# MAEVe

## Melbourne Research Alliance to End Violence Against Women and their Children

## Submission to The Royal Commission into Victoria's Mental Health System

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# Royal Commission into Mental Health, Victoria: Submission from the Melbourne Alliance to End Violence Against Women and their Children (MAEVe)

## Background

MAEVe strives to make a difference to the lives of women, men, children, families and communities by addressing and preventing violence against women and their children through interdisciplinary collaboration and participatory research co-designed with survivors. We do this by drawing together research and evaluation capacity from across the University of Melbourne in partnership with community, industry and government agencies.

We recognise the need for prevention of domestic and family violence and the need to establish a culture of nonviolence and gender equality, and to shape appropriate attitudes towards women and children. We see domestic and family violence as a gendered issue with women and children more likely to be the victims of violence and men the perpetrators. Women and children who survive domestic and family violence often have significant mental health problems that can be complex and ongoing. The existing mental health system does not respond adequately to victim/survivors.

Through our response to questions 1,2,3,4,5,7,9,10 and 11 we will provide evidence and recommendations to help strengthen the mental health system's response to all those affected by domestic and family violence.

MAEVe works with the NHMRC Safer Families Centre of Research Excellence, an international collaboration of scholars (https://www.saferfamilies.org.au/our-team) co-directed by Professor Kelsey Hegarty, Professor Cathy Humphreys and Professor Stephanie Brown with a Centre based at the University of Melbourne.

## Question 1: What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

### Victim/survivors of domestic and family violence

Despite the fact that women who have experienced domestic and family violence have a three times increase in depressive disorders, a four times increase in anxiety disorders and a seven times increase in post-traumatic stress disorder[1] there is little understanding amongst the community about the impact of domestic and family violence on women's mental health and wellbeing. Domestic and family violence is a significant contributor to the burden of disease in Australia and women are affected [2, 3] more than men.

The Victorian Royal Commission into Family Violence acknowledged this issue in submissions and recommendations which highlighted the need for reform in the relationship between mental health services and the domestic and family violence service system to improve the experience of victim/survivors and perpetrators in the mental health system [4]. We wish to draw attention to the work of that Commission which provides foundations to be built upon in addressing the intersection between domestic and family violence and mental health.

As the recommendations of the Royal Commission into Family Violence are implemented, the community, and particularly health care professionals, need to be educated about the significant impact domestic and family violence has on the mental health of victim/survivors. In relation to the types of violence women experience, there is often an emphasis on physical violence. However, psychological violence and abuse can be as detrimental to mental wellbeing as physical violence[3]. Women who experience more than one form of abuse are at increased risk of mental disorders and associated comorbidities[3].

There is also a bidirectional relationship between domestic and family violence and mental illness, not only is domestic and family violence and abuse a risk factor for

psychological disorders, but women who have pre-existing mental health issues are more likely to be targets for domestic abusers[5]. Further, perpetrators of domestic and family violence may exacerbate and undermine victim/survivors efforts to manage their mental health and access health services[6].

Domestic and family violence is often' hidden' in Victorian communities and victim/survivors who seek help for the impact of violence on their mental health face significant barriers. Barriers to help seeking include shame and fear of stigma, structural barriers such as cost and lack of time, lack of knowledge about available mental health services[7]. Other barriers identified are based on fear, including fear of consequences, fear disclosure will lead to further violence, fear of not being believed, and fear of the involvement of social services with children[8].

Mental health is often raised as affecting perpetrators of violence against women and their murder. However, as noted in the Chief Psychiatrists guideline and practice resource on family violence, 'the belief that people with mental illness are likely to perpetrate violent crime is steeped in stigma and discrimination rather than facts' [9:9]. While some men who use violence will have mental health problems, recognition is needed that their use of violence and abuse may not be a result of their mental health condition, but rather their violence supportive attitudes which may need to be addressed[10].

## Recommendations

- An understanding that domestic and family violence underlies mental health issues for many women needs to be highlighted for the community and, in particular, the mental health workforce;
- Specific services responding to domestic and family violence in the community need ongoing education about how to respond to the mental health impact of family violence on victim/survivors;
- Legal and policing services in the community should understand the impact of domestic and family violence on victim/survivors' mental health and allow for this in their dealings with victim/ survivors;

- Health services, particularly primary care, community health and community mental health care providers need to be educated to respond appropriately to victim/survivors of domestic and family violence and their children;
- Mental health services should understand that perpetrators of domestic and family violence often restrict or control the access of victim/survivors to mental health treatment and should not be used as a source of evidence about a woman's mental health status.

## Question 2: What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Essentially, the mental health system works well for those who can afford the services of psychiatrists and psychologists to access early treatment and support for high frequency disorders such as depression and anxiety. Even in this situation, or in the public mental health system, we know that the underlying social condition of domestic and family violence is not identified or responded to by mental health clinicians[8]. Further, the experience of domestic and family violence, including sexual violence, is across the lifespan[3]. Many opportunities for prevention and early intervention are being missed in childhood and with young people, as abuse and violence is very common and starts early in life. Exposure to adult domestic violence and direct child abuse are major causes of mental health disorders across the life course [11].

Currently, apart from child sexual abuse, very little attention is paid in primary care and mental health services to issues of abuse and violence in domestic and family settings. We are missing a major risk factor for mental health in our management of behavioural disorders in children, internalizing and externalizing disorders and in the onset of depression and anxiety in young people, particularly girls. Headspace, which is supposed to be the solution to early intervention, pays little attention to domestic and family violence [12] and lacks staff that are trained in dating and sexual violence. This situation needs to be improved if we are to prevent mental illness and support people to get early treatment and support.

### Recommendations

- All prevention and early intervention mental health policies include references to domestic and family violence as an underlying issue for mental health needing to be addressed;
- All primary and mental health care services develop a health system model (as recommended by the World Health Organisation)[13] that addresses the

organisational and staff level changes that are required to support staff to undertake domestic and family violence work, including sexual violence;

- All primary and mental health care services ask routinely about domestic and family violence and deliver a first line response (as recommended by the World Health Organisation) for domestic and sexual violence;
- The commonwealth government fund a Medicare item number for family safety planning to 1) allow general practice to ask about domestic and family violence when there are indicators, 2) undertake a first line response and 3) refer according to need to trained and accredited specialist domestic and family violence and sexual violence services under this plan, similar to mental health care plans.

## Question 3: What is already working and what can be done better to prevent suicide?

### Intimate Partner Violence and Suicide

Evidence shows that there is a strong relationship between domestic and family violence and suicidality with a systematic review concluding that there is a strong and persistent relationship between domestic and family violence and suicidal thoughts and behaviours. The review also found that the severity of abuse is related to higher suicide rates [14]. The studies in this review were mostly focused on female victims of domestic and family violence.

In 2017 there were 3,000 suicides in Australia. Of these, 861 were in Victoria. Seventy five percent of those who committed suicide were men and 25% women. Eighty percent of those who intentionally self-harmed had comorbidities with 43% having mood disorders, including depression[15].

In an analysis of suicides in Victoria between 2009-2012 MacIsaac et al [16] suggest that a substantial number of these suicides have a history of exposure to domestic and family violence. The study found that:

- Domestic and family violence was present in almost half of female suicides in Victoria and one third of male suicides. Women were more likely to be victims of domestic and family violence. 23% of women dying from suicide had been victims of physical violence, 18% had suffered psychological violence and 16% sexual abuse;
- Domestic and family violence among women is associated with depression, anxiety, post-traumatic stress disorder (PTSD) and alcohol and drug abuse. These conditions are associated with long-term increased mortality;
- Although male violence in Australia primarily occurs between strangers, men who died from suicide most often perpetrated abuse against a partner;

- The majority of men and women exposed to domestic and family violence had disclosed this to a professional, family member or friend prior to death. The majority of women and men are willing to discuss their experience of violence, a fact that must be utilized in suicide prevention.

MacIsaacs et al [17] also conducted a systematic literature review examining the relationship between domestic and family violence and completed suicide. It found that being a victim or perpetrator of this violence is associated with a risk of suicide

**Women with severe mental illness**

Women with severe mental illness have high rates of sexual violence perpetrated against them. The odds of sexual violence against women with severe mental illness are six times higher for lifetime sexual violence than in women in the general population [3]. In a survey of women with severe mental illness, 40% reported rape or attempted rape with over half of these reporting attempted suicide as a result of their experience. Forty seven per cent of victims reported that the sexual violence had been perpetrated by a current or former partner[18].

**Suicide prevention and family violence**

There is a dearth of research and policy focus on domestic and family violence and suicide. One of the objectives of the Victorian Government's suicide prevention framework 2016-2025 [19] is to support vulnerable people. Although victims and perpetrators of domestic and family violence are at high risk of suicide in Victoria, they are not reconised as a vulnerable group.

The link between domestic and family violence and depression, anxiety, post-traumatic stress disorder (PTSD) and alcohol and drug abuse in women is well established. However, the link between domestic and family violence and higher risk of suicide amongst women has not been highlighted.  Further, suicide in men is linked to perpetration of violence on an intimate partner. There is a need for attention to be paid to suicide prevention for victims and perpetrators of domestic and family violence.

## Filicide and mental illness

A study of filicide in Victoria found that 29 children (75%) were killed by a perpetrator who had been diagnosed with a mental illness[20]. Depression was common in male (71%) and female (73%) perpetrators. Eighty-one per cent of perpetrators of filicide had been in contact with a service eg GP, mental health, counselling, child protection etc. The most common associated risk factors for filicide was mental illness and parental separation.

### Recommendations

- Victoria's suicide prevention framework should include victims of domestic and family violence as a vulnerable group to be supported;
- There needs to be an investment in research on domestic and family violence and suicide focusing on early intervention which will include exploring the issues which keep women entrapped and unable to leave a violent and abusive relationship;
- Victims of domestic, family and sexual violence who have mental health conditions should be screened for suicidal ideation;
- Men who present with mental health problems should be screened for perpetration of domestic and family violence and suicidal ideation. Where there is suicide ideation or threats of suicide in the context of domestic and family violence, threat of homicide will also need to be assessed and action taken to protect children in particular;
- For such an intervention to be successful, mental health professionals and experts in service delivery in domestic and family violence need to work together. Most significantly, mental health professionals need to be aware of the link between domestic and family violence and suicide.

## Question 4: What makes it hard for people to experience good mental health and what can be done to improve this?

We suggest that you look at the NHMRC Safer Families Centre of Research Excellence website for the short digital stories by women, including health professionals, who have experienced domestic and family violence. They are very powerful and tell the story very clearly about what makes it hard for people to experience good mental health and what can be done to improve this. See https://www.saferfamilies.org.au/survivor-stories-tools. You need to sign in but they really will say in the words of women with lived experience exactly how they feel and how the system is letting them down. They also make comments about what has helped them.

To overcome the difficulties people experience to good mental health we need the following recommendations. These recommendations are based on careful work with survivors and perpetrators of domestic and family violence and on the latest evidence. Safer Families Centre of Research Excellence is undertaking evidence syntheses and projects (see https://www.saferfamilies.org.au/projects) that will inform the future developments needed in the mental health system. We are undertaking a Cochrane systematic review on psychological treatment for intimate partner violence and have multiple doctoral students working on the intersection between mental health and domestic and family violence. We would be happy to provide the latest evidence.

### Recommendations

- All colleges and associations of mental health clinicians should have policies on domestic and family violence and understand effects across the lifespan;
- The World Health Organisation and World Psychiatry Association curriculum on domestic and family violence should be mandatory training for mental health clinicians;
- Alcohol policy and public health measures should address the link between domestic and family violence and alcohol misuse;

- Funding of mental health services and access to services should take into account how the effect of domestic and family violence results in financial issues and housing issues.

***In health settings:***

*At the Organisational level*

*There is a need for;*

- Training of all managers in an understanding of trauma and violence informed approaches;
- Clinics to have posters which provide information on FV support services;
- The environment to be safe – corridors and lighting;
- Adequate private spaces;
- Waiting times to be minimised;
- Organisations to incorporate the voices of patients and staff;
- Models of care that to allow people to be seen separately;
- Women only inpatient corridors;
- Comprehensive referral networks and co-ordinated care.

*At the Staff level*

There is a need for;

- Training of all mental health workers and administrative staff in the dynamics of domestic and family violence;
- Staff training in the use of the FV Multi-Agency Risk Assessment and Risk Management framework (MARAM) as appropriate for their mental health service;
- Support for staff who experience domestic and family violence;
- A team approach;
- Reflective practice;
- Staff to understand that information about mental health should not be collected from partners;

- Restraining practices to be reviewed;
- Co-ordinated care so that patients do not need to re-tell their stories.

## Question 5: What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

### Domestic and family violence

Domestic and family violence is a significant driver of poor mental health outcomes. The Australian Longitudinal Study on Women's Health shows that socio-economic status is linked to domestic and family violence [21]. Communities with a higher proportion of those of low socio-economic status are more likely to have higher rates of domestic and family violence and poorer mental health outcomes. They are also more likely to have limited access to health and support services particularly in regional and rural areas. Similarly, exposure to domestic and family violence as a child is a risk factor for perpetrating and experiencing domestic and family violence as an adult [21]. Thus, economic disadvantage, poor access to services and the experience of domestic and family violence in childhood are all key drivers of violence and of poor mental health.

However, there is a lack of data on domestic and family violence and how known risk factors such as socioeconomic status, employment, income, disability and geographical location interact. Issues of intersectionality and diversity are also critical with marginalisation and discrimination impacting in different ways on people with disabilities, LGBTQI, and from Culturally and Linguistically Diverse communities and Aboriginal and Torres Strait communities. Responses tailored to need and the specificity of the community or group are required to ensure that the service system response is accessible and appropriate[22].

There is also a lack of data on services and responses that victim/survivors and perpetrators receive, including specialist services, mainstream services and police and justice responses. Better data on incidences of domestic and family violence in communities will enable a more tailored mental health response to victim/survivors of domestic and family violence and to perpetrators. Similarly, better data linkage between

services will be able to identify at risk families and help ameliorate existing and intergenerational domestic and family violence. Early intervention and better education about domestic and family violence across communities may help reduce the mental health consequences of exposure to domestic and family violence in childhood and adulthood.

Stigma of mental illness and stigma of family violence co-exist and better information needs to be provided to communities about the link between mental illness, mental health, and domestic and family violence. Economic drivers of disadvantage are difficult to address but early intervention with children and young adults showing signs of mental distress should include screening or early identification of domestic and family violence. Linking domestic and family violence services with mental health services will enable a sharing of skills and information in addressing domestic and family violence and in responding appropriately to mental health issues exacerbated or caused by domestic and family violence.

## Recommendations

- Domestic and family violence is a significant driver of poor mental health outcomes and better data collection is required to understand and address this;
- Some communities are more vulnerable than others to domestic and family violence and the resulting mental health issues. There should be a focus on gathering better data from these populations to better tailor support services to their needs;
- Intergenerational domestic and family violence has significant impact on children and young people and their mental wellbeing. The cycle of intergenerational violence and poor mental health needs to be addressed with services for children and young people and a focus on respectful relationships;
- Stigma is associated with poor mental health and with domestic and family violence. A focus on educating communities about the link between domestic and family violence and poor mental health would help address that stigma and raise awareness about that link;

- Domestic and family violence and mental health services should work together to support victim/ survivors, perpetrators and children experiencing domestic and family violence.

## Question 7: What can be done to attract, retain and better support the mental health workforce, including peer support workers?

### Mental health workforce and domestic and family violence

The mental health workforce could act as a significant resource for victim/survivors of domestic and family violence. International guidelines, including those from the World Health Organisation (WHO), recommend that the mental health workforce should facilitate violence and abuse disclosure as part of clinical assessments. Given that the prevalence of violence against users of mental health services is so high, the guidelines recommend routine inquiry by mental health services. These guidelines also recommend that the workforce provides support and ensures safety [3]. Any discussion about domestic and family violence or abuse should be conducted in a safe place and in private and, before any discussion takes place, mental health professionals should know how to respond. The training associated with the new family violence information sharing legislation and the Multi-Agency Risk Assessment and Management (MARAM) provide opportunities for the mental health workforce. There is a legislated expectation that mental health services will use the Identification and Screening tool within their intake and assessment services. Embedding the training for domestic and family violence in the mental health workforce will provide a key point of development in the move to recognise and respond to the links between mental health and domestic and family violence.

Currently, evidence suggests that mental health practitioners report barriers to asking about domestic and family violence. These barriers include role boundaries, competency and confidence and being unsure if asking about family violence was part of their role [8]. Practitioners also reported feeling ‘uncomfortable’ asking about domestic and family violence, a lack of training, lack of time, lack of effective interventions and fear of offending the individual [8]. Even though mental health practitioners are used to asking individuals about their propensity to violence, asking about being a victim of violence was not part of their routine risk assessment. Nyame et

al [23] report that only 15% of mental health practitioners routinely ask about domestic and family violence, 60% reports a lack of knowledge about domestic and family violence, 27% believed that they did not have adequate referral resources, 27% provided information on sources of support and 23% made a referral to counselling. Clinical mental health professionals are educated in the biomedical model of care and are more comfortable in this model of focusing on diagnosis and treatment and this often prevents mental health care professionals from addressing the cause of mental health issues. Professor Pat McGorry is cited in the Royal Commission into Family Violence as saying:

*In the general mental health system, in terms of a therapeutic response, the focus is typically a narrow one on the individual person presenting in front of the health practitioner…I do not believe that most practitioners would be family focused or routinely assessing for family violence, or necessarily giving it much attention* [4:30]

The problem for victim/survivors is that their mental health issues are not treated as a 'normal' response to living with violence or as a symptom of abuse, but rather are reified or decontextualized from their abuse experiences[24]. In the worst-case situations, the perpetrator of abuse uses the woman's mental health issues to hide his abuse and to discredit the woman and her abuse experience. It is extremely common for perpetrators of abuse to report to police, when called to attend a family violence 'incident', that the woman is 'mad' and lying about the abuse. When mental health services are not alert to the victim/survivor's issues of domestic and family violence, they may inadvertently collude in the 'secondary abuse' of the woman by failing to connect her issues of depression, trauma, PTSD and suicide attempts with the abuse she is experiencing.

An international review [25] identified that only 10-30% of domestic and family violence and abuse victims are identified by mental health professionals . Despite this, domestic and family violence and abuse victims want mental health professionals to ask about and validate disclosure of violence in a non-judgmental manner. There is a lack of understanding amongst mental health professionals about the complexities of domestic and family violence and abuse. For instance, there is often a view amongst mental

health professionals, that is also held by the wider society, that victims of domestic and family violence and abuse should leave their partner. However, evidence shows that leaving an abusive partner can be the most dangerous action a victim can take with women being at greater risk of homicide in the months following separation [26].

**The VOICE project**

Unpublished data from a research project currently underway in the Safer Families Centre of Research Excellence suggests that there is a problem in the way that psychologists respond to intimate partner violence. The VOICE Project has interviewed 20 women survivors of intimate partner violence about their experiences of seeing psychologists in Victoria. Most of the women had seen more than one psychologist and almost all talked about negative experiences. The women talked about experiences with psychologists which mirrored the behaviours and tactics of intimate partner violence. The women were often blamed for the abuse when psychologists focused on why they got involved with the abuser in the first place and why they didn't leave. Often, especially if they had experienced non-physical forms of abuse, the psychologist did not believe that it was intimate partner violence, or it was dismissed or minimised. Many were stopped from talking about the abuse and often felt erased as individuals when the psychologists focused on other issues or solely on their symptoms.

Many of the women in this study felt that the psychologists they saw did not understand the dynamics of intimate partner violence or the effects that it had on their wellbeing. Although some women had also had positive experiences, almost all the women in the VOICE project had experiences with psychologists that had done further harm. The negative experiences with psychologists re-traumatised many women in this study and affected their future help seeking. The experiences of the women in this study do not cover the breadth of psychologists' responses to women survivors of intimate partner violence, however they do raise issues of concern about the preparedness of psychologists to respond appropriately and helpfully to intimate partner violence and the damaging effect when they do not. The experiences of the women in the VOICE project suggest that when considering how to attract a mental health care workforce, there

must be a focus on ensuring that it is a workforce that is adequately prepared and trained to respond to domestic and family violence.

## Education and Training

Recommendation 102 0f the Royal Commission into Family Violence, Victoria [27] states that a number of relevant medical colleges should coordinate the development of a family violence learning agenda. The Chief Psychiatrist has developed a guideline and practice resource in family violence outlining expectations of Victorian public mental health services regarding family violence [9]. This focusses on mental health services; *"…recognising, understanding, enquiring about and responding to family violence"* [9:1].

Training in the dynamics of domestic and family violence for mental health practitioners is one priority. However, more is required to improve identification of victims of domestic and family violence and abuse. Ongoing training and support in non-mental health settings has shown that, for health professionals, integrating training and the support and advice of domestic and family violence specialists facilitates disclosure of violence and improves response [28]. Similarly, identification, treatment and referral of perpetrators of domestic and family violence would help reduce violence and safeguard women and children.

The mental health workforce also needs to be involved in primary prevention of domestic and family violence through raising awareness of the effect of domestic and family violence on mental health and the intergenerational trauma that can be caused.

### Recommendations

- The mental health workforce should inquire routinely about domestic and family violence and abuse;
- Any discussion about domestic and family violence and abuse should be conducted in private and safely;

- Training should be provided to all mental health practitioners to improve their identification of domestic and family violence and abuse and to respond appropriately;
- The mental health sector should help raise awareness of the high incidence of mental health conditions amongst victim/survivors;
- The mental health sector should advocate for funding of specialist services and interdisciplinary teams to provide practical support to victims;
- Mental health professionals need to be supported by domestic and family violence specialists through ongoing integrated training.

## Question 9: Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

### A focus on trauma informed care

A key area of attention should be the implementation of trauma informed care across mental health and related organisations.

### Defining trauma-informed care

Human service systems such as the mental health and alcohol and drug sectors often serve victim/survivors of trauma without "treating them for the consequences of that trauma", and, more significantly, "without even being aware of the trauma that occurred" [29:3]. In such a context, a system's usual operating procedures, practice standards and treatment response can inadvertently re-traumatise consumers of these services. As such, a service system needs to be trauma-informed. This means being aware of a consumer's history of past and current abuse. There is a need to understand the role violence and victimisation plays in the lives of consumers of mental health services and *"to use that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that facilitates consumer participation in treatment"* [29:4] Trauma-informed care is explicitly envisaged as a systemic change approach to be reflected at all levels of the service system and not simply as being aware of an individual's trauma history when working with them. This system, or organisational level, perspective is reflected in many of the current definitions of trauma-informed care. For example, the US Federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) describes a trauma-informed approach to service provision in the following terms;

*When a human service program takes the step to become trauma-informed, every part of its organisation, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organisations, programs, and services*

*are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization. [30]*

The key elements of trauma-informed care in the above definition – understanding the impacts of trauma and (re) organising service practices in light of that – are reflected in definitions used by most other human service organisations. Importantly, in a trauma-informed system, a history of trauma is considered the **expectation** rather than the exception.

Thus, a trauma-informed system is one in which all components of a given service system have been considered, evaluated and organised through a basic understanding of the role that violence plays in the lives of people seeking services and alongside an awareness of the dynamics of trauma and how these may present in consumer populations [31].

**Trauma-informed care and domestic and family violence**

Victim/survivors of domestic and family violence can experience post-traumatic stress as well as other mental health conditions. This is sometimes overlooked when treating victim/survivors. Post-traumatic stress results from fear for life or safety or having experienced significant traumatic events. Reactions can be physical, including heart palpitations and sweating, or emotional, including panic, being wound up and hyper alert or, conversely, being numb. Australia's mental health system is not adequately structured to recognise the relationship between trauma and the development of mental health problems, and hence in responding in an informed manner. This has serious implications for victim/survivors' health and wellbeing. A mental health system based on a 'diagnose and treat' approach may fail to reconise the underlying violence in which mental health problems, and specifically issues of trauma in victim/survivors, may well be a symptom of abuse. A clinical assessment informed by a set of Diagnostic and Statistical Manual (DSM) criteria means that the substantive issue of what so profoundly happened to the person does not inform service or practitioner responses. Domestic and family violence can have a significant impact on the mental health of

victim/survivors. A trauma-informed approach to addressing their mental health and wellbeing should be central to any education or training for mental health practitioners and to the organisations they work in.

**Trauma-informed approach**

A trauma-informed approach, as described by the Substance Abuse and Mental Health Services Administration, USA [30] and others, includes a **realization** by organisations and practitioners that clients may be affected by trauma; a **recognition** of the signs of trauma; the need to provide a trauma-informed **response,** and **resistance** to re-traumatising clients and staff.

The key principles of providing trauma-informed care are;

- Physical and psychological **safety** for staff and clients;
- **Trust and transparency** between staff and clients;
- A **collaborative** approach to healing;
- **Voice and choice**: the organisation aims to strengthen the experience of choice for people it cares for as well as for staff;
- A strength-based approach to care focusing on **empowerment;**
- **Cultural safety**: the organisation incorporates policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served, gender responsive, and incorporate a focus on historical trauma.

More recently, we have been working with a Canadian group of academics on Violence Evidence Guidance Action (see https://vegaproject.mcmaster.ca/) who have developed a Trauma and Violence Informed framework which goes beyond the above to include abuse and violence aspects (see https://equip2013.files.wordpress.com/2016/11/tvic-tool-for-bc-organisations.pdf).

## Strategies for trauma-informed systems change

Trauma-informed organisational and systems change is not nearly as developed in Australia, the UK or Canada compared to the United States [32]. While there may be a growing desire for, and provision of, training for trauma-informed care and practice among mental health professionals and other human service practitioners, a national or coordinated approach to reform, practice and policy development such as that driven through the SAMHSA mechanisms is absent. In recognition of this, a National Trauma Informed Care and Practice Advisory Working Group, convened by the Mental Health Co-ordinating Council released a position paper and recommendations for a national strategic direction [31]. The National Strategic Direction paper argued that substantial progress had been made in developing a research and practice base for undertaking trauma-informed care and practice and in translating that research into practice guidelines. A key area of future focus was on implementation of trauma-informed practice at a scale enough to create measurable cultural change [31]. This involves;

- capacity building;
- infrastructure development;
- policy development and implementation;
- workforce development; and
- national standards and guidelines.

### Recommendations

- There is a need for a focus in policy development on implementing a trauma-informed approach in mental health and domestic and family violence;
- Standards and guidelines are needed to enable the workforce to develop skills for, and practice in, a trauma-informed way;
- Mental health practitioners need to be educated to identify clients who may be affected by trauma, abuse and violence;

- Their response to these clients should go beyond diagnosis and treatment and reconise the underlying experiences that have led to the trauma;
- Organisations serving victim/survivors should ensure that all staff are trauma and violence-informed.

## Question 10: What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

### Intersectoral collaboration

Evidence indicates that health systems globally face the same issue of siloed service delivery even though the problems caused by domestic and family violence (including sexual violence), alcohol and other drug use (AOD) and mental health are multidirectional[33, 34]. This is  despite two decades of published literature proclaiming the benefits of inter-sectoral collaboration for meeting the needs of people affected by violence, alcohol and other drug use (otherwise termed substance use), and mental health [35-38], as well as a growing focus on trauma-informed care.

In 2016, the team led by Professor Kelsey Hegarty completed the WITH study (Women's Input into a Trauma-informed systems model of care in Health settings) [39] which was funded by Australia's National Research Organisation for Women's Safety (ANROWS). We found many barriers to change in health systems. For instance, with limited time available, there often tends to be a focus on direct service to clients over talking with other services. The main facilitating factors emerging from consultation with staff and stakeholders across the service settings were as follows:

- the need for relationship building between teams;
- a greater shared understanding of roles and language;
- improved integrated care and coordination of referrals;
- further training of staff;
- more workforce support;
- strong leadership and governance; and
- improved information systems for monitoring and evaluation.

## Mental health, drug & alcohol, and domestic and family violence/child protection

The team led by Professor Cathy Humphreys has undertaken three national projects funded by ANROWS or the Commonwealth Department of Social Services to increase the effectiveness of the response to children living with domestic and family violence[40]. The current STACY (**S**afe &**T**ogether: **A**ddressing **C**omplexit**Y**) explores the intersections between family violence, mental health, and alcohol and ather drugs, and child protection services through 'Communities of Practice' and an active senior management advisory group drawn from each of the service sectors.

It is clear from the cases bought to the 'Communities of Practice' that those involving the nexus between mental health issues and domestic and family violence are some of the most challenging given the difficulties in engaging mental health practitioners and their managers to appropriately address the domestic and family violence issues, share information and work collaboratively with other services involved in responding to domestic and family violence. A further issue is that the adult focused mental health services have little focus on their clients as parents. This means the interrelationship of the mental health and domestic and family violence issues for either or both parents (that is, the perpetrator and/or adult victim/survivor) and their impacts on children's safety and wellbeing are unlikely to be addressed within the therapeutic, mental health response.

The prevalence of substance use and co-morbid mental health issues like depression, anxiety, self-destructiveness, post-traumatic stress disorder and suicidal behaviour is documented as higher in women who have experienced domestic and family violence [41] [42]. It is not surprising then that domestic and family violence and alcohol and other drug specific services ultimately end up providing care for the same women[43]. While simultaneously targeting substance misuse and domestic and family violence is more effective than addressing either as a single issue,[44] it is surprising that joined-up

service provision and responsive care remains elusive and that service models often exist in philosophical tension; siloed approaches are more common than not [40] [45-47].

Partnerships that coordinate interventions would improve outcomes for women and children yet these remain underdeveloped[48, 49].

## Mental health, sexual violence and trauma-informed care

In Australia, one in five women have experienced sexual violence, mostly perpetrated by someone they know, and often an intimate partner [50]. There is a strong association between sexual violence and mental health problems for these women [51]. Mental health and sexual violence services often have a shared client group, and ideally, women would have a pathway to safety and wellbeing no matter which service they approach first, i.e. “No Wrong Door”[52]. However, although nationally, and at various state levels there is policy/guideline work around trauma-informed care and practice [53, 54], gender sensitivity [55], connection of services [56] and domestic and family violence sector reform, it does not appear to be very common for services to communicate with each other, provide cross-referrals, or address issues outside their scope of expertise. While it is true that sector specific trauma-informed guidelines have been implemented to varying degrees by services, there is a gap around how services can implement trauma-informed practice to work more effectively when both issues are present. This is an issue for the domestic and family violence sector as sexual violence is a common component of domestic and family violence and because most sexual violence against women is perpetrated by an intimate partner.

## System change

Our findings from the WITH and STACY studies show that in the Australian context there is arguably an underdeveloped theorisation of systems change in complex human service environments relative to work generated in the US and European contexts. This is despite many initiatives that aim to achieve precisely this, as evidenced by the

investment in integrated, multi-disciplinary, co-ordinated and wrap-around models of care in numerous settings (sexual assault crisis responses, mental health and alcohol and other drug sectors, child protection and domestic and family violence services). As noted in a recent comparative study of trauma-informed care in inpatient mental health settings, *"the implementation of trauma informed care requires a philosophical shift on how mental health services are delivered system wide"*[57] Change processes will need to go beyond training to be effective. However, this change process faces several challenges. The first is that while there is a degree of consistency about trauma-informed care, there is variation in how underlying principles are defined. This can create issues in trying to translate them into objectives and organisational practice. Secondly, there is a lack of knowledge about translating trauma-informed care into acute and inpatient settings: how does one do trauma-informed care in a crisis context where restraint is required, for example? Thirdly, there is limited knowledge on *"facilitating organisational change in a complex public health system with vested professional interest groups"* [58]. Fourthly, here is a need to recognise that in adult focused services, many of the clients are also parents whose children should not be ignored. Finally, funding is often siloed, making integrated service provision a challenge. Learnings and concepts from systems change in other complex human service systems could be useful for the next phases of trauma-informed care in Australia.

## Recommendations

1. To improve Victoria's mental health system for victim/survivors of family and sexual violence more collaboration and integration of services is needed. To enable this there needs to be:
    - **Relationship Building:** Staff need to be connected within care teams, within the hospital, and with external services through opportunities to talk together. They need to develop trust over time and a shared understanding of their different frameworks and roles;
    - **Integrated co-ordinated care:** Staff need clearly defined roles and referral pathways that are mapped intra-organisationally and inter-

organisationally. Policies supporting the trauma-and-violence-informed work and staff 'champions' to drive the work are needed;

- **Reflective systems**: Organisations that engage in regular reflection are more likely to promote quality improvement. This includes prioritising feedback from women about what they would like changed in the system as well as providing feedback to practitioners;
- **Staff input into changes in strategy, policies and resources is also essential**: Auditing how women flow through the system on their pathway to safety and well-being and what practitioners are enacting would allow quality improvement to be monitored;
- **Environment and workplace scan:** Regular assessment of the environment and workplace facilitates improvements in areas requiring attention. This includes checking for spaces to have private and confidential discussions, and reviewing staff work flow patterns to allow sufficient time to engage with women on these sensitive topics. Assessment of culture, values and beliefs that are occurring within a workplace can impact any change process. Monitoring and evaluation also requires better data systems to be developed.

2. To enable change, staff need:
    - **Support to ensure they are ready** and open to being involved in cross-service training and discussions;
    - To be able to provide **constructive feedback** to management on what can be improved, including on worker safety issues;
    - To engage in **audits** (of the environment, of workplace practices, and of women's pathways);
    - Prioritise **self-care** to avoid vicarious trauma and burnout.

## Question 11: Is there anything else you would like to share with the Royal Commission?

We have consulted with our lived experience panel of women survivors of domestic, family and sexual violence (the WEAVERs) for feedback about their experience of the mental health system. The WEAVERs have experienced a fragmented mental health system which lacks an understanding of the impacts of domestic, family violence and sexual violence. They have experienced difficulty in accessing appropriate care and a system that can re-traumatise women. They report that they are regularly referred from one service to another, having to repeatedly tell their story with little therapeutic outcome. They also report a lack of a trauma informed response to their mental health needs.

Given their experience of the mental health system the WEAVERs have the following recommendations.

### Recommendations

### Education and training of staff and support workers

- A stronger focus on domestic, family and sexual violence in the pre-registration education of medical, mental health and allied health professionals;
- Education and training in trauma informed care;
- Ongoing education and training on the mental health impacts of domestic, family and sexual violence post-registration;
- Experts in domestic, family and sexual violence need to work with mental health professionals to improve the mental health systems response to survivors and share their expertise;
- A focus on educating staff in self-care strategies and the development of self-care plans for staff;
- Peer support workers to be provided with funded training from the Department of Health and Human Services (DHHS) to create a sustainable peer support workforce;

- Medication is only part of the response to mental health care and other therapeutic responses need to be trialled.

### Other therapeutic responses

- A strength-based approach to recovery with survivor and peer led groups supporting consumers to empower and strengthen each other;
- Loneliness and social isolation issues face mental health consumers, and there needs to be greater investment in initiatives that are community based that provide consumers with support;
- Therapies such as art therapy, music therapy, yoga, writing therapy etc should be offered in the community;
- Community based initiatives lack secure funding that would ensure sustainability. Investment in initiatives act to connect people and can prevent relapse;
- Initiatives such as *Equally Well* https://www.equallywell.org.au/ should be utilized by services to provide a more holistic approach to the mental and physical health of consumers.

### Other barriers

- Housing is one of the biggest issues facing people escaping domestic and family violence and living with mental illness and other disabilities. There needs to be more research into how people access support from housing services and what the outcomes are. Investing in safe and sustainable housing is important if a sustainable solution to addressing issues in the mental health system is to be achieved.

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