Royal Commission
into Family Violence

WITNESS STATEMENT OF DREW BISHOP

I, Drew Bishop, Senior Social Worker, of North West Area Mental Health Service (**NWAMHS**) at Level 1, 362 Bell St, Pascoe Vale South, 3044 in the State of Victoria, say as follows:

1. I am authorised by NWAMHS to make this statement on its behalf.

2. 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.

North West Area Mental Health Service

3. NWAMHS is part of the broader mental health network, North Western Mental Health (NWMH), which is in turn part of Melbourne Health. NWMH is one of the largest publicly funded providers of mental health services in Australia. NWMH (and thus NWAMHS) operates in conjunction with Northern Health (Northern Hospital, Broadmeadows Health Service, Bundoora Extended Care and Craigieburn Health Service) and Western Health (Sunshine and Western Hospitals).

4. NWMH provides comprehensive hospital-based, community and specialist services to youth, adults and aged people, operating out of all hospitals in north-west metropolitan Melbourne and a number of independent locations.

5. NWMH incorporates four area mental health services (**AMHS**) which are each responsible for servicing two local government areas, namely: Northern AMHS which services the cities of Whittlesea and Darebin; Inner West AMHS which services the cities of Melbourne and Moonee Ponds; Mid West AMHS which services the cities of Melton and Brimbank; and NWAMHS where I work which services the cities of Hume and Moreland.

Current role

6. I am a qualified social worker and have worked in mental health services since January 2003.

7. I have held my position as a Senior Social Worker at NWAMHS since August 2010. In this position I am employed as a Team Leader and am responsible for providing clinical leadership within the Shared Care Team along with overseeing the day to day operational running of the team. I also provide psychotherapy and treatment, secondary consultation, and assessment for people with major mental illness.

8. I have a Bachelor Degree in Applied Science (Psychology), a Bachelor Degree of Social Work, and a Post-Graduate Certificate in narrative therapy. I have worked across various settings within the mental health field, including inpatient psychiatric units, community mental health teams, and a primary mental health team.

9. From May 2008 – August 2010, I worked as the Senior Social Worker/Family Clinician at the inpatient unit of Northern AMHS. Prior to this I worked in the inpatient unit of Mid West AMHS (January 2003 – April 2004) and as a social worker in the community mental health team of Mid West AMHS (April 2004 – May 2008).

10. My current team is a community based mental health team called the Shared Care Team. We work in conjunction with general practitioners to help them service people in the community who present to them with mental health problems. We provide mainly psychotherapy, consultation, assessment, and education. We are an all-of-life service and we will see anyone irrespective of their age, this includes children under 15 years of age. The Shared Care Team is a novel service within NWMH. Other services within NWMH will only see people aged from 15 and older. The Shared Care Team receives some extra funding to provide this service to NWAMHS, and as a result has developed some specialisation in particular areas of mental health.

11. As part of my role, I have developed relationships with two family violence services in the area, Salvation Army Crossroads Family Violence Service (previously known as Mary Anderson Family Violence Service) and Berry Street.

Salvation Army Crossroads Family Violence Service

12. Our work with the Salvation Army Crossroads Family Violence Service is not specifically funded.

13. In my work with the Salvation Army Crossroads Family Violence Service, I provide consultations as well as group reflective practice to staff once a month. This

includes education about mental illness and mental health disorders and how those link to family violence because there is a large cross-over between the two. Reflective practice may involve case review work or education and often relates specifically to their practice.

14. I also work to improve the mental health literacy of family violence workers so that they can work better with their clients and access services. As part of the relationship, their service has access to a mental health service through me. I am able to help workers improve access to services for their clients which may include facilitating assessments, accessing the right mental health service for them, or providing general mental health consultation and advice about accessing services or working with people with a mental illness

15. A lot of family violence workers I have spoken to feel that they have trouble interacting with, and accessing, mental health services. For example, they may need to call the NWMH Centralised Triage which covers the four area mental health services (North West, Northern, Mid West and Inner West AMHS).

16. Our NWMH Centralised Triage team is a twenty four hour, seven day a week telephone based information, referral, and assessment service. This service processes approximately 60,000 incoming calls and 84,000 outgoing calls per year.

17. It is the job of Triage workers to determine the type of service to provide to people who are contacting them. This can be anything from organising an appointment at the appropriate service, providing general or specific mental health information and referrals, or co-ordinating a crisis response. The Triage workers use a Department of Health and Human Services mandated Triage Scale to assess people's risk, needs, and the urgency of response using a mental health perspective. Family Violence services use different criteria to assess risk and need. Because of this, a mental health service and a family violence service's assessment of risk and need can be very different.

18. In my experience, the style of language used by family violence workers and mental health services often does not really gel and, due to the difference in language, the family violence referrer's expectation of the mental health service is sometimes not met. This can mean that a family violence worker may assess their client as needing a crisis response for one reason, however, the NWMH Centralised Triage service does not for another reason, and a crisis response is not enacted. This may

leave the family violence worker feeling as though they have not been heard and are unable to access mental health in the way they would like to.

19. Mental health services including NWMH Centralised Triage use particular risk management criteria as a guide to respond to risk and mental health problems in a structured and prioritised fashion. Because there are differences in the meanings and assessment of risk and need between the two services this can sometimes result in a mismatch of expectations. I work with family violence workers to help them access and navigate the mental health service system. This is helpful for when they might have a client expressing suicidal ideas or someone they are identifying as not very well from a mental health perspective.

20. Family violence workers have expressed to me they often feel that when they contact the mental health services, they are being told, or feel like their client is not 'risky' enough for a crisis response, or that they cannot get an assessment as immediately as they would like it. These workers feel they are then left with a level of risk that they do not feel comfortable with and that they feel they cannot manage without some psychiatric input. Part of my role is to provide that input or to coach family violence workers about the type of language to use when speaking to mental health services. This may include helping them to focus on risk as determined by mental health criteria and how to word their referrals in a way that is more likely to result in a response from mental health services. I am helping to bridge the service gap so both services can communicate effectively and understand each other.

21. Those workers have told me that they now feel more confident when contacting mental health services. If they have doubts, they can contact me and I will try to help them to gain access to a service. Alternatively, I can advocate on their behalf if they need it.

22. I also facilitate more direct access to mental health services. Ordinarily, a family violence worker would need to access such a service through the NWMH Centralised Triage team or via a referral from a general practitioner. However, I am able to book their client in with one of my team members for an assessment. We are able to do that because my team are all experienced senior mental health workers and have worked in various settings including inpatient units and community teams. They are therefore well positioned to provide a diagnosis or some sort of management plan for clients. We do not necessarily take those clients

on for ongoing treatment but we provide assessments so that they have at least seen a mental health professional and can be referred from there.

23. Because my team and I are all senior mental health professionals, our work includes working with local services in order to build relationships, network, and improve their ability to work with people who have mental health problems. Each of us looks after a specialty area that is designed to address an identified service gap where particular health problems are related, such as mental health and family violence. My specialty area is Family Violence which I specifically chose because I have some previous professional experience in working with services in that area, along with an interest in Family Violence. Other specialty areas include drugs and alcohol, postnatal depression, physical health, research, and the culturally and linguistically diverse community. Because mental illness is so vast and encompasses such a range of social problems, we have specialties to meet those needs.

Secondary consultation work with family violence agencies

24. One of the benefits of my secondary consultation and reflective practice work is that we are able to increase family violence workers' mental health literacy so they feel more confident in working with people who have mental illnesses or mental health concerns which may arise secondary to family violence issues. We also support family violence workers' ability to work with mental health service agencies without feeling like they are being dismissed. I have been told that these workers now feel more confident working with more complex clients.

25. Some family violence services may be very reluctant to accept clients with mental health issues because of the complexities involved. I feel that because of our relationship with family violence agencies, especially the Salvation Army Crossroads Family Violence Service, many workers now feel confident that if they need assistance with the matter, they can refer to me or my team. Therefore, they are more likely, and better equipped to, take on clients with mental illness or mental health concerns.

26. The relationship also benefits NWAMHS because my family violence literacy has improved greatly from my experience, particularly through being on the ground with the workers and agencies and talking to them to understand what they go through on a day to day basis. I have also had some training about the Common Risk

Assessment Framework (**CRAF**). I have been able to share all of that knowledge and learning with my colleagues and the rest of NWAMHS so there has definitely been some shared learning between the family violence and mental health services.

27. In my view there are some particularly important factors required to develop a successful relationship between family violence and mental health services. First, it is important that the work is recognised as important and is resourced. The mental health worker needs to be allocated sufficient time to build and maintain the relationship, as well as to do the specific work (such as secondary consultations and assessments).

28. Secondly, it is important that we have a shared goal and reciprocal relationship. With my work and that of my teams, we meet one of the needs agencies have which is education in relation to working with people with mental health issues. As far as I am aware, family violence workers do not otherwise get that education and support from a mental health service. They have told me they really enjoy the reflective practice, they learn a lot from it, and their mental health literacy has greatly improved. It is also of benefit for me to be visiting the service so I am not just a voice on the phone. The face-to-face contact and time spent together help to strengthen the relationship.

Opportunities for outreach mental health services

29. We have previously been able to provide additional services to Salvation Army Crossroads Family Violence Service through another one of our staff attending their site once a week to conduct assessments. That worker was also planning to conduct some group sessions with women in the refuge, where depression and anxiety is a common presentation. Unfortunately, that work stopped due to the availability of the mental health worker and competing demands within the team. These demands included an increase in referrals coming from other services, case loads, and the cost associated with having two workers provide a service to one agency without additional funding.

30. If funding and availability had permitted it, I think it would have been a great opportunity to provide mental health services to victims of family violence within refuges. Furthermore, the work load of providing consults, assessment, education, and group work along with all the other responsibilities of being a mental health worker was too much for one person and services had to be prioritised.

31. I understand that some refuges have limitations around male professionals providing a service on site and that this type of policy can vary from refuge to refuge. Due to this, my ability to be able to enter a refuge as a male professional has to be given careful consideration and may prevent me from delivering services unless I am educated in a particular way. This may include being educated in gender sensitive practice or theories around gender roles as well as the issue of family violence and its impact. Not all mental health workers are educated in these areas.

32. I have worked with many women and children who have experienced family violence in a one-to-one setting and in my experience there has been little problem with me being male. From a therapeutic perspective, I would say that it is beneficial for victims of Family Violence to develop positive relationships with males and male professionals. When working in a therapy model, it is the worker's role to model a positive and safe relationship with people who have been traumatised so they can begin to understand what functional and safe relationships with men can look like. Women and children need to have positive experiences with men so they can learn that not all men are violent and abusive.

33. Within the issue of Family Violence, men can be seen as agents of trauma and family violence services may be concerned that male workers would re-traumatise victims. It is a skilled mental health worker's job to be able to first acknowledge the trauma someone has experienced and then address the impact of this trauma. If workers were to attend refuges in an outreach model there would be an expectation that they would know how to do this irrespective of their gender. Policies that exclude men can severely limit availability of staff who can, or would like to, do the work. It also limits the therapeutic benefit that male professionals can bring to victims of Family Violence.

Risk Assessment Management Panel (RAMP)

34. Our working relationship with Berry Street is different to that with the Salvation Army Crossroads Family Violence Service. We do not work in a consulting role with Berry Street as frequently, probably due to geographical restrictions. Our main work with Berry Street is to contribute to its RAMP project in the city of Hume.

35. My work with the RAMP largely relates to working in a consultation capacity. It may sometimes mean that the victim is referred for an assessment if their mental health

presentation requires it. Often if the victim has had previous contact with a mental health service we have access to considerable mental health information which, with the victim's consent, can be shared with the RAMP members. While the perpetrator may also have accessed mental health services, the absence of consent of the perpetrator makes it more difficult to share that information.

36. From a health and hospital perspective, it is difficult for us to deliver detailed and explicit information about a perpetrator without consent however, I find that in many cases, the police or other service agencies are already aware of the perpetrator's mental health issues. One of the ways we are able to share the information is when those perpetrators are posing a serious risk to the life, health, safety, or welfare of an individual, or that of the community. So we can share limited information with the RAMP however, it would be easier if we could share the information in its entirety given the risk posed to the victims.

37. I understand that information sharing more generally is a current issue hindering the RAMPs. I do not know the details, but understand that there is some issue with information sharing resulting in the RAMPs not being rolled out as quickly as had been intended.

38. I think the RAMPs work really well and it would be useful to have the RAMPs in each area if we can overcome any issues relating to information sharing. The RAMPs provide a good opportunity for all agencies to join together and develop a joint plan to identify some of the needs for families as a whole and to share information to address those needs. We sign a confidentiality agreement at the start of each panel so people's confidentiality is protected within the confines of the meeting and no information is shared beyond the members of the panel without explicit agreement by the panel and chair or as required by law.

Suggested improvements in mental health services

39. In my opinion, there is a lack of training for mental health workers in terms of screening for family violence. We definitely need more education for mental health workers who work directly with clients who may be affected by family violence.

40. We need ongoing education for mental health workers in relation to screening for family violence and working with victims of family violence. The area covered by NWAMHS has one of the highest rates of family violence in Melbourne so it is really important that our workers, especially those in direct contact with clients, know how

to screen for it and address the trauma associated with it. I think it is important that this training is delivered, or at least co-facilitated, by mental health professionals because the mental health system has a lot of its own language style, terminology and specialist skills.

41. I know from my experience as a social worker that even the mental health and general hospital social workers speak different styles of language and both groups of social workers have different skill sets from each other. We need to acknowledge the differences between the two systems of general health and mental health, including mental health assessment skills that probably would not be touched on if education was just delivered by general health. This would include other skills that focus on the contribution of family violence to personality disorders and other mental health problems. Co-facilitated training delivered by family violence workers and mental health professionals would be ideal, as would a co-delivered service. This may involve a refuge therapeutic group program or outreach partnership as I previously outlined.

42. NWAMHS and my team have a few clinicians who specialise in working with children and they report seeing a high incidence of family violence. From our perspective, there appears to be a trend of children exposed to family violence also experiencing mental health issues. Although these mental health concerns may also be related to other social factors, such as low socio economic status or drug use, there does appear to be a trend with children presenting with depression, anxiety and anger management problems correlating with family violence issues in the geographic area that we cover. It would be beneficial to be able to do more work with these children through research to see how broadly the problem of family violence affects our community.

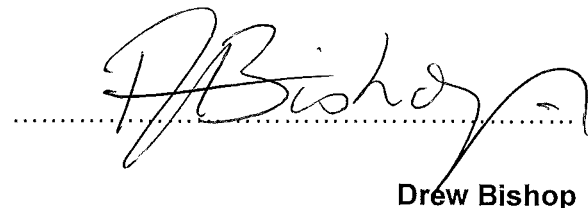
43. As I understand, there are limited services that provide therapy to children who have experienced Family Violence. Family Violence can significantly impact a child's mental health and they can develop disorders including depression, post-traumatic stress disorder, anxiety, or problematic personality traits that can negatively affect their ability to form functioning relationships. As my team has some focus on Family Violence and is an all-of-life service, we have been able to identify these children and offer them some mental health intervention. Presently, my team will attend schools to see children or can see them at the health centre where we work. I can also provide some recommendations to my team members about children and Family Violence if needed.

44. My team is in a position of being able to provide a mental health service to an agency that is within the NWAMHS geographical area as opposed to only being able to provide services to a person who lives in our geographical area. This allows us to see anyone who is a client or student of the service or school we are visiting as opposed to relying on the address of the person we are seeing to determine service eligibility as is true in other health care models.

45. Refuges are not permanent addresses for people. I believe that this person-address dependent model may be a constraint that Child and Adolescent Mental Health (**CAMHS**) and other mental health services would be facing. This would prevent services from being able to provide an onsite outreach service to refuges or schools as we are able to. People would be moving into other geographical areas from refuges which in most cases would mean another mental health service is responsible for them. Once people have moved out of a refuge, obtaining mental health assistance would be dependent on children or parents attending the sites of mental health services to seek assistance.

46. I believe that there is a role for mental health services to provide outreach for women and children in refuges, schools, or Family Violence services. Therapy models can take on different forms and approaches may involve on site group work, family work/mother-child work, individual work, or working with the Family Violence worker that is supporting them.

47. Constraints to these approaches may include the education of the mental health worker to deliver family violence sensitive interventions; the education of family violence workers to deliver mental health sensitive interventions; limitations on the gender of the mental health worker delivering the service; the fact that a refuge is not a permanent address for women and children; or availability of professionals and funding to provide this speciality given service demand.



Drew Bishop

Dated: 17 July 2015