



LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY

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Submission Cover Sheet

Inquiry into Immediate Trauma Support Services in the ACT

Submission Number: 006

Date Authorised for Publication: 13 December 2023

CarersACT

MENTAL HEALTH
carers
voice



**Submission to the inquiry into Immediate
Trauma Support Services**

December 2023



About Carers ACT

Carers ACT is the leading body for carers in the ACT. We work to ensure that carers enjoy improved outcomes in health, wellbeing, resilience and financial security. We also work to ensure that caring is acknowledged and recognised as a shared responsibility of family, community and government.

Our purpose is to support, connect and empower carers to maintain their caring role and personal wellbeing. The *Carers Recognition Act 2021* recognises the value of carers and the care relationship and defines carers in the following way:

“A person is in a care relationship with another person if the first person (the carer) provides care to the other person for 1 or more of the following reasons:

- (a) the other person has a disability;
- (b) the other person has a mental disorder or mental illness;
- (c) the other person has an ongoing medical condition;
- (d) the other person is aged and frail;
- (e) the other person is a child or young person, and the carer is a kinship carer or a foster carer for the child or young person.”

Carers include family members, friends, relatives, siblings, or neighbours. In the ACT more than 50,000 people provide care. Carers provide an important role in the family and in the broader community, supporting the quality of life of the person they care for. A carer’s role can include help with daily living activities such as housework, transport, health care, shopping, and meals, reading and writing, emotional and mental support and personal care.

About Mental Health Carers Voice (MHCV)

MHCV is the Peak Body for mental health carers to inform service delivery and policy development in the ACT. The program is funded by the ACT Government and is coordinated by Carers ACT. We work with carers to effect change for a better system of support for families caring for someone with a mental illness.

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Introduction

Carers ACT Mental Health Carers Voice welcomes the opportunity to contribute to the inquiry by the ACT Standing Committee on Justice and Community Safety reviewing immediate trauma support services.

As the peak body for mental health carers in the ACT, we are acutely aware of the wellbeing impacts of trauma on carers, families, and supporters. According to the 'National Study of Mental Health and Wellbeing' released in 2022, one in five Australians experience mental illness each year.¹ In this context, it has been estimated that 15% of Australians provide care for people living with mental illness.²

It is likely therefore that given Canberra's current population, **over 75,000 Canberrans provide care for someone experiencing mental ill health or have experienced mental ill health themselves.** The '2021 Carer Wellbeing Survey' underscores the heightened vulnerability of carers in the ACT, who are almost twice as likely to report low levels of personal wellbeing compared to the general population.³

Understanding Trauma

Before exploring the specifics of trauma support, it is essential to establish a shared understanding of the term 'trauma' in the context of this submission. In contemporary medical and psychiatric literature, trauma is defined as injuries not only inflicted upon the body but also upon the mind.⁴ Experiencing a traumatic event can trigger a cascade of biological changes and stress responses, manifesting as feelings of fear, confusion, and a sense of loss of control. In this context, immediate trauma refers to sudden, powerful, and upsetting crisis incidents that intrude into daily life, posing significant threats to a person's physical or psychological well-being.⁵ These crisis incidents encompass acts of violence or aggression, a loved one's encounter with life-threatening illness, and traumatic loss resulting from a suicidal crisis. Given the episodic and unpredictable nature of mental illness, mental health carers face unique challenges that contribute to a higher prevalence of such crisis incidents.

We are aware that the ACT has a wide array of existing crisis support services provided through ACT Emergency Services Agency (ESA), Canberra Health Services (CHS), and non-government organisations. However, we have heard from carers of people with mental ill health that they often face challenges in accessing immediate trauma support services following crisis incidents due to siloing, privacy barriers, and limited knowledge of service availability, particularly when priority is given to navigating the crisis at hand for the consumer.

Carers have expressed their need for immediate trauma support services that are accessible, well-coordinated, and responsive to their specific needs and experiences. In aligning with the care relationship principles of the *Carers Recognition Act 2021* (ACT),⁶ we advocate for a fundamental shift in the approach taken by ACT's immediate trauma support services. Carers, families, and support people must not be an afterthought; rather, they should be integral to the trauma response mechanisms, ensuring that support provided is "timely, responsive, appropriate, respectful, and accessible."⁷

In the subsequent sections, we will address specific instances of trauma, such as with interpersonal violence, suicidal crises, and acute mental health episodes. Primarily, we believe that by integrating and prioritising support for families and carers within the existing trauma response mechanisms, we can ensure a more holistic and effective approach to immediate trauma support services in the ACT.

Summary of Recommendations

1. Encourage the implementation of the Triangle of Care model across mental health services, emphasising the importance of identified carer liaison staff, psychoeducation, and links to local carer support services.
2. Map and consolidate existing navigation services, ensuring that they are inclusive of carers during the acute presentation stage.
3. Review more progressive privacy and consent statutes in other states and territories, such as NSW, to implement in the ACT.
4. Fund dedicated family and carer roles in health services (whether as peers or clinicians) and ensure they are provided with necessary frameworks to seamlessly integrate into the existing mental health system.
5. Provide comprehensive trauma-informed training to ED staff to ensure compassionate and supportive interactions with family and carers during acute presentations of mental illness.
6. Implement the recommendations of the 2023 PACER Evaluation – particularly highlighting:
 - 2.1 providing comprehensive follow-up information and support to consumers and carers after PACER interventions.
 - 2.2 identifying and facilitating additional linkages for PACER consumers who do not need hospitalisation but require a safe location for respite.
7. Fund new or integrate existing hospital diversion models to act as emergency respite options. Consider the implementation of models like crisis housing, Urgent Care Centre or Peacock Centre, to provide a safe space for both care recipients and carers.
8. Implement and strengthen a domestic violence protocol for mental health callouts at home, considering the safety and wellbeing of carers.
9. Scope the applicability of a postvention continuity of care model that includes families and carers in the case management team.
10. Apply a postvention support framework agreed to by CHS, ESA, and coronial services to ensure prompt co-ordinated responses.
11. Recognise the necessity for immediate, in-person postvention support for families and carers facing a suicidal crisis, tailoring options to the unique challenges and preferences in the aftermath of such traumatic incidents.
12. Implement family and carer peer support worker to existing postvention systems like WayBack to provide holistic support to people navigating the mental health system.

Acute Mental Health Episodes and Hospital Presentation

Navigating acute mental health episodes, particularly those necessitating presentation to hospital emergency departments (ED), can be an intensely traumatic experience for both individuals undergoing these episodes and the carers supporting them. To address this, "Safe Spaces" (also known as safe havens or safe haven 'cafés') have been implemented in Australia as ED diversion strategies, gaining nationwide popularity.⁸

Canberra has its own application peer-led model in Belconnen, which is currently under evaluation and is planned to be replicated in the Southside. However, it's important to note that Safe Spaces are not a substitute for clinical interventions. According to the 'AMA Public Hospital Report Card 2023', there's been a concerning increase in the acuity of patients with mental illness visiting EDs across the country. In the ACT, from 2004–05 to 2020–21, **the rate of ED presentations related to mental health issues has almost doubled per 10,000 population.** Notably, between 2016 and 2020–21, the ACT saw the most significant increase in ED presentations for mental health conditions where patients arrived by ambulance, marking a rise of 10.6%.⁹

Amidst these concerning trends, initial contact with the mental health system during acute mental health episodes becomes a pivotal point in shaping the trajectory of recovery. Unfortunately, anecdotal insights from carers reveal that at these critical junctures, whether initially initiated through Access Canberra or at the ED, carers' concerns are often overlooked, leaving them feeling helpless and overwhelmed in the face of immediate trauma. Consequently, supporting carers in these crisis events requires practical strategies such as system navigation and psychoeducation, coupled with the whole of system recognition of carers as individuals both possessing expert knowledge about the people they care for and having their own distinct needs and wants.

Recognition

Foundationally we know that immediately following acute incidents, carers must be recognised not only as a crucial part of the care team but also as individuals requiring support. The importance of carer involvement in care planning is well-documented and is a key principle embedded in various frameworks and legislative instruments, including the *Carers Recognition Act 2021* (ACT), the *Mental Health Act 2015* (ACT),¹⁰ and the NSQHS (Standard Two and Five).¹¹ However, carers often report that they are systematically excluded from care planning due to concerns from staff over potential breaches of privacy and consent laws. Jurisdictions such as NSW let carers self-identify and share information as a 'principal care provider' even if not designated by the consumer¹² while the ACT's *Mental Health Act* does not include such provisions. Moreover, over 23% of carers reported that even when the person they care for gives consent, ACT services often fail to involve them in care planning.¹³ This lack of inclusion intensifies feelings of isolation, frustration, and stress associated with acute mental health episodes.

Similarly, given the trauma associated with acute presentations of mental illness in the ED, especially during the first instance, it is crucial to identify and provide appropriate individual support to carers, family members and support people.

Carers, particularly those from CALD and First Nations backgrounds, often do not self-identify as such and are likely to be unaware of the support services available to them.

Unfortunately, alongside the traumatic stress already induced by the episode, acute mental health episodes can also trigger feelings of guilt and shame in carers. It's essential that all healthcare staff are equipped with trauma-informed training and approach families and carers with non-judgemental compassion and understanding.

The Triangle of Care model, initially introduced in the UK, offers an innovative solution to the issue of carer recognition in healthcare settings. It outlines six partnership standards: swift recognition of carers' essential roles, staff training for effective engagement, establishing confidentiality protocols, dedicating staff posts, providing informative introductions, and ensuring a variety of support services are available.¹⁴ Several pilot projects in Australia have successfully implemented the "Triangle of Care" model. For instance, a promising project in the Perth Metropolitan region, in partnership with Helping Minds, yielded positive results. These included heightened staff awareness of the necessity of engaging with carers, the creation and execution of strategies supporting carer inclusion in line with standards and legislation, and an enhanced provision of support and advice to carers.¹⁵

We recognise the immense pressures faced by our overworked and understaffed health services, and we understand that it may not always be feasible for health staff with other responsibilities to prioritise identifying and engaging with carers. Hence, it is critical that dedicated staff roles, as recommended in Standard 3 of the Triangle of Care model, are allocated to this frequently neglected aspect of trauma-informed health care. In 2020, Carers ACT and CHS Mental Health Justice Health and Alcohol and Drug Services (MHJHADS) initiated a pilot project to introduce 'Family and Carer Clinicians' roles within the Adult Mental Health Unit and Access Mental Health service.¹⁶ Such roles exist in other Australian states and territories and go beyond the functionalities of the current social worker positions in the hospital as they offer targeted support for carers and families, acknowledging and navigating the barriers of consent and privacy. The evaluation of this initiative revealed overwhelmingly positive feedback from carers who rated the support as extremely beneficial. The carers strongly endorsed the continuation of these roles, emphasising the vital importance of dedicated positions to support families and carers immediately following the acute phases of mental health episodes.

Practical Supports

Equally important to recognition is the practical supports post traumatic hospital presentations, particularly in the first instance, to help manage feelings of helplessness, frustration, and burnout. This in turn gives carers the space to look after their own needs and address the trauma of the acute episode in healthy ways. Regrettably, the fractured nature of the system has left onus on carers to navigate and advocate for the people they care for with limited support.

To address these issues, MHCV has developed a resource known as the Carer Navigator – one among several online navigation services available.¹⁷ However, we acknowledge that during an immediate traumatic situation such as an acute episode, carers may not initially utilise online resources. Discussions at the system level are ongoing about navigation, particularly during the current Commissioning process in the ACT.

These discussions include the potential addition of face-to-face peer navigators, a role similar to the 'Family and Carer Clinician'. Nevertheless, we advocate strongly for distinct roles for carer and consumer peer navigators, due to the barriers around consent and the unique experiences of both parties.

We also recognise the challenges presented by the early stages of the ACT's peer workforce strategy. These challenges are compounded by the size of the ACT's population and limited training opportunities, resulting in fewer available peer workers compared to other states and territories.

We appreciate the valuable support provided by certain services within CHS, such as the Liaison and Navigation Service (LaNS).¹⁸ This service, however, is limited in its criteria, as it is primarily catered towards individuals with mental ill health and physical comorbidities. Community-based supports like Canberra Head to Health have received positive feedback for their ability to act as a navigation support and provide a warm hold mechanism.¹⁹ Unfortunately, when carers present to the Emergency Department, they are often unaware of these services. Therefore, any integration of peer navigators/Family and Carer roles, or similar support for carers must therefore be accessible and well-coordinated with existing services to enhance overall effectiveness and avoid duplication.

Alongside navigation, carers have highlighted the benefits of psychoeducation when first encountering acute illness. Research by the Mental Illness Fellowship of Australia (MIFA) underscores that carers who receive comprehensive training and psychoeducation, coupled with adequate support, are better equipped to care for their loved ones.²⁰ Such assistance not only aids the wellbeing, rehabilitation, and recovery of the care recipient, but also bolsters the carers' confidence and capability in managing the often-challenging care journey. Currently, carers must depend on the clinicians' goodwill and undertake their own research to learn more about the conditions they are dealing with and the resources available to them. Models like Recovery Colleges offer innovative solutions to this dilemma. Regrettably, the ACT's Recovery College pilot, initiated in 2018, was discontinued after two years, despite having achieved positive outcomes for both carers and consumers.²¹

Recommendations:

1. Encourage the implementation of the Triangle of Care model across mental health services, emphasising the importance of identified carer liaison staff, psychoeducation, and links to local carer support services.
2. Fund dedicated family and carer roles in health services (whether as peers or clinician) and ensure they are provided with necessary frameworks to seamlessly integrate into the existing mental health system.
3. Map and consolidate existing navigation services, ensuring that they are inclusive of carers during the acute presentation stage.
4. Review more progressive privacy and consent statutes in other states and territories, such as NSW, to implement in the ACT.
5. Provide comprehensive trauma-informed training to ED staff to ensure compassionate and supportive interactions with family and carers during acute presentations of mental illness.

Interpersonal Violence

Recognising the potential trauma associated with acute mental health episodes and hospital/ED interaction, models like Police Ambulance Clinician Early Response (PACER)²² and Home Assessment and Crisis Response Team (HAART)²³ have been successful in offering an alternative to hospitalisation or incarceration in the first instance. These models fit into the fundamental shift of mental health policy in Australia away from institutionalisation, adopting Basaglian-style reform over the last few decades.²⁴ Nonetheless, this policy shift has left the majority of caring responsibilities to be shouldered by carers.

The ACT PACER 2023 evaluation report noted that over 70% of people experiencing acute mental health crises remained in the community after engaging with the emergency service.²⁵ Despite what may be a positive outcome for the consumer and emergency service, mental health carers are often left in domestic situations of aggression and violence lacking the requisite training or skills to deal with them. The 2021 MHCV Biannual Survey found that of all the mental health carers in the ACT that responded, around half had felt unsafe in their caring role over the last 18 months.²⁶ The implementation of a domestic violence protocol in mental health callouts at home is therefore necessary to mitigate risks. This protocol should extend beyond addressing the immediate crisis, considering the well-being of carers who often find themselves in challenging and potentially unsafe situations.

When balancing the tensions of feeling unsafe with the love for the care-recipient, the stigma of mental illness, and avoidance of incarceration, carers are left with little to no alternatives. The PACER evaluation report revealed additional burdens on carers, with 52% of carers finding that there is still opportunity to provide support so that they feel safe and capable of handling the post-crisis period.²⁷ In cases where people experiencing acute mental health crisis are unable to be placed elsewhere, a more suitable option would be specialised emergency respite. Specialised emergency respite offers a space for the care recipient to receive focused mental health care while affording carers the opportunity to distance themselves from crisis situations and recuperate. Models like the Peacock Centre in Hobart²⁸ and the Urgent Mental Health Care Centre in Adelaide²⁹ demonstrate potential models for emergency respite, offering a pathway from Safe Haven/PACER/HAART to a peer-led or clinical short term acute treatment centres. Looking beyond local models, crisis houses in the UK provide a residential setting for intensive, short-term support during mental health crises, offering emergency carer respite in a home-like environment.³⁰ Ideally, emergency respite options, including crisis housing and facilities like the Peacock Centre, would be accessible to provide a safe space for both the care recipient and the carer during periods where interpersonal trauma threatens wellbeing.

Recommendations:

6. Implement the recommendations of the 2023 PACER Evaluation – particularly highlighting:
 - 2.1 providing comprehensive follow-up information and support to consumers and carers after PACER interventions.
 - 2.2 identifying and facilitating additional linkages for PACER consumers who do not need hospitalisation but require a safe location for respite.

7. Fund new or integrate existing hospital diversion models to act as emergency respite options. Consider the implementation of models like crisis housing, Urgent Care Centre or Peacock Centre, to provide a safe space for both care recipients and carers.
8. Implement and strengthen a domestic violence protocol for mental health callouts at home, considering the safety and wellbeing of carers.

Suicidal Crisis

In Canberra, the lack of postvention options for carers facing a suicidal crisis exacerbates the challenges inherent in such traumatic situations. While online resources like Everymind's 'Mind Together'³¹ and SANE's 'You Are Not Alone'³² exist, the immediacy and severity of incidents such as attempted or completed suicides often render families and carers in a vulnerable state, making online resources less accessible.

There is an apparent need for expanded support options, acknowledging the preference for person-to-person contact during these critical moments. MHCV is aware of and involved with various coordinated efforts in suicide prevention and postvention currently happening both locally and nationally; including, but not limited to, the National Mental Health and Suicide Prevention Agreement, subsequent Bilateral Agreement, Universal Aftercare Project, and several committees at the Capital Health Network, NGO, Office of Mental Health and Wellbeing and ACT Health Directorate levels. While the intent and spirit of collaboration among these projects is commendable, they highlight the ineffective duplication that stems from a system fragmented by federalism and bureaucracy.

Despite the availability of services such as the WayBack program by Woden Community Services, the support presently does not extend to families and carers, indicating a gap in the existing system. Carers have proposed the inclusion of a dedicated peer support worker to ensure they are adequately equipped to provide effective care. They have also signalled the need for a comprehensive case management team for aftercare and postvention supports, including a peer worker, a counsellor, a psychiatrist, the family and carers, and the individual in need.³³ Such a team could work together to devise a tailored treatment plan, fostering mutual understanding among all stakeholders.

Given the high prevalence of suicidal crisis among First Nations populations, it is important that such a team employ Aboriginal and Torres Strait Islander individuals to work in their communities. These recommendations align with continuity of care models that aim to enhance the quality and continuity of care following a suicide attempt, such as the Baerum and Norwegian models.³⁴ The models establish a systematic 'chain of care' linking general hospitals and community aftercare services with patients discharged post-suicide attempt and immediate follow-up is carried out by a dedicated case management team tasked with coordinating the patient's care. Nonetheless, feedback from carers emphasises a broader issue of lack of transparency and involvement in navigating the mental health system.

Clinicians often hesitate to share information with carers due to privacy and consent concerns, even when the individual resides with the family. This inevitably creates obstacles to delivering effective care and support.

Recommendations:

13. Scope the applicability of a postvention continuity of care model that includes families and carers in the case management team.

14. Apply a postvention support framework agreed to by CHS, ESA, and coronial services to ensure prompt co-ordinated responses.
15. Recognise the necessity for immediate, in-person postvention support for families and carers facing a suicidal crisis, tailoring options to the unique challenges and preferences in the aftermath of such traumatic incidents.
16. Implement family and carer peer support worker to existing postvention systems like WayBack to provide holistic support people navigating the mental health system.

Conclusion

Recognising the profound impact of trauma on mental health carers, families, and supporters, MHCV advocates for a carer-inclusive reorientation of immediate trauma response mechanisms. Within the ACT, carers encounter significant challenges in accessing essential support services, especially in the aftermath of crisis incidents such as acute mental health episodes, including those requiring hospital presentations, interpersonal violence, and suicidal crises.

MHCV urges the Standing Committee to consider and implement the recommendations provided in this submission. We firmly believe that prioritising robust support for carers in the aftermath of traumatic incidents will inherently contribute to a more holistic and effective approach, ultimately ensuring the wellbeing of all individuals impacted by mental illness in the Canberra region.

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⁷ *Carers Recognition Act 2021* (ACT), s 8(1)(g).

⁸ “Safe Spaces,” Life in Mind (accessed November 2023), [Safe spaces - Life in Mind Australia](https://www.lifeinmind.org.au/safe-spaces).

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¹¹ “The National Safety and Quality Health Service (NSQHS) Standards,” Australian Commission on Safety and Quality in Healthcare, (accessed December 2023), [The NSQHS Standards | Australian Commission on Safety and Quality in Health Care](https://www.nsqhs.gov.au/standards).

¹² *Mental Health Act 2007* (NSW), s 72A.

¹³ Mental Health Carers Voice, “Filling the Cup Back Up – 2022 ACT Mental Health Carers Survey Report,” (Canberra: Carers ACT, 2022), 10, [2022-MHCV-Survey-Report.pdf](https://www.carersact.com.au/wp-content/uploads/2022/11/2022-MHCV-Survey-Report.pdf).

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