Family Violence Reform Implementation Monitor

Call for Submissions: Monitoring the Family Violence Reforms

The Family Violence Reform Implementation Monitor's Call for Submissions is open from 1 June 2020 – 20 July 2020 through Engage

Organisational submissions

Ballarat Health Services Mental Health Services (BHS MHS)

Ballarat Health Services is the parent organisation responsible for the delivery of the Area Mental Health Service in the Grampians region (Central Highlands comprising of 6 LGAs and Wimmera comprising of 5 LGAs).

Ballarat Health Services Mental Health Services (BHS MHS) catchment is located in the north-west of Victoria and covers 47,980 square kilometres, stretching 400 kilometres from the western outskirts of Melbourne to the South Australian border.

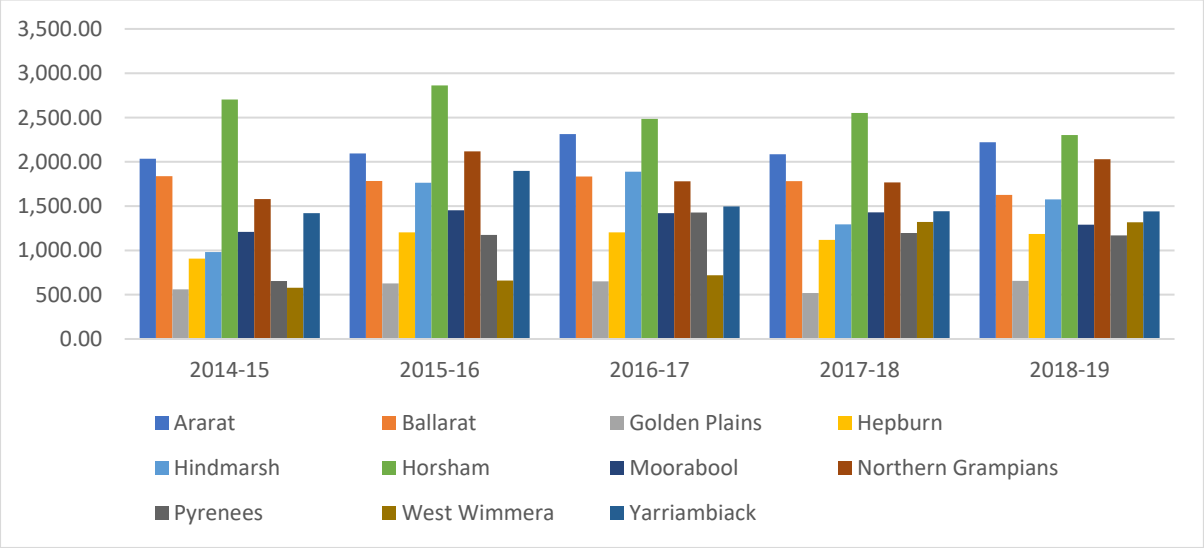
The catchment is comprised of the following eleven (11) Local Government Areas (LGAs):

- Hindmarsh;
- Yarriambiack;
- West Wimmera;
- Horsham;
- Northern Grampians;
- Ararat;
- Pyrenees;
- Ballarat;
- Hepburn;
- Moorabool; and
- Golden Plains.

Family Violence Data from Crime Statistics Agency

In Victoria, the number of family violence incidents reported by the Police has increased by 8.6% in 2018-2019 in comparison to 2017-2018. The graph below captures the family violence incident rates for the Local Government Areas (LGAs) that are covered by BHS MHS for the duration of July 2014 to June 2019.

Family Violence incident rate by LGAs of BHS MHS - July 2014 to June 2019



Some LGAs have seen an increase in family violence interventions by police, while others have seen a decrease. A number of the Grampians LGAs are in the top 20 for family violence reported incident rates state-wide. The increase or decrease in this data may not be reflective of changes in the incidence of family violence (i.e, the amount of family violence happening in the community) but only of those police are called to.

How has the family violence service system changed since the Royal Commission?

(1) What are the major changes in the family violence service system since the Royal Commission into Family Violence made its final report and recommendations in 2016?

- **Please share specific examples from your own organisation or sector.**

MARAM Frame work organisation: BHS MHS (Designated Mental Health Service) was prescribed as a MARAM framework organisation in September 2018.

Family Violence Executive Sponsor: BHS MHS identified the family violence executive sponsor to lead the directorate to align to the MARAM.

Close working with SHRFV: BHS MHS family violence executive sponsor/delegate of the executive sponsor has worked closely with the Strengthening Hospital Responses to Family Violence (SHRFV) project to lay the initial family violence related foundation work for the directorate. SHRFV has offered the following 3 training modules to BHS MHS staff.

- A shared understanding of family violence (40-minute foundational e learning module) – 101 BHS MHS staff has completed this.
- Identifying and Responding to family violence module – attended by 11 BHS MHS staff
- Family Violence Work place support training – attended by 16 BHS MHS staff, a good proportion of them are from middle level/senior level management

Mental Health Specialist Family Violence Advisor: BHS MHS successfully recruited to the mental health specialist family violence advisor role in August 2019.

Mental Health specialist family violence advisor has rolled out 13 in- service sessions across the directorate on Family Violence Information Sharing Scheme and Child Information Sharing Scheme to complement the information sharing schemes e learning modules rolled out by the Victorian Government.

Non-clinical guideline for FVISS and CISS: BHS MHS lead a family violence working group with representation from mental health and other BHS stake holders to develop a non-clinical guideline/supporting documentation forms for operationalising family violence information sharing scheme and child information sharing scheme. Specialist consultation from family violence sectors were sought by engaging external stake holders (local family violence service providers, system navigator of The Orange Door, Principal Strategic Advisor of Central Highlands) and family violence peak bodies (DV Vic) during the process of developing this guideline.

BHS MHS Roadmap to MARAM Alignment: BHS MHS has recently developed "BHS MHS Roadmap to MARAM Alignment - 12-month initial implementation plan" to systematically work towards the strategic priorities of MARAM alignment. As part of this implementation plan, BHS MHS is working on a mapping document to map BHS MHS roles to MARAM responsibilities. BHS MHS is also exploring ways to embed MARAM victim survivor risk assessment and safety planning tools to the current mental health clinical risk assessment and risk management framework.

Family Violence Competencies: BHS MHS Clinical Education Team is providing leadership and vision in the family violence training space by building in expectations for family violence competencies into the staff competency matrix. FVISS and CISS e learning modules and MARAM brief and intermediate training (victim survivor and perpetrator resources when released) are identified as essential training for BHS MHS clinical staff to align the family violence competencies to MARAM. Other relevant family violence related training is also promoted. BHS MHS clinical education team in collaboration with the mental health family violence advisor is closely consulting with the principal strategic advisors (PSAs) of Grampians Region and State-wide coordinators of the MH and AOD FV advisor programme to consolidate and review advice in this evolving space.

State-wide benchmarking exercise: A state-wide benchmarking exercise with other area mental health services has also been undertaken by the Mental Health Specialist Family Violence Advisor to support evidence-based decision making in finetuning the family violence competencies in the training space.

RAMP: BHS MHS is a core member in RAMP Central Highlands and RAMP Wimmera.

Family Violence work in BHS MHS informed by family violence experts and other sector partners: Mental health specialist family violence advisor is involved in the state-wide community of practice forums facilitated by family violence peak bodies (DVVic and NTV) and Grampians wide family violence networks coordinated by the principal strategic advisors of Central Highlands and Wimmera to draw on the expertise of these forums and networks to shape the family violence work of BHS MHS.

Intersectional Lens: BHS MHS acknowledge the need for an "intersectional lens" in clinical practice to appropriately and sensitively support service users from ATSI, CALD, LGBTIQ+, refugee, asylum seekers and other diverse ethnic and cultural backgrounds.

- **We welcome comment on changes to both your sector or your organisation's service delivery, as well as any broader system issues.**

Resourcing

Whole of Hospital: From a "whole of hospital" perspective, BHS MHS is of the view that there is limited evidence to indicate sustainability of family violence work post the SHRFV time frame. Dedicated and ongoing family violence specific resourcing will be beneficial to continue to embed the Royal Commission recommendations across the hospital setting.

*Psychiatrists and Medical staff: T*here are scope for better engagement of the psychiatrists and medical staff in family violence training. Work load and time pressures are often identified as ongoing barriers to engagement. It may be beneficial for medical team to have a family violence training pathway incorporated into their continuing professional development. Having a dedicated family violence resource for the medical team is likely to boost engagement and encourage participation.

State wide Coordination for Mental Health and AOD advisor programme: The state-wide coordinators have played an important role in supporting the advisors by offering one to one debrief opportunities, reviewing capacity building resources and plans, facilitating COPs and offering timely advice and guidance as needed. These roles have been incredibly helpful in facilitating an environment for shared learning and supporting the advisors in advocating for the specific needs of their sectors/services. Lack of state-wide coordination is likely to leave the mental health and AOD family violence advisors with limited support structure at a state-wide level.

MARAM Alignment

Monitoring and compliance framework: The framework organisations will benefit from a monitoring and compliance framework articulating the KPIs for MARAM alignment.

Dashboard Reporting: A "dashboard reporting" system to monitor training compliance of staff will be a great tool to have to support MARAM alignment.

Limited access to MARAM training: We have received numerous feedbacks from our staff to evidence limited access (in terms of training sessions made available) to MARAM brief and intermediate training. Given MARAM is legislated, barriers to access this training is impacting on BHS MHS progress towards MARAM alignment.

CPD points: Attaching CPD points to MARAM training could perhaps be an effective strategy to motivate staff attendance in MARAM training.

MARAM Expectations for Tier 3: It would be helpful to have more clarity on what are the specific parameters that demarcates a Tier 3 to a Tier 1 in the MARAM framework. The difference in the risk assessment tools used by each tier is flagged as an important differentiating parameter. It is suggested that one of the main differences between a Tier 1 comprehensive risk assessment tool and Tier 3 intermediate risk assessment tool is a set of questions catering to “additional considerations” of the victim survivor. However, identifying and acknowledging “additional considerations” when working with the service users has been encouraged in mental health clinical risk practice for a long time. Clearly understanding the professional and practice boundaries of each tier within the MARAM framework is crucial for purposeful and constructive cross sector collaboration to keep victim survivor safe and perpetrators accountable.

Mental Health Family Violence Risk Register: In order to get a qualitative and quantitative assessment of the family violence risk managed by a framework organisation at any point in time, a mental health family violence risk register will be beneficial. It will be helpful if the risk register clearly identifies the victim survivors and perpetrators/alleged perpetrators and the MARAM risk level. Guidelines and protocols supporting the development of a risk register will be of benefit to framework organisations. It will also be helpful to explore if CMI (State wide mental health triage system) could be a potential host for this register.

Cross Sector Collaboration: It is important to built in a “single shared assessment” model (a model practiced in the UK in learning disability and mental health sectors) minimising the need for any victim survivor to repeat their stories multiple times as they engage with various parts

of the service system. Having clearly defined protocols and practice contracts between sectors is critical to operationalise this. A professional case conferencing approach with victim survivor participation would also support best practice. However the current practice guides have limited guidance on how to operationalise cross sector case conferencing. At present, professional case conferences are "practitioner dependant" (depending on the motivation and practice approach of an individual practitioner). It would be beneficial if specialist family violence sector or the Orange Door take the lead in coordinating and convening the case conferences regularly. A few examples of a similar case conferencing approach in other areas are the high risk infant/youth panels convened by child protection, youth justice multi-agency panels, RAMP panels for managing the highest risk (however a similar recurring platform is also necessary to manage the other risk thresholds based on structured professional judgement or risk)

(2) How has the experience of accessing services and support changed since the Royal Commission for victim survivors, including children, and perpetrators of family violence?

- **Please share specific examples or case studies where possible.**

There is emerging evidence to suggest that BHS MHS has started receiving FVISS and CISS requests from other Information Sharing Entities (ISEs) and Risk Assessment Entities (RAEs). There is also evidence to indicate that BHS MHS staff has started to use FVISS and CISS to request risk relevant information for the purpose of victim survivor safety, perpetrator accountability and child wellbeing.

For example, when our aged community team identified that the service user they are working with is a perpetrator of family violence, they made a FVISS request to the Magistrates Court (ISE) to ascertain the status of the intervention order and also shared risk relevant information with Victoria Police (RAE) to keep victim survivor safe and perpetrator accountable.

Another example is from our perinatal community team - 21-year-old female, 34 weeks pregnant was identified as a victim survivor of family violence. In consultation with the mental health specialist family violence advisor a safety plan was developed to support the victim survivor to link her in to family violence counselling and support services. Collaborative practice with cross sector agencies and BHS ante natal services was identified as key to keep victim survivor safe and facilitate safe discharge post birth. Perinatal community team based

their interventions on MARAM principles, particularly MARAM principle 5 that encouraged them to consider the unborn child as victim survivor in their own right.

In cases where dual diagnosis presentations are identified in the family violence context, clinical practice involving close collaboration with family violence and AOD sectors are encouraged.

Secondary consultation with mental health specialist family violence advisor is identified as one of the ways to strengthen family violence clinical practice. BHS MHS is piloting a "family violence virtual clinic" to offer regular and dedicated opportunity to clinical staff for secondary consultation with mental health specialist family violence advisor. A family violence FAQ series is been circulated on a monthly basis to raise the awareness regarding the family violence reforms.

Looking forward – what is still required in the family violence system

(3) What are the most critical changes to the family violence service system that still need to occur?

Services for Adolescents using family violence: It is the view of BHS MHS that there is limited service provision and support in the Grampians region for adolescents using family violence. This is one area which will benefit from increased resourcing.

Mens Behaviour Change Programme (MBCP): It will be helpful to understand the effectiveness of MBCPs in the context of perpetrator interventions and unpack the evidence if any in relation to the low voluntary uptake of this programme.

Family Violence Risk of mental health consumers: ongoing review with child protection, Vic Pol, specialist family violence service and AOD service: A platform that facilitates regular and ongoing review of family violence risk of family violence risk with statutory services, specialist family violence services and AOD services will support victim survivor safety and perpetrator accountability. A "RAMP like" platform will be beneficial for a coordinated response to those that does not meet the RAMP

threshold but are still engaged with statutory services and specialist family violence services.

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

Policy position on emails: While there has been an increased awareness of the need for timely information sharing using the information sharing schemes, the existing policy position on emails (i.e. health information cannot be sent via email) is a barrier for sharing risk relevant information with other ISEs and RAEs in a timely manner. It will be beneficial to have revised guidelines from DHHS to support health services to adopt a more contemporaneous position on email communication.

Guidelines from Mental Health Tribunal: BHS MHS will benefit from practice guidance regarding the release of mental health records to the consumers for mental health tribunal when a family violence risk is suspected or substantiated. There is a potential for compromising the safety of the victim survivor if a next of kin/family member/nominated person/support person is a perpetrator/alleged perpetrator and have access to the records.

(5) Are there any improvements that could be made to the implementation approach of the family violence reforms?

Mental Health Peak Body: BHS MHS understand that the peak bodies like DVVic, NTV, VAADA are offering leadership for the implementation of family violence reforms for their respective sectors (family violence, AOD). It appears that there continues to be uncertainty and confusion regarding the peak body for mental health. BHS MHS will be appreciative of leadership and guidance from a similar body in Mental Health for the implementation of the family violence reforms.

Organisational Embedding Guide: While this resource has provided a generalised checklist to commence MARAM alignment, BHS MHS of the view that an embedding guide that is more tailored to the specific needs of mental health services would have been more beneficial. At

the time of drafting this submission, BHS MHS understand that Family Safety Victoria is planning to release an updated version of this guide.

Quantitative Benchmarking: BHS MHS has approximately 360 clinical staff who will be expected to attend MARAM training in order to align their family violence competency to MARAM. We have received numerous feedbacks from the community mental health clinicians and bed based mental health nursing staff that their attempts to register for the training has not been successful. Given the current training is targeting Tier 2 and Tier 3 workforces, BHS MHS is of the view that undertaking a quantitative benchmarking to estimate the anticipated workforce numbers for ongoing planning of MARAM training sessions.

Accessibility of MARAM training: A good proportion of BHS MHS workforce work shifts. Again, BHS MHS has received feedback from shift workers that the time slots during which MARAM online training is delivered is not conducive to their shift working. It would be helpful to have more flexible schedules for MARAM online training. It is also the view of BHS MHS that “Train the Trainor” model may be better suited to meet the family violence training needs of our directorate.

Dedicated MARAM training Sessions for our teams: One of the requests emerging from our teams is the viability of dedicated/targeted sessions that all team members can attend together for the purposes of time effectiveness, collaborative learning and achieving compliance. BHS MHS is of the view that our sector will benefit from “Train the Trainor” model.

Regional Approach to Training: While BHS MHS acknowledge that that the MARAM training content is relevant and necessary for effective family violence practice, there is feedback from our workforce that the content is very dense. BHS MHS have concerns regarding the potential training fatigue that our workforce may experience. A regional approach to family violence training coordinated and sequenced by the Principal Strategic Advisors of the Grampians Region (Central Highlands and Wimmera) could perhaps support better planning, sequencing and delivery.

Training Data: BHS MHS will benefit from access to attendance data of MARAM training for gap analysis of the family violence related training needs of the work force and to monitor compliance.

Impact of the COVID-19 pandemic

(6) What has been the biggest impact of the COVID-19 pandemic on your organisation or sector? How have the services that your organisation or sector provides had to change?

BHS MHS has undertaken intense planning and preparations to facilitate service delivery in the background of COVID-19. Our service users and sectors partners has continued to contact our service for referrals and secondary consultations. The mode of service delivery (telehealth, telephone and face to face) was determined on a "case by case basis".

We have noticed that there has been an increase in the presentations of our consumers in the context of deterioration of their illness at ED and increasing demand on inpatients beds, we understand this is being experienced across the State. We also note that there has been an increase in Triage category A and B across the state. This increase in demand has been due to lower levels of Face to Face (F2F) visits and the increased use of Telehealth because of the COVID-19 restrictions.

(7) Has the COVID-19 pandemic highlighted any strengths or weaknesses in the family violence service system?

One of the main challenges that BHS MHS has tried to understand and work on is effective and safe engagement with our victim survivors using telehealth. "How to provide a safe and sensitive space" for victim survivor engagement is a key question we continue to ask.

(8) Are there any changes resulting from the COVID-19 pandemic that you think should be continued?

COVID-19 has set the stage for testing the potential of telehealth and virtual systems for patient engagement and capacity building. Virtual conferencing platforms like MS teams and Zoom has made networking with internal stake holders and external stake holders easier and more convenient.