**CALD Carer Lived Experience Perspective  - 3 minutes**

It is important that services recognise the variety of ways that people may conceptualize family, carers and support people. People from Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) backgrounds generally have a broad conception of family including extended family and community, and services must respond to this in their approaches to working with these consumers and their families. Recovery is not individual here but relational and some of the recovery goals for consumers and their families (which might be of origin or of choice) may be striving for functional interdependence rather than pushing for independence which is often equated with a fracturing of relationships. **Fracturing of relationships is what the current mental health system does well**.

It does this not because staff don't care and because they need a cook book on culture to refer to as a how to guide, but because the system supports a homogenous, monocultural, individualistic, biomedical approach to recovery with one of the world's most diverse populations. If we are to stop tearing families apart, we need to invest in a relational approach to recovery fostering healthy relationships.

**A mothers' story**

A Mother from a refugee background sitting in a meeting with a Dr pleading for her 18 year old son, discharged from Youth to adult mental health services, to be kept in hospital as she is terrified 'if he comes home he will die'. The Dr ignores her pleas dismissing her as over protective and overinvolved. The carer consultant there supporting her has known her for years and knows this mother has done everything she could to support her son through youth services. The carer consultant steps in to support the mother and son by telling the Dr, who has no prior knowledge of this family, that this mother knows her son and his situation very well to no avail. They send him to a Continuing Care Unit (CCU). The staff at CCU confirm he is too unwell to be there. Within 2 weeks he had taken his own life.

**We need a Victorian Mental Health system which provides services that are safe havens for healing in a relational context.**

This means they are:
- physically, culturally, sexually, gender and emotionally **safe**
- Family **inclusive**
- **Fair** - Free from discrimination and stigma and
- Sufficiently **funded** to provide tailored responses to the consumer and their family - available when and where they are needed for as long as needed

The case study presented provides strong evidence for why we need cultural transformation of the system from an individual to a relational one. The Royal Commission must mandate the implementation of family inclusive practice as core business if tragedies such as this are to be avoided going forward. Thank you.

**Appendix 1**

**Victorian Mental Health Carers – snapshot**

**Background notes for context**

Those supporting someone they love with mental health issues don't generally identify with the term 'carer' as they see their role as relational and based on whether they are a mother, sister aunt, father brother, friend.

- 2/3rds are women or girls, 1/5th care for more that 1 person and ½ have been supporting for over 10 years and 38% do this for over 40 hours a week. CALD carers spending more hours than the average providing care

- 15% are under 25 Years of age and at risk

- The majority of the Victorian Carer Lived Experience Workforce (CLEW) are women and Carers supporting at least one family member. This workforce is under resourced, undervalued and underpaid.

- Carers of people with unpredictable episodic conditions, especially when these episodes are frequent, may find it harder to plan their working responsibilities around their caring role

- 64% of applicants for carer support fund financial support are female and services have experienced an unprecedented increase in applications for assistance due to Covid-19

**Appendix 2**

**Covid-19 Experience of family and friends supporting someone with mental health challenges**

- Calls from CALD carers have increased noticeably during this time. and interestingly they are as a whole engaging well with the technological changes

- carers calling our service have been more emotionally distraught as it is harder to get through to the 'right' services

- Fear of risk of relapse has increased with associated impacts for families

- Less consistent responsiveness than usual experienced from services to families seeking support due to pressure on hospitals

- All group activities  - respite and social postponed impacting social isolation

- Increased concern for vulnerable children and young carers

- carers have shared being expected to take on a greater than usual role without discussion / negotiation around how that fits their broader life, because of reduced face to face supports available. In some cases it has meant family members moving home after years in out of home residential support.

- social restrictions have led to increased tensions between carers and consumers which in some cases has led to them reaching a crisis point with increased calls to CATT.

- Concern has also been raised by carers about what would be hospital's policy for keeping consumers safe during an outbreak of COVID-19 in an inpatient unit.

- Families having significant increase in stressors around multiple support roles becoming stress points eg: aged parents, adult children returning home due to job losses, home schooling responsibilities, working from home

- We have also seen an increase in carers having been subjected to family violence and elder abuse

- Older carers being isolated and disconnected from consumer. When trying to maintain contact there is added anxiety around COVID-19 restrictions

- Housing and financial issues impacting across family and support systems eg: use of Carer support fund has increased.

- Fear of accessing health services ED/GP/inpatient and community services due to COVID