3 I have been the Mental Health Program Manager at the Bouverie Centre since March 1997. I am responsible for leading the design, development and implementation of the Centre's role in building the capability of Victoria's publicly funded mental health services to constructively include families in treatment and care. The centrepiece of this work is the 'Beacon Strategy,'[1] which involves partnerships with mental health services to implement family-based practices and to build knowledge about how these practices can be most effectively and efficiently implemented in mental health services. In practical terms, my role includes oversight and delivery of workforce training, consultation and implementation support and advice. My role also includes providing family therapy to a small number of families where a family member has a serious mental illness.

4 Prior to working at the Bouverie Centre I worked in adult mental health services for 12 years, including as a Senior Social Worker in an Area Mental Health Service.

5 In addition to my role in Victorian mental health services, I have been responsible for projects relating to the implementation of family inclusive practices nationally with headspace, the Veterans and Veterans' Families Counselling Services (now known as Open Arms) and the Australian Defence Forces. I worked extensively with the Werry Centre in New Zealand to implement Single Session Family Consultation **(SSFC)** nationally across mental health and addictions services.

6 I have delivered training in family inclusive practices in China on numerous occasions through the Bouverie Centre's relationship with the Institute of Mental Health, Peking University. I have also been responsible for the development of a range of online training

[1] https://www.bouverie.org.au/support-for-services/the-beacon-strategy

including for MH Pod (SSFC), the Nominated Person and Carers Provisions of the *Mental Health Act 2014* (Vic) and SSFC Training (Australia and New Zealand).

7 In 2015, I received a national award for exceptional contribution to mental health services in Australia. I have the following qualifications:

(a) Bachelor of Social Work from the University of Melbourne (1982);

(b) Graduate Diploma in Family Therapy from La Trobe University (1989); and

(c) Doctor of Philosophy (Implementation of Family Interventions in Adult Mental Health Services) from La Trobe University (2015).

8 Attached to this statement and marked 'BO-1 is a copy of my current curriculum vitae.

FAMILY INCLUSIVE PRACTICE

The core elements of good family inclusive practice

9 At the Bouverie Centre, we use the term 'family involvement.' This is a broad concept which spans clinical contact, informal interaction with families and the inclusion of families in areas such as governance and, more recently, the peer workforce. The term 'Family Sensitive Practice' refers to work with the individual consumer that invites consideration of their family and other relationships as well as incidental and less formal contact with families. The term 'Family Inclusive Practice' is limited to practices in which there is direct and intentional contact with family members of a person receiving treatment and care.

10 The Bouverie Centre defines 'family' as including "biological relatives, partners, ex-partners, people in co-habitation, offspring, parents, siblings, friends, carers, community and others who play a significant role in the person's life."[2] We take the notion of family in its broadest sense, and use the term as a way of describing anybody who might be important in that person's life, whether it is a same sex partner, a friend or an uncle.

11 The Bouverie Centre and La Trobe University published a framework entitled: "*From individual to families: a client-centred Framework for involving families"* (the **Framework**).[3]

12 There are three underpinning principles of family involvement:

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[22] The Bouverie Centre, Victoria's Family Institute and La Trobe University, *From individual to families: a client-centred Framework for involving families,* page 5

[3] https://www.bouverie.org.au/images/uploads/Bouverie_Centre_Framework.pdf

(a) Firstly, families are likely to be powerfully affected by the mental health difficulties of a family member. This is well-established in research.[4] This principle also recognises that the way in which services are provided and clinicians interact with family members can influence the impact on families. Families also have needs in their own right, not just as caregivers, which should be recognised and addressed.

(b) Secondly, families can play a vital role in the recovery process, by providing both emotional and practical support, including often being involved in pathways to accessing help in the first place.

(c) Thirdly, the best way forward when dealing with challenging circumstances is to have a 'three-way perspective' (or trialogic approach) which is discussed below at paragraphs 26 to 28). In summary, it is the notion that you are more likely to develop good solutions to difficult problems and circumstances, both for the person and their family, when you bring together the person experiencing the difficulties, the important people around them (such as family and friends) and trained professionals and practitioners.

How the mental health system can better support families and carers in their caring role

13 My views relate here primarily to adult mental health services, with which I am most familiar. The circumstances in aged care can be seen as broadly similar, however child and adolescent mental health services operate quite differently.

14 There must be a wide-ranging approach to how the mental health system involves and supports families and carers. The approach needs to reflect the fact that family needs differ between family circumstances and are likely to change over time. The idea of a 'one-size-fits-all' response does not align with our experience.

15 In the Framework, we talk about a 'person-centred family involvement', which is that the default approach for inclusion of families is through negotiation with the consumer. There is recognition that this is not always possible and in those circumstances, mental health services can still respond to families in a helpful and compassionate manner. All practitioners should be able to be inclusive and respectful, and be able to acknowledge the distress that family members may have. In short, all practitioners should be able to 'think family'. The opportunities for involving families exist in clinicians being interested in a consumer's family and social relationships, including families in the provision of

[4] Shiraishi, N., & Reilly, J. (2019). Positive and negative impacts of schizophrenia on family caregivers: a systematic review and qualitative meta-summary. Social psychiatry and psychiatric epidemiology, 54(3), 277-290.

treatment and care, a more formal inclusion of families and assessment of their needs, right through to their participation in therapeutic work with the consumer.

The Pyramid of Family Involvement

16 The Framework outlines "the Pyramid of Family Involvement" where everyone involved in the care of a person (including administrative staff and reception staff) have a role to play in responding in the inclusive way outlined above. The services provided at each level of the pyramid are ideally embedded in a wider organisational, 'family sensitive culture' where inclusion of families is seen as a normal and widely accepted aspect of the way in which the service operates.

17 At the base of the pyramid are family sensitive practices (as described above in paragraph 9) where even work with individuals includes an interest in the consumer's family and other relationships. It also covers practitioners taking opportunities to connect with families and acknowledge their role and potential distress, as part of their everyday work role. For example, greeting the family member by name, positively acknowledging the support they are providing, and inviting them to attend the session (provided the consumer consents): *"Hi Mrs Bloggs, it's good to see you're here with John. You'd be welcome to join us today if John is ok with that."* This form of practice is relevant to all consumers and therefore requires that all staff can work in this way. In this context, relatively little staff training is required and it is largely directed at influencing attitudes towards families.

18 The next level involves bringing family members together with the person experiencing mental health difficulties to offer a more thorough assessment of what they might need as a family to be able to better cope with the challenges they are facing. That is where our model of single session family consultation fits in (see paragraphs 22 to 25 below). In our services, there is potential as part of the family meeting processes to do more than just be friendly, inclusive and respectful to families. Through these processes we can actively start working with families to identify what they might need. It is important to note that not all families need or want that level of input. This level of practice is relevant to a large proportion of consumers and their families, but not all. Therefore training is likely to target a smaller group of staff whose role enables them to offer these meetings to families.

19 At the peak of our pyramid, we have more specialist family interventions. These are known to be effective in addressing significant problems that families and consumers experience. For example, where families are dealing with circumstances where the mental health conditions are less responsive to medication, and recovery becomes more challenging. The specialist family interventions are usually intensive in nature, and not all families can, or want, to be involved in their relative's treatment in this way. However, it is important that services have this capacity for those families who need and want more

intensive involvement. Typically, these interventions require more training of practitioners but, in line with the likely demand, a smaller group of staff might offer these interventions.

20 The Pyramid of Family Involvement is similar to ideas such as stepped care, where you provide the level of service sufficient for people at a particular point in their trajectory and then have the capacity to provide more if they need it.

Single Session Family Consultations and the benefits this method delivers

21 Single Session Family Consultation as a brief, time limited approach to the inclusion of families makes it easier for practitioners to incorporate it within their routine practice. Moreover, it does not require extensive training and has the potential to build on their existing skills. For example, practitioners are well versed in understanding mental health problems and their impact, and they often have a wealth of experience in dealing with people experiencing these problems. This model provides an opportunity for them to share that experience and knowledge with families. Ultimately, Single Session Family Consultation enables practitioners to be helpful to families and build a partnership with them that will support the consumer's recovery as well as attending to the family's needs.

Benefits for consumers

22 I believe for consumers, single session family consultation creates a context where family involvement is more likely to be positive and supportive of recovery, because it makes a point of negotiating the process of meeting with the family. It tries to create an environment where the consumer feels more comfortable about family involvement by acknowledging that a family meeting can be a daunting experience for a lot of consumers and for the family members.

23 If time is spent negotiating the terms of a family meeting, such as what will and will not be talked about, who will and who won't be at the actual meeting, then there is a greater likelihood that what is important to the consumer will be talked about; and they will be supported by the clinician to share some of their experiences with the family. That has the really important benefit of helping the family move beyond a technical understanding of a mental health condition and allows the family to develop a deeper appreciation of what it is like to experience a mental health difficulty. This development of empathy and understanding is critical in creating a supportive environment in which a person can recover.

Benefits for families and carers involved in the sessions

24 For families, Single Session Family Consultations provide an opportunity to have a more meaningful connection with the practitioner, the opportunity to ask questions about their concerns and to hear from their relative. It is interesting that often, despite living with

someone on a day to day basis, some conversations with families about the nature of mental health difficulties and their impact are difficult to have without a third-party present. This can mean that families develop a deeper appreciation of the difficulties faced by the consumer, and the consumer may also understand more about the impact of their condition on the family and the struggles the family face in trying to work out how they can best support them.

25 This creates opportunities for very important conversations, but also to attend to what is a priority for the family. As an example, I might be interested in what I have discussed at paragraphs 21 to 24, but a family member might be saying that the most pressing issue for them at the moment is "*how am I going to pay my electricity bill, because if the power gets cut off, it's going to be really difficult for all of us*." Therefore, Single Session Family Consultations is a model that actually responds to what the family are saying are their priorities, rather than necessarily what the clinician or the service think might be important to discuss.

Trialogue

26 Trialogue is a concept developed to help develop understanding between family members, consumers and practitioners. The broad principle articulated at paragraph 12(c) around good family sensitive practice and inclusion is about having that three-way perspective in conversation. However, the use of the concept of trialogue has been more often applied to generating new ideas and responses to acknowledged problems in the mental health field in larger forums, rather than to direct clinical care.

27 Trialogue looks at issues that might be of concern to these different groups of carers, practitioners and consumers and involves them in discussions to come up with novel and interesting ways forward. As an example of Trialogue in practice, the Bouverie Centre runs an annual mini-conference where we pick a topical issue in mental health, such as managing risk, dealing with the impact of suicide and dependence or independence for people experiencing mental health difficulties. We then facilitate a three-way discussion between groups of consumers, family members and practitioners around the topical issue.

28 The Trialogue concept responds to the way in which services have been structured and funded over the last 20 or so years, which is to divide consumers, carers and professionals into separate camps. This creates an echo chamber experience where people are talking to people of like mind, but are not challenged to think about the issues from another perspective, such as *"what would a consumer think about what I'm saying?"* or "*what would be a carer's perspective on the issue?"*

29 The concept of trialogue has been used in circumstances other than the Bouverie mini-conference mentioned in paragraph 27, such as a review of a model of care in a service, or a service seeking feedback about how to improve care or in one example to choose the family intervention that would be implemented in the service. The point of contrast with other consultation processes is that while there might be an opportunity to consult with each group separately, the emphasis in trialogue is on bringing these voices together in a facilitated conversation. It is a different application of Trialogue, but, it is more about generating novel ideas arising from these conversations and breaking down barriers, the 'us and them' between the different groups that have developed over time in the mental health sector.

The role of family inclusive practice in supporting families and carers in their own right

30 One of the principles that underpin family sensitive practice is a recognition that families have needs in their own right, not just as caregivers. That is, family members are not there as an exclusive support to the person experiencing the mental health difficulties and should not be responded to by practitioners as if this is their only important role. Family members may be dealing with a range of other issues that are difficult for them in their own right (for example, loss of employment or illness) or have other caring responsibilities. We are not proposing that all of these issues should be addressed by mental health services, but they at least need to be acknowledged and the family member offered suggestions for additional help. In any case, practitioners need to be aware that the difficulties experienced by family members will impact on their capacity to provide support to the consumer or to create a supportive home environment.

31 The potential for mental health services to attend to the family's needs is significant, but in practice, the response is limited. Mental health services can help the family identify what they might need and try to assist them access appropriate support. This is happening more often than previously through a range of mechanisms including models such as Single Session Family Consultation, however more active and intensive forms of involvement, namely through evidence based interventions remains the exception rather common practice.

32 Sometimes, the way in which we have framed the provision of care, and the way in which it happens in practice, is that there is a person identified as a primary carer. Usually, a family member takes on that role. However, it is not usually a role that a family member makes an obvious choice to undertake, usually family members fall into or find themselves in that role.

33 One key element of family inclusion is that it is important, where possible, to include family members in addition to the primary carer. It is common that one person in a family does take on a primary caring role and it is certainly convenient for practitioners to only have

one person as a point of contact. However, there are risks with this kind of arrangement. One of those risks is that there is one family member who ends up taking on all of the caring responsibility. It is often a woman, the mother or the sister, who ends up taking on that that caring role. Over time, particularly if the condition is enduring, this is a recipe for depression and anxiety for that person and it places strain on that pre-existing familial relationship of husband, son or sister.

Assisting family members who may otherwise by 'missed' by the system, such as children and siblings through the family inclusive model

34 Looking beyond the family member in a primary care role is important for another reason: attending to less visible and sometimes quite vulnerable family members. Infants and young children are especially vulnerable due to their dependence on their parents who may have a mental illness. Similarly, older parents caring for an adult with a mental illness may be isolated due to stigma or especially vulnerable if they are exposed to aggressive or demanding behaviour.

35 We know that when families are affected by a mental health difficulty, the impact usually extends in differing ways to family members, and some family members can remain invisible to services in that process. In particular, children of parents with a mental illness are not necessarily invited to attend meetings to discuss treatment or be present at appointments for their parent. Siblings may also not be included because parents may wish to 'protect' them by excluding them from contact with treating mental health professionals. In reality, siblings may be very aware and impacted by what is happening and yet have limited or no access to information or support.

36 It is really important that we have a service response that is inclusive of those people who may have less of a voice, have less visibility, and may not be in active caring roles, but are nonetheless powerfully affected by their relative's illness. Therefore, having a family inclusive approach ensures that there is a consideration of those other family members who might be affected, be involved and who are otherwise not recognised.

37 It can also be important to include friends. Friends might be excluded from being involved in care when they are the people who are most important to that consumer.

WORKFORCE

The biggest barriers to embedding family inclusive practice as standard practice across mental health services at a system level and how they can be overcome

38 Firstly, we have an individualistic culture within mental health services where the focus is on the individual and within the individual, on their symptoms and the likelihood or the risk of them coming to harm or causing harm. I would characterise that sort of model of care

as one of 'medicate, manage and monitor.' That culture of service provision has developed over the last 10 to 15 years and partly reflects a pressure on services and on throughput. That instrumental and focused attention on those issues of monitoring mental state and managing the person through the system is not an environment that is necessarily conducive to more therapeutic and psychologically oriented work with people. It tends to have a narrow gaze, focusing on the client and being less attentive to the context in which they are living, their work environment and their social and familial connections. This cultural factor has been a very significant barrier to embedding family inclusive practice as standard practice across mental health services.

39 Secondly, at another level, the government has neglected stewardship and leadership of mental health services. More often, I hear the language of 'shaping' and 'influencing' what mental health services do rather than leading. This means that there is considerable variation and a lack of consistency between Area Mental Health Services as Health Networks are given considerable scope to 'interpret' how a program should operate. Rather than articulating an overall vision for mental health services in a manner that occurred in the late 1990's, there is a tendency to 'bolt on' new specialist programs in response to apparent need rather than to integrate them within existing services. This makes services more difficult to navigate and disrupts continuity in therapeutic relationships (as people move through different programs or have multiple people involved in their care). The lack of co-ordination between Federal and State funded programs further compounds these difficulties. Whilst the legislative arrangements and the policy statements include rhetoric that is very supportive of family involvement, there is less attention to ensuring that this practice is occurring on the ground. For example, while data is collected in relation to practitioner contact with families and some services do set expectations regarding family involvement, services are not required by Government to report on this as part of performance measures There has been a lack of action in ensuring translation of admirable policies into actual practice.

40 Thirdly, there are practical barriers, such as some service provision being restricted to operating from 9am to 5pm. If a family has members who are working and services only operate during business hours, coming to appointments or being involved in a family-based intervention becomes difficult because it means they have to take time off work to be involved.

41 Fourthly, the environment of mental health services can be one that is not welcoming of the involvement of families. This is particularly noticeable on inpatient units where family members are likely to be highly distressed because the environment feels strange, confronting and sometimes frightening. This is where training staff in family sensitive practice is critical. There may also not be physical space for family members – for example, interview rooms are small and the idea of including families can become difficult

because of actual space restrictions. These limitations also communicate messages about whether families are considered as a legitimate and welcomed player in the provision of care.

42 In terms of these barriers, I consider the cultural issues and the lack of clear leadership and monitoring from government as more important in facilitating family inclusive practice, than the other more pragmatic factors.

The biggest barriers that prevent practitioners from involving families and carers in treatment at a practice level

43 While there are organisational and cultural constraints to family involvement referred to already (at paragraphs 38 to 42 above), constraints also operate at other levels. There are constraints that operate at the level of consumers. Consumers may not want their family to be involved in the way that the family might want to be involved in their care. This is often challenging for the practitioners and difficult for the families. There are also constraints when families may, by virtue of negative experiences in the past with services, do not respond enthusiastically to an invitation to be involved. It is important not to discount those real world realities that despite having a family sensitive and inclusive culture, some consumers and some families will not necessarily respond positively to the idea of family inclusion.

44 On the other hand, the way in which services operate and the way in which practitioners work obviously has a significant bearing on whether consumers will want their family involved and whether the family want to be involved. If practitioners are talking about the possibility of family involvement with consumers from the outset, and seeing it as a natural and normal part of the work that they do, it is likely that more families will be included. Some of the understandable and legitimate issues a consumer might have about having their family being involved can also be worked through with a clinician who is open to family involvement.

45 Further, attending to small, but important aspects of hospitality are important and lay the foundation for greater family involvement. This is sometimes starkly missing in mental health services. It is not the fault of individual practitioners who are often trying to do the best they can in the context in which they are working. But, it is most likely reflective of that culture that I discuss in paragraph 38. For example, for the nurse on the ward who sees a family member looking lost in what might be a very frightening environment to them, approaching them and asking, “Can I help you? Are you looking for someone?” Or a receptionist greeting a person and their family member in a familiar and friendly way. As someone who does a lot of work within services, the absence of such behaviour is noticeable.

Time and capacity

46 In terms of constraints for professionals, when considering studies about implementation of family interventions in the mental health context, lack of time is almost always mentioned as a top issue. It is hard to know exactly what that means because people do find time to do other activities. In fact, other activities such as conducting mental state examinations or recording client contacts are valued and professionals manage to get them done. In some ways, it reflects the relative priority that is put on the performance of certain tasks and activities that are seen as core or essential. Family involvement often tends to be seen as more peripheral. Therefore, when resources are limited and services are under pressure, family involvement is at risk of falling off the agenda for workers.

47 My experience of working alongside practitioners is that time spent on things like documentation and accountability related activity, makes it difficult to do some of the family inclusive activities. While caseloads may have been brought down to a more manageable level, the space created appears to have been filled with additional paperwork rather than time devoted to direct client and family work. Hopefully technology might provide less onerous and time-expensive processes for collecting and recording important clinical information.

Training and support requirements and professional cultures

48 Professionals are influenced by their training. From my experience, in some of the professions, such as psychology and nursing, it seems less emphasis is paid to the value and importance of family involvement. Occupations such as social work and occupational therapy are more likely to take a broader view and recognise the value of family involvement. However, family involvement transcends disciplines - you can have nurses who are instinctively and wonderfully inclusive of families and social workers who may not be very good at it at all.

49 If clinicians in their undergraduate training have not had exposure to working with families (which is very often the case as the focus is on one-on-one interventions) the idea of having more than one person in the room is often quite daunting. I have been struck working alongside clinicians who felt anxious about that - they are quite happy having one person in the room, but they can feel quite vulnerable with any more. That signals the importance of undergraduate training that introduces the notion of work with families as part of a professional role. It seems difficult to me to argue that any of the helping professions could practice in a way that wasn't at some level inclusive of families; for a start, that would be contradicting practice and treatment guidelines for the major mental illnesses. However, the reality is that there is a level of discomfort with family involvement.

50 We need to be circumspect about the power of training, particularly professional training delivered once clinicians are in the workforce, as a vehicle for effecting change in practice. It is necessary, but not sufficient. Training is helpful, it provides people with the skills, but they need an environment in which they can use those skills. This is where the attitude of senior management is important in creating an environment that says: "we think this work is important for you to do".

51 Increasingly, there is recognition of the role of middle management to family inclusive practice.. In settings where there is strong middle management, family inclusive practice can be supported and encouraged with a space created for the practitioner to use the skills they acquire during training. The space should be one in which the practitioner is accountable for using the skills that they have learned, but also one where there is support through supervision and consultation for that work to be undertaken. Therefore, training with organisational support, good policy settings and good feedback loops is important. Our experience is that when practitioners start working with families, they often receive very encouraging feedback from the families and the consumer about that experience – this has certainly been the case with single session family consultation. That can lead to reinforcement of good family inclusive practices within a workplace.

Legal constraints such as privacy and confidentiality and understanding legal requirements

52 About a decade ago, the mention of family involvement in training groups would have prompted the response: what about confidentiality? what about legislative restrictions on sharing information? This is less the case now. Whilst those constraints do exist, and practitioners' understanding of legal requirements can be limited, in some cases concerns about confidentiality can be used as an excuse for not wanting to involve families because it might be perceived as messy or complicated or time consuming.

53 Over time, we have come to appreciate that what drives the reluctance of many practitioners to include families, is the implications it has for their relationship with the consumer. Nowadays, we hear more often that practitioners are concerned that the involvement of family might disrupt the therapeutic relationship. That is not a trivial concern. Sometimes when working with people who have limited insight or are very ambivalent about their engagement in mental health care, the relationship between practitioner and consumer is quite tenuous - anything that threatens that relationship could mean that the person falls out of care with unhappy consequences for them and the family. Therefore, assisting practitioners navigate those concerns and have discussions about what information will and will not be shared can allow the practitioner to work their way through those issues. In most instances though not all, a practitioner can have an effective relationship with their client and the client's family members.

Helping the mental health workforce to provide person-centred and family-inclusive treatment, care and support

New and/or specialist functions and skills needed

54 Specialised functions and skills have been outlined in the discussion of the Pyramid of Family involvement above at paragraphs 16 to 20.

55 We know that we can have families involved in productive meetings that are of benefit to both the consumer and the family member. We then have another level of skills which are not routinely provided or used in mental health, the more advanced skills required for specialist family interventions (the top of the pyramid for family involvement). There is training available and there are models, such as family psychoeducation, which is a very well researched, evidence-based practice that has also been incorporated into treatment guidelines for conditions such as schizophrenia and bipolar affective disorder. Yet, its availability and use in routine care is quite limited.

56 There are a couple of notable exceptions. For example, the Multiple Family Group is a family psychoeducational intervention that brings groups of families together with the consumer, to support each other and address day to day difficulties. These groups can meet from 6 to 12 months on a fortnightly basis. It is a very well researched intervention.[5] There are two services in Victoria that are using that intervention: the Inner West Area Mental Health Service and the Jigsaw Youth Mental Health Services at Barwon Health.

57 One of the challenges is implementing these models in routine practice. The Multiple Family Group has been partly successful in meeting this challenge because you only need to train a couple of staff in order to deliver the program to a group of families. However, groups are not for everyone. We need to make other forms of these interventions, particularly one-on-one interventions such as Behavioural Family Therapy, available to practitioners so that this work can be incorporated into their work with the consumer. We know that like any other new practice, these ways of working are challenging but possible to implement.

58 My view is that the emphasis should not be on creating more models for working with families. We need to focus our attention on how we implement existing models in routine practice rather than assuming that a brand new model will address the implementation challenge. This dilemma is not unique to family interventions nor even to mental health care. For example, practices such as cognitive behavioural therapy have also been difficult to implement on scale in mental health settings.

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[5] McFarlane, W. R. (2016). Family interventions for schizophrenia and the psychoses: A review. *Family Process*, *55*(3), 460-482.

59 Along with a focus on implementation, it is also useful to think about how can we adapt existing models. For instance, a single session family consultation or behavioural family therapy as models have been adapted to respond more effectively to families where there are young children or where the consumer has a dual diagnosis. Therefore, we need to focus more on how we implement what we already have so that they become accessible to more people accessing public mental health services.

Greater involvement of lived experience workers benefiting family inclusive treatment models

60 The greater involvement of lived experience workers can benefit and enhance family inclusive treatment models. At a basic level, the carer and consumer lived experience workforce can break down some of those barriers and camps between practitioners and consumers, and practitioners and families (discussed at paragraph 28 above), by working alongside each other. There is a sense of shared purpose that is created by having people with a lived experience as part of the workforce, and a cultural benefit.

61 In more practical ways, in my experience family members with lived experience can be really great at engaging families who might be initially mistrusting of other mental health professionals. Consumer lived experienced workers can also build bridges between clients, families and practitioners through the use of some of the family intervention models. They can assist through the sharing of their own experience, allow families to appreciate that certain approaches might be helpful and foster family involvement.

62 Another useful function of the lived experience work force can be keeping clinicians and the services accountable for the services that they provide. For example, in one service where families receive a single session family consultation, they receive a follow up by a lived experience worker to obtain feedback about that experience as part of the evaluation process.

63 Finally, there are opportunities for co-delivery of some family intervention models with clinicians. For example, group programs for family carers can work really well when facilitated by a clinician and a person with lived experience. Involvement of the person with lived experience might be for the duration of the delivery of an intervention, or for part of it at the beginning, or an as needed basis.

PRIORITY COHORTS

Adapting broad family inclusive practice models to community groups with particular needs, such as LGBTIQ+ and CALD communities

64 My view is that models should be adapted, rather than setting up completely different models to meet diverse needs. There is no doubt that practitioners need to get a level of content knowledge, understanding and exposure to the issues that, for instance, might be facing a young person who is coming out, or having a patient from a Sudanese family with a mental illness. There will be aspects of these circumstances that practitioners have to be interested in and learn about.

65 The notion of inclusion is within the way we would think about a family sensitive practice and about seeing 'family' in broad and diverse terms rather than in narrow definition. There is still an imperative to be interested and find out about the particular needs of all of those groups.

66 In the case of CALD communities, one of the interesting things is that many of these communities have collectivist cultures where family inclusion is actually the norm and the default - they often experience our mental health services as being somewhat excluding of them. Therefore, the idea of family inclusion is not the challenge, but rather requires us to be aware of our own cultural background and beliefs and to navigate our way through cultural values and practices of the families we work with. There is an instinctive and natural desire to be involved that we do not harness – often, mental health services respond by seeing people as unitary and isolated and not taking full advantage of the resource and the support that might be available with families.

67 However, more generally, it is important to note that sometimes families are the source of considerable harm and distress, as in family violence and sexual abuse, and families are not always a source of support, nurture and care. Family is sometimes a context in which great harm occurs. But even in those contexts, there may be people within a family, an extended family or within a friendship network who can be usefully involved in a person's care, even if the relationships are not salvageable nor desirable within the person's family of origin.

68 Therefore, we need to acknowledge that whilst families can be a great source of means for recovery, sometimes in family there can be great harm done. Engaging with that and dealing with the issues is the way of better helping people rather than the traditional approach, where practitioners exclude families completely. Even when family members are behaving in harmful ways, sometimes the person with mental illness may still want them involved in some way in their life, but just don't want to be harmed by them.

Adapting family inclusive practice models for families in particular life stages, such as the perinatal period

69 For the reasons discussed in paragraphs 60 to 63, adaptability is part of the approach. For instance, when we think about the notion of children, for the average practitioner involving families is a daunting prospect and involving families where there are young children evokes additional anxiety for many practitioners. When you are accustomed to dealing with adults, having children running around in an interview room can be disconcerting and feelings of not knowing what to do or being adequately equipped can arise. Therefore, there is a need to provide extra input that helps practitioners navigate that territory.

70 There is an effective model called “Let's Talk”, which is a parenting model for families where a parent has a mental illness. In that model the practitioner simply enquires about their client’s parenting role and how they think their children are going. These are, in some ways, seemingly simple models that are extremely useful for bringing up one aspect of a consumer's life that has historically been ignored. Practitioners often look at consumers’ work life, broader family life and social life, but we have not historically thought so much about clients as parents. Let's Talk is an effective model for bringing the parenting conversation into the everyday work that a clinician does with a client.

DIGITAL PRESENCE

Observations of family inclusive practice when working in a digital context

71 COVID-19 has actually accelerated a trend, rather than created a new phenomenon. Considering our service and many others that we have an interaction with, there had already been steps to move direct clinical work with individuals to an online environment, or at least to have that capacity. Certainly, in the training arena, online training has become very popular. There was an instinctive sense that doing work with families online would be more complicated. You would either need to have one family together in a room at the end of a computer, or you have could have multiple family members in different places in the one house or in different parts of the country or even the world.

72 Our venturing into the digital context more actively during the COVID period has demonstrated that it is possible to meet with families in an online context, and there are some advantages. For example, some people might feel more daunted by physically being in the room with some of their family members than on a screen, another person mentioned that they would feel more comfortable if their family members were physically somewhere else. There are situations of high tension where digital options can provide a greater sense of safety for people.

73 Further, online platforms provide solutions to the problem of access to family members being involved in care in rural and remote areas or where the consumer is physically distant from their family member. It is an exciting possibility for such families to be involved in real time. Whereas once we would have excluded them or at best maybe recorded a bit of the session and given them that or had a chat over the phone. We are still learning about the best ways of conducting these kinds of sessions. Our early indications have shown the value of having clear structures and processes for those meetings, which we would like to have in any event, actually sits well with an online environment where it is easy to talk over people and be unclear of who has the floor at any given time.

74 We are embracing the digital context and are hopeful as to its potential. We are working hard to explore and develop digital ways of working. Other services, such as headspace do a lot of work in the digital environment and do it well.

SUPPORTING RECOVERY FROM TRAUMA

The short, medium and long-term recovery needs for people who have experienced trauma

75 Trauma is not my area of expertise, however, I have drawn on experiences and information received by my colleagues at the Bouverie Centre.

76 The short-term recovery needs for people who have experienced trauma involve creating a sense of safety. It is extremely difficult for people to deal with trauma if they do not feel safe in their current circumstances. They also benefit from a trusting relationship with another person such as a family member or friend and a therapeutic relationship. Further, they need practical strategies for managing some of the cognitive and somatic disturbances that come with trauma, such as mindfulness exercises.

77 The medium-term recovery needs for people who have experienced trauma are a continuation of the short-term needs, but there is also a need to address maladaptive ways of coping with the impact of trauma. That is, strategies people might use in order to manage their distressing feelings and experiences. Examples include substance use, or withdrawal. People might use such strategies initially, which can develop into a pattern of coping over time. Some people may also require more specific psychological interventions such as Eye Movement Desensitization and Reprocessing (EMDR) or Trauma-focussed Cognitive Behavioural Therapy.

78 In the long term, people might relapse or have experiences which trigger some of those unwanted responses down the track. Therefore, they need to be able to access support to receive intervention to deal with those difficulties.

Best practice in supporting the recovery of individuals from trauma

79 The Bouverie Centre and La Trobe University have a guideline on supporting the recovery of individuals from trauma called *"Guidelines for Trauma-informed Family Sensitive Practice in Adult Health Services."*[6] The Guidelines are primarily directed to health care professionals. Some of the key elements of the Guidelines are to ensure practitioners understand what trauma is, and understand the neurobiological dimensions of the impact of trauma.

80 One aspect of trauma that is a focus for the Bouverie Centre is understanding the impact of trauma on relationships. This is extremely relevant for mental health. If you frame mental illness as a traumatic experience for the person with the condition and for family members, you also begin to appreciate that the traumatic experience can be part of what leads to a breakdown in relationships in these families.

81 Different people within a family may have different responses to what has occurred and find themselves in conflict over the best course of action or their understanding of the problem. Therefore, helping families understand the impact of trauma can be a really important aspect of a trauma informed response. There is a phrase: "ask what has happened to you, not what is wrong with you." This acknowledges the impact of trauma and the fact that something significant has happened, which has had an impact on the person, rather than inferring a degree of pathology or deficiency in the person.

Best practice across different cohorts and different types of trauma

82 Trauma can occur in a diverse range of contexts, from early childhood within a family, to trusted family members to external events. The nature of the trauma and the context in which it occurred will have different implications for the ways in which people respond and cope with those difficulties. Therefore, it is important to acknowledge that trauma occurs in a range of ways and while there are some commonalities, there are also going to be some differences in the way people respond to those experiences.

Proven effective interventions in minimising the impact of trauma

83 Some of the interventions that have proven effective in minimising the impact of trauma relate to creating a sense of safety and being alert to the possibility that certain experiences might be triggering for individuals when they are coming into treatment, for example, they might be very uncomfortable in an enclosed space.

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6 https://www.bouverie.org.au/images/uploads/Bouverie_Centre_Guidelines_for_trauma-informed_family_sensitive_practice_in_adult_health_services.pdf

84 Other interventions that have proven to be effective involve trauma informed care. This includes ensuring the client feels believed and supported. It also includes acknowledging and accepting that something significant has happened and helping the person develop a coherent narrative about their experience. Often in trauma, experiences can feel very fragmented. It is then important to develop a sense of a coherent story that doesn't leave the person as deficient or broken, but actually makes sense of their experience and their reactions to that experience.

A 'trauma-informed' approach in mental health services

85 In very broad terms, a 'trauma-informed' approach is about being sensitive to the fact that trauma may play a significant role in the development of serious mental health difficulties. It is being sensitive to the fact that people may have had those experiences, both with the onset of their mental health difficulties and through the process of treatment. Treatment itself can be traumatic so it is being aware of these issues, being interested in people's experiences of that kind and being sensitive to things in the environment that might trigger a response when providing the usual care, such as the way in which questions are asked. At all times, the practitioner must ask: "how might this be experienced by the person? Is what I'm doing likely to actually reduce their sense of safety and have them feeling more vulnerable? Or is it something that's actually contributing to them having a sense of safety and a place where they can talk and share their experiences more easily?"

Settings to be considered for the delivery of trauma-informed care, treatment and support

86 Given trauma is a widespread phenomenon, restricting the provision of trauma-informed care, treatment and support to public adult mental health services is unnecessarily restrictive. Therefore, providing access to effective treatments and services across a broad spectrum of services in contexts like community health centres, through mental health plans and Medicare is needed. Some services will need a more advanced capacity to deal directly with these issues, but all services would benefit from having a trauma informed approach.

Implementing an effective system wide application of trauma-informed care and recovery-oriented approaches in Victoria

87 The principles discussed at paragraphs 9 to 12 in relation to family inclusive practice would apply here. In a way they are different dimensions of mental health care, but what they share is being a change from existing practice. Again, I would argue that this requires strong leadership at a government and departmental level that identifies that this is important and ensures resources are directed to the provision of this form of care. There

is a need for strong leadership within services (see paragraph 39 above) and leadership at the middle management level (see paragraph 51 above).

88 As I outlined above in paragraph 51 above, training is important but training alone is not sufficient. If we are serious about making trauma informed care and recovery-orientated approaches a feature of care, we need a very different attitude to the way in which we deliver training. We should be thinking about a comprehensive approach to practice change, rather than a 'train and hope' method. Often, there is political appeal to say 5,000 staff have been trained in something, rather than a serious attempt to say "these are practices that are important and we want to concentrate our efforts and monitor the results after training."

89 In addition to leadership, in order to implement an effective system wide application of trauma-informed care and recovery-oriented approaches in Victoria, we need to prepare services before we introduce new ways of working. This includes looking at the structures, supervision, support and organisational authorisation for work. There is nothing more frustrating for practitioners to be trained in modalities and then to return to their work, only to find that it is not possible within their context to do the very work that they have been trained in. If their role is not flexible enough to permit them to do the very practices that they have been trained in that they would like to do, it can almost be counterproductive to provide the training in the first place. It also leads to practitioners becoming disaffected with training more generally.

90 Training in recovery or trauma informed care can just become the next lot of training that is provided, but for which there is no follow up or sustained implementation. If there is no overall organisational mandate and support and there is no accountability to ensure the practitioner actually uses the approach, then the investment in training is largely wasted.

sign here ►

print name Dr Brendan O'Hanlon

bdate 17th of June 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT BO-1

This is the attachment marked 'BO- 1' referred to in the witness statement of Dr Brendan O'Hanlon dated 17th of June 2020.

CURRICULUM VITAE

PERSONAL DETAILS

Name **Brendan O'Hanlon**

Current position **Mental Health Program Manager**

The Bouverie Centre, La Trobe University

EDUCATIONAL BACKGROUND

Tertiary Qualifications

2006-2015	**Doctor of Philosophy** **La Trobe University**
1988-1989	**Graduate Diploma in Family Therapy** **La Trobe University**
1978- 1982	**Bachelor of Social Work** **University of Melbourne**

PROFESSIONAL EXPERIENCE

Employer **The Bouverie Centre, La Trobe University**

Position Held **Mental Health Program Manager (full time position)**

Period of Employment	**1997 to present (1997-8 part-time)**
Description of Role	Leadership of The Bouverie Centre's role in building the capability of public mental health and related services to constructively include families in care. The role includes providing family therapy to families where a member experienced a serious mental illness, training and consultation, resource development (including online and video) and research.
Key Achievements	National roll-out of Single Session Family Consultation (SSFC) within headspace. National roll out of SSFC in New Zealand's mental health and addictions services including the design of a blended learning and train the trainer package. Development and oversight of a series of Mental Health Beacon projects that involved implementing family interventions in Victorian mental health services (2013-2020) Review, development and oversight of The Bouverie Centre's co-ordination role in relation to Families where a parent has a mental illness (FaPMI) Co-investigator (implementation design) and others on the project 'Developing an Australian-first recovery model (Lets Talk) for parents in Victorian mental health and

family services' ($1.7M) (2012) from the Mental Illness research Fund (MIRF)

Project manager for a national roll-out of SSFC and Lets Talk in the Veterans and Veterans Families Service (2010)

Project Co-ordinator of The Building Family Skills Together (BFST) project (2006-9) which researched the implementation and effectiveness of Behavioural Family Therapy within a public mental health setting.

Investigator in a Beyond Blue funded randomised control study of multiple family group interventions for people experiencing treatment resistant depression. This included the facilitation of two intervention groups.

Production of the 'F Word', a video exploring consumers' experiences of family involvement in treatment and care (2005)

Contributing to the design and delivery of the Get Together FaST Training and Service Development Initiative that trained clinicians and disability support workers across Victoria

Employer **North West Area Mental Health Service**

Royal Melbourne Hospital

Position Held	**Senior Social Worker**
Period of Employment	**1991-1998 (part-time 1997-8)**
Description of Role	Three years as a social worker and four years as senior social worker located within the Continuing Care Team.
Key Achievements	Establishment of a Family Interest Group to promote family work in the Area Service Establishment of a Family Support and Education Program in collaboration with the Schizophrenia Fellowship Lead role in the establishment of a case management and Individual Service Plans within the Continuing Care Team
Employer	**Mental Health Branch, Department of Human Services**
Position Held	**Project Officer (secondment)**
Period of Employment	**1995 (Three months part-time)**
Description of Role	This position involved researching and drafting a position paper for the Mental Health Branch on Parenting and Mental Illness. This included analysis of statewide registration data to determine the proportion of adult clients who were parents of dependent children.

Employer	**Royal Park Hospital**
Position Held	**Senior Social Worker, Acute Program (secondment)**
Period of Employment	**1992 (Three months full time)**
Description of Role	This position involved supervising Social Workers and Psychiatric Service Officers on the three acute inpatient units at Royal Park Hospital

Employer	**Heidelberg Community Mental Health Centre**
Position Held	**Social Worker**
Period of Employment	**1987-1991**
Description of Role	As a social worker located within Centre performed a number of roles including clinical case management, service development and community development.
Key Achievements	Conducting a comprehensive survey of the needs of residents of a local Specialised Residential Service.

Employer	**Department of Human Services (Preston Office)**
Position Held	**Social Worker, Child Protection Unit**
Period of Employment	**1987 (Six month contract position)**
Description of Role	Intake, assessment and intervention of reports of child maltreatment including writing of reports and court appearances

Employer	**Department of Human Services (Preston Office)**
Position Held	**Senior Social Worker, Child Protection Unit**
Period of Employment	**1985 (Six months)**
Description of Role	This position involved the establishment of the Child Protection Unit within Community Services Victoria including the supervision of three social workers, significant administrative duties and liaison with local community agencies

Employer	**Children's Protection Society (Footscray and Geelong Regional Offices)**
Position Held	**Social Worker, Child Protection Unit**
Period of Employment	**1983-1985**
Description of Role	As a member of regional child protection units conduct intake, assessment and intervention of reports of child maltreatment including writing of reports and court appearances.

RELATED PROFESSIONAL DEVELOPMENT ACTIVITIES

- Recognized for Exceptional Contribution to Australian Mental Health Services (2015)
- Travel to the United Kingdom on two occasions to undertake a five-day training programs in Behavioural Family Therapy and to examine the implementation of the model within local mental health services (2005-2006)
- Chairperson of the Organising Committee of 'Holding It All Together': First National Conference for All Involved in Meeting the Challenges for Children & Families where Parents have a Mental Illness held in Melbourne.
- Past President of the Association of Mental Health Social Workers (two years)
- Past Executive Member of the Health Department Section of the Victorian Public Services Association
- Award for Excellence (1997) Association of Mental Health Social Workers

PUBLICATIONS

Articles

Allchin, B., O'Hanlon, B., Weimand, B. M., & Goodyear, M. (2020). Practitioners' application of Let's Talk about Children intervention in adult mental health services. **International Journal of Mental Health Nursing.**

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Book Chapters

O'Hanlon, B., Poon, A., Harvey, C., et al (In Press) Chapter in Meadows, G., Farhall, J., Fossey, E., Happell, B., McDermott, F., and Rosenberg, S. **Mental Health and Collaborative Practice: An Australian Perspective, Fourth Edition**.

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Online Contributions

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MH Pod (Subject Matter Expert) Social relationships: working with families (2014)