MONITORING THE FAMILY VIOLENCE REFORMS

FV AND MENTAL HEALTH

SUBMISSION BY

The Royal Melbourne Hospital
NorthWestern Mental Health

HOW HAS THE FAMILY VIOLENCE SERVICE SYSTEM CHANGED SINCE THE ROYAL COMMISSION?

NorthWestern Mental Health:

NorthWestern Mental Health (NWMH) is a large public mental health service system that has worked consistently since the RC to ensure our workforce is able to

- identify and respond to FV;
- assess and respond to victim/survivors;
- meet legislative changes e.g. Information Sharing Schemes; MARAM framework; staff entitlements re personal FV leave and support etc;
- work with the FV sector for safety planning and management;
- identifying Elder Abuse;
- identifying adolescents who use violence and understand the interplay of them also often being a victim/survivor of FV;
- establish a way of working with our consumers who are perpetrators.

This last point has been particularly difficult as the Men's Behavioural Change and perpetrator system response does not easily address the particular needs of men with a mental illness who

perpetrate family violence. Mental health clinicians work with and treat men who use violence over a longer period of time, and could potentially do some work to mitigate the use of violence, but without specific training in this area, many clinicians feel unprepared and under-skilled. They do however sit with the knowledge and the risk.

In early 2018 NWMH employed a FV Project Lead. The role only had a small EFT fraction – was 0.5EFT, and after the SFVA's were employed in 2019 it was reduced to 0.2EFT. This did allow for NWMH to be prepared for employment of Stage 2 SFVA's and provides them with some team management, support and supervision.

NWMH has an Aged Persons Mental Health Program (APMHP) which has established links with an Elder Abuse service, the Melbourne Health Integrated Model of Care Team, including establishing a protocol on referrals going between our SFVA who covers the APMHP and Elder Abuse specialist.

NWMH is establishing a network of experienced clinicians who nominate to be FV Advocate for their clinical team. There is however some difficulty accessing training for the large NWMH workforce.

NWMH spans across 4 RAMPs and have delegates that sit on each of them. Due to inconsistencies between the 4 RAMP in how they are run and operated, including how to refer into the RAMP has made navigating the system more difficult.

Clinical Specialists:

> Forensic Clinical Specialists who work with consumers who have a mental illness and a criminal record/are assessed as being at risk for offending. There are ongoing discussions around their role with perpetrators given they do not have expertise in working with perpetrators of FV;
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> FaPMI (Families where a Parent has a Mental Illness) Coordinators work with consumers who are parents and are able to identify wellbeing and risk concerns for children. There

are ongoing discussions around their role in identifying issues and intervention/safety planning, particularly with victim/survivors and children.

The number of identified FV situations for NWMH consumers has increased exponentially. The information about FV incidences was often collected and documented but clinicians did not always understand the information with a family violence lens. This has been vastly improved with having SFVAs who are FV experts embedded within the service.

The success of having SFVAs within the system has only highlighted the need for more SFVAs. Currently there are 2 full time workers to cover 6 Program/Areas. Each program has at least 3 clinical community teams, an acute in-patient unit, medium and long stay residential services, and a crisis response team. There is no possibility for 1 person to adequately cover 3 such programs. The SFVAs end up consulting only on the most complex and serious of situations, of which there are many. The capacity building and early intervention work is still predominantly left to the treating clinicians who are both busy providing a clinical mental health service and not well trained in working with family violence, whether with victim/survivors or perpetrators.

An increasingly obvious gap is the need for mental health to embed workers who are experts in working with men who perpetrate family violence, into the mental health clinical teams as the SFVAs have been able to do. There is also a growing need for mental health experts to be embedded within the FV services to help them to understand FV with a mental health lens.

We desperately need more SFVAs across each Area Mental Health Service/Program: one position for each service focusing on victim/survivors; another position in each service working with consumers who perpetrate violence; a further position within the Youth service dedicated to working with families with focus on the adolescent who uses violence.

HOW HAS THE EXPERIENCE OF ACCESSING SERVICES AND SUPPORT CHANGED SINCE THE ROYAL COMMISSION FOR VICTIM SURVIVORS, INCLUDING CHILDREN, AND PERPETRATORS OF FAMILY VIOLENCE?

Since the RC, there have been greater numbers of referrals from NWMH to specialist FV services, but there are ongoing referral issues, and possibly an increase in the number of issues due to 1) the FV Services' own increased workload and 2) difficulties interfacing with other service systems and the ISS: namely Police/CP; 3) ongoing miseducation around mental illness.

3 case scenarios highlight either a gaps in system, responses from Specialist Family Violence Service that were unhelpful, examples of discrimination against people with a mental illness or in the very least no understanding of mental illness.

Young consumer of mental health service, informed the case manager that her male partner was forcing IV drug use on her as well as other emotional, sexual and physical abuse including attempted strangulation. Her mental state made it hard for her to advocate for herself with this man: she couldn't say no. She also refused to allow the case manager to contact police on her behalf as that would only make him angrier and put her at more risk. Her access to health care was restricted by him. The decision was made by the treating team to proactively share information with Vic Pol under FVISS. Police stated they would not act on the information unless the case manager made a formal statement.

This was not what the case manager needed to do – they needed the police to check on this vulnerable young woman and protect her from this male. The police eventually went around to the flat and enquired around her safety, but as the perpetrator was present she denied any risk. Sometime after, the young woman fled the situation, managing to flee interstate, and was then safe. She was however, unable to maintain mental health treatment, starting all over again with another system/team. If police had used the information shared with them under ISS, they could have arrested the man, and the young woman would have been able to a) trust the system would help her and b) maintain links with her treating team.

They also highlight the complexities of working with families where there are multiple perpetrators, multiple issues and the need to be creative while still following principles and the law.

Consumer/Perpetrator in care of parents. Extensive forensic history (recently broke nose of nurse on in patient unit) and long history of intergenerational Family Violence. Father also perpetrator on wife, son perpetrates FV on both parents. Brother stabbed father 8 times in front of police. Mother Stage 4 breast cancer and quite frail. Father's history of perpetrating violence was shared without his knowledge.

Consent obtained by mother to engage with FV services on her behalf. She is not the identified consumer of mental health services. Referral completed for Berry Street Family Violence. Plan was to engage with Berry Street whilst son and husband are out of the home. Mother will let us know when they are out of the house so the call can be made to Berry Street on her behalf. She can't emotionally make the call due to years of abuse and adverse responses from police in the past. Has refused IVO at this stage as she feels it will make matters worse. Happy to engage re safety planning and psychosocial support.

Emailed Berry street referral who stated it doesn't meet their criteria for self-advocacy and empowerment.

Discussion had with Berry St about the reasons why she can't call herself. FV services make 'cold calls' on the back of L17's so it was asked that Berry St also make this call in this situation. After discussion with team leader at Berry St they rejected the referral and decided not to call victim/survivor.

Referral then made to Kildonan Family Violence Service who also refused stating it is too high risk and due to the mental health issues is not an appropriate referral. Referred to Salvation Army for assistance, also refused.

Risk left with treating team and victim/survivor left vulnerable.

An Aboriginal woman; long history of engagement with mental health and homelessness support services. Had periods when doing really well. Trauma history. Currently experiencing homeless with a violent perpetrator, who the consumer reports 'keeps her safe' from the many other perpetrators that hurt homeless women.

The treating teams RAMP referral was rejected, due to no police information. The treating team explained that there was a history of the perpetrator abusing the consumer, kicking her out of the property and then calling the police to report concern for the consumers' mental health. Upon police arrival the consumer usually presented as unwell, resulting in the consumer being sectioned under the mental health act and no record of the family violence from police.

During a call between the SFVA and RAMP Coordinator, the SFVA was advised that the RAMP would be reluctant to take away the autonomy of an aboriginal woman by accepting the referral to RAMP. The SFVA was also advised by the RAMP coordinator that this case sounded more like a mental health issue and that the consumer should be sectioned under the mental health act. The SFVA explained that mental health and homelessness services have been supporting the consumer for a number of years and what has been identified by the consumer and her support services, is the need for a specialist FV service intervention.

The SFVA informed that the consumer had given consent for RAMP, the treating team and other support services have contacted the Orange Door and other specialist FV programs in the consumers' area for support. Upon this the SFVA was advised that the consumer should make her way to OD to present in person, to which the SFVA stated that the consumer is currently experiencing homelessness and is unable to travel 30-45minutes to receive family violence supports. This situation is currently still unresolved.

LOOKING FORWARD – WHAT IS STILL REQUIRED IN THE FAMILY VIOLENCE REFORMS?

SOLUTIONS

Orange door: Family Safety Victoria are planning for the OD in the West. It is essential for mental health to be a part of this planning committee to ensure that mental health consumers are represented in and not excluded from the services.

Data: no consistent data collection tool.

Within the mental health CMI database and on the Contact sheets there is an option of coding interventions where the issue of FV was addressed. Bed based services do not use contact sheets and there for the work done on IPUs and bed based services isn't captured. A simple Contact sheet code also does not capture the extent of complexity or impact of FV on treatment. Doesn't allow for analysis of treatment outcomes. While SFVAs do collect information about the work they do, there is no data base system for them to enter details into, each SFVA is collecting slightly different information.

No peak body for clinical mental health services

Within the sector, there is a peak body for consumers of mental health services (VMIAC) and for those who are for someone with a mental illness (Tandem). The Office of the Chief Psychiatrist provides guidance and advice for implementing services, but in terms of those providing mental health services, the Area Mental Health Services, there is no peak body, as with VAADA for the AOD system.

This means that mental health services are not represented at meetings discussing the roll out of MARAM, development of perpetrator tools. etc

SHRFV

The Strengthening Hospital Responses to FV initiative is being scaled back, with funding ceasing next year. Currently NWMH has strong links with the SHRFV team at RMH/RCH/RWH and as a precinct group we provide a comprehensive response to FV across large health services. There will be many gaps for those hospitals around the FV response without SHRFV funded positions, especially when they are prescribed under the Information Sharing Schemes.

Capacity building in the Family Violence sector in relation to mental health

As demonstrated in the case examples above, there is a gap in the specialist family violence services around working with people with a serious mental illness. This is a specialist area and just as mental health services have benefitted from having FV specialists employed within the services to provide expertise and capacity build, the same needs to happen with mental health experts being employed within family violence services, both victim/survivor and perpetrator services.

Working with adolescents who use violence

Adolescents/young people who use violence are often victim/survivors of violence themselves. Having a history of family violence in childhood is a predictor of poor mental health/developing mental illness. Many adolescents who have a mental illness are excluded from adolescent violence programs due to their mental illness.

What is needed is a Pilot program for adolescent FV where the young person has a mental illness.

Orygen Youth Health has many excellent clinicians who already provide treatment for young people with a mental illness who use family violence. They could be a part of a pilot program that worked individually with the young person but also a program that looks at working with families to reduce violence in the home, group work programs for young people experiencing using violence in the home etc.

Working with the family where there is violence

The existing service system has a rigidity around identifying who is the ‘perpetrator’ and who is the ‘victim’, and is insufficiently flexible to recognise and respond to violence perpetrated by multiple family members towards multiple family members.

An extension to this, is that there are inadequate service options that support families with family violence recovery. This could go a long way to significantly reducing intergenerational trauma and ongoing family violence. FV services appear largely designed to help women and children leave safely, with little capacity to provide therapeutic recovery services if they do so.

Further to this, there are a large number of families that do not want to leave one another, but want to be supported to create greater safety and healthier relating at home. This is particularly so for families where someone has a mental illness as that person requires support and care from their family. FV services have been unable to assist beyond basic safety planning in this instance.

One solution would be to pilot a 'whole of family' model of intervention. This approach is particularly relevant when working with adolescents who use violence.

'Whole Family' models of intervention:

- Allow for adolescent family violence to be understood within the context of the history of the family as well as current family dynamics; in this context the young person can be supported to take responsibility for their behaviours *and* life experiences that may have impacted the young person to use violence can be acknowledged, this approach also focuses on strengthening relationships to support the young person to make changes
- is useful when working with families in which multiple family members engage in the use of violence and a family member may be both 'perpetrator' and 'victim', at different points in time – thus change may be required of several all family members
- recognises that some families want to stay together and need help in creating greater safety in their relationships

<u>Working with perpetrators who have a mental illness</u>

Many Men's Behaviour Change services do not accept referrals of men who use violence and also have a mental illness. As some of these men will continue to access mental health services for treatment of their mental illness, there needs to be engagement from specialist men's

behaviour change practitioners with clinical mental health treating teams around behaviours and vulnerabilities of perpetrators with a mental illness, to be done on an individual basis.

There is also a need for a specific men's behaviour change group for perpetrators who have a mental illness.

One solution is for No To Violence and mental health clinical services to pilot a *behaviour change group for male perpetrators with a mental illness* **and** also either embed experts in men's behaviour change into clinical mental health services or for these experts to work with the clinician who provides treatment.

Are there any parts of the family violence reforms that have not yet progressed enough and require more attention?

Training of staff MARAM: while there has been much training available across all service sectors, it has been challenging to find training that adequately addresses the complexities for clinicians working in the mental health sector. These issues include: when the consumer is the victim/survivor of FV; when the consumer is the perpetrator of FV;

AOD: We are aware AOD services are also covered under Recommendations 98 and 99 of the RC. There has been some attempt to align the services systems of AOD and mental health within local areas. Despite the many similarities, this is still a long way to go to get these systems working well together, and even further to go when considering aligning with FV services as well.

Keeping kids in focus: within adult and aged mental health services, while being aware of children of consumers and considering their wellbeing is within the remit, the truth is that many busy clinicians are unaware of children within the homes; feel unskilled in assessing their wellbeing; are unsure of how to give children a voice. It is also true that many consumers of mental health services are reluctant to discuss the wellbeing of their children, especially any concerns they have, as many people still fear that their children will be removed by CPS.

ISS not covering general hospitals: for mental health staff working in emergency departments when their general health colleagues are not covered under the ISS, navigating the requests for information to be shared under the ISS is quite tricky.

ISS difficulty with sharing information: there are many examples of difficulties using the ISS with other large service systems (police/CP/specialist family violence). As mentioned in one of the case examples, NWMH have had difficulty proactively sharing information with other ISEs and RAEs. Examples of the receiving service saying they wont take the information; services asking what we expect them to do with the information; times when services have said they will take the information but not act on it; confusion about how they want to receive the information (told to speak to a particular team only to be told to go back to the original team).There needs to be some clearer, mandatory guidelines for services about what to do when receiving information that has been shared proactively.

Consumer with current full exclusion IVO from ex-wife and 2 young children and on a corrections order re Family Violence. Attending Corrections psychologist. Consumer with community team for ongoing mental health issues, diagnostic and recovery based. Case manager provided review 2 days prior to incident. It was found his suicidal ideation was constant, morbid jealousy of wife constant but homicidal ideation towards wife not current. 2 days later the corrections' psychologist called case manager stating consumer had suicidal ideation and homicidal ideation toward wife and children and left office stating he was going to kill them and himself. SFVA advised case manager to call police and CP, and to provide all details immediately. This was done and police acted immediately. 5 minutes later the consumer's mother called case manager and stated her son was going to kill his wife and children pouring petrol on himself and them. Police provided with this further information. The consumer/perpetrator was arrested in possession of a can of petrol and en-route to his ex-wife and children's home. He was remanded in custody for 6 months.

Mental health service acted and shared information for a great outcome for Ex-wife and children.

Referral pathways: there are still services who refuse referrals of either victim/survivor or perpetrators of FV who have a mental illness. Apart from being discriminatory, it leaves mental health clinicians sitting with a lot of risk.

Perpetrator assessment and treatment: we understand this work is currently underway, but it is a long time coming. It is imperative that mental health services are consulted during the development phase. Having a peak body for clinical mental health services would make that process simpler.

Adolescent FV tool: we understand this work is currently underway, but it is a long time coming. It is imperative that mental health services are consulted during the development phase. Having a peak body for clinical mental health services would make that process simpler.

Data: as mentioned before, a centralised data collection tool/system is needed.

Elder Abuse

Links with Elder Abuse services to ensure staff in all settings are aware of the issues.