Formal Submission to the Royal Commission into Victoria's Mental Health System

BETHANY COMMUNITY SUPPORT INC

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Mental Health and Family Violence

Bethany Community Support welcomes the opportunity to provide a formal submission to the Royal Commission into Mental Health, with a specific focus on the intersection between mental health and family violence.

Family violence refers to violence between family members, in which the perpetrator exerts power and control over the other, and the most common form of family violence involves intimate partner violence (usually referred to as domestic violence), which tends to be perpetrated by men against women and their children (AIHW, 2018). Family violence has been shown to impact upon women's mental health (Ayre et al., 2016; Lagdon et al., 2014; Trevillion et al., 2012), and there is emerging research linking mental illness to men's perpetration of family violence (Askeland & Heir, 2014; Shorey et al., 2012; Stuart et al., 2008). Therefore, the issue of mental health is an important consideration for family violence services responding to both victims and perpetrators.

Mental Health and Family Violence Victims/Survivors

In Australia, family violence has been found to contribute to more burden of disease (the impact of illness, disability and premature death) than any other risk factor for women aged 25-44, with mental health conditions (namely, anxiety and depressive disorders) identified as the largest contributor to the burden (Ayre et al., 2016). Another Australian study found that women who experience gender-based violence (including intimate partner violence) are more likely to experience mental illness over the course of their lifetime, and that this risk increases with increased exposure (Rees et al., 2011). Moreover, rates for mental illness were found to be highest for anxiety disorders, followed by mood disorder, substance use disorder, post-traumatic stress disorder, and suicide attempts (Rees et al., 2011).

On a global scale, women who experience multiple forms of domestic violence and those who are repeatedly victimized have been shown to be at increased risk of mental illness and co-morbid mental illness (Garcia-Moreno et al., 2005). For example, those presenting with depressive symptoms also were more likely to report substance abuse and suicidal ideation (Garcia-Moreno et al., 2005). In the US, the majority of women (62.6%) who had experienced intimate partner violence (in the form of sexual assault, physical assault and/or stalking) reported at least one symptom of post-traumatic stress disorder (Black et al., 2011). In addition, the mental health consequences for women who are sexually abused appear to be more severe than for those who are physically abused, such as more severe post-traumatic stress (Bennice et al., 2003; Temple et al., 2007).

In a systematic review of the literature, women with depressive disorders, anxiety disorders and PTSD were found to be at increased risk of experiencing adult lifetime partner violence than women without mental disorders (Trevillion et al., 2012). Compared to women without a mental illness, women with depressive disorders, anxiety disorders, and PTSD were 2.5 times more likely, 3.5 times more likely and 7 times more likely, respectively, to have experienced domestic violence. In addition, women with other mental health diagnoses (e.g., eating disorders, obsessive compulsive disorder, schizophrenia, bipolar disorder) were also more likely to have experienced domestic violence compared to women with no mental health diagnosis.

Another systematic review of the literature explored the impact of all types of intimate partner violence victimization on various mental health outcomes (Lagdon, Armour, & Stringer, 2014). Depression was noted as a significant outcome of experiencing intimate partner violence and psychological violence alone had an effect on depressive outcomes. Repeated exposure to different forms of violence within a relationship increased the risk of depression, and depression frequently

co-occurred with PTSD. PTSD was also identified as a significant outcome and psychological violence alone was a key predictor of PTSD. Repeated exposure to different forms of violence within a relationship increased the risk of PTSD, and the severity of intimate partner violence was also associated with the development of PTSD and co-morbidity of PTSD with depression. Psychological, physical and sexual violence were found to be associated with anxiety, with a higher number of studies indicating that psychological violence exposure was associated with anxiety.

Mental Health and Family Violence Perpetrators

Past research has shown an association between traits of borderline and antisocial personality disorder and the perpetration of intimate partner violence (Stuart et al., 2008), and between depression and PTSD and intimate partner violence (Bell & Orcutt, 2009; Stuart et al., 2003). Shorey et al. (2012) extended this research to investigate associations between intimate partner violence and other mental health issues – namely, depression, PTSD, generalized anxiety disorder, panic disorder, social phobia, and alcohol/substance use. Aside from sexual aggression and panic disorder, all mental health problems were positively associated with intimate partner violence perpetration, and as the frequency of mental health problems increased, the frequency of intimate partner violence perpetration also increased. Shorey et al. (2012) further found that the estimated prevalence of mental health problems among their sample of men was higher than the general population, and that alcohol use disorders were the most prevalent mental health problem among their sample, which is known to have a strong dynamic risk relationship with intimate partner violence.

A Norwegian study found a high prevalence of psychiatric morbidity among men voluntarily attending treatment for intimate partner violence, with 70% of men indicating at least one psychiatric disorder and nearly half of the men indicating two or more disorders (Askeland & Heir, 2014). Three major groups of disorders were highlighted, including depressive disorders, anxiety disorders, and alcohol/substance abuse, and the prevalence of psychiatric disorders in this sample was higher than that of the general Norwegian male population. Askeland and Heir (2014) argue that treatment of psychiatric disorders is not an integrated part of most intimate partner violence programs, which may be a significant oversight in light of the findings.

Mental health issues appear to be commonly associated with family violence perpetration across both genders in the relevant literature, including PTSD, psychopathological, antisocial and/or borderline personality disorders, anxiety disorders, depression, suicidality, ADHD, and, bipolar disorders (Thomas, 2019). In addition, research has found high rates of co-morbidity of mental health problems and substance use among perpetrators of family violence (Askeland & Heir, 2014; Davoren et al., 2017; Siegel, 2013). Nevertheless, the nature of the associations between mental health problems and family violence perpetration are unclear and a causal relationship or the identification of predictive factors is yet to be established (Shorey et al., 2012). Moreover, Gondolf (2007) suggests that caution is warranted for psychopathological explanations as indicating causality, as this may displace responsibility for the violence.

Witness Statement of Professor James Ogloff, Royal Commission into Family Violence 2015

In his submission to the Royal Commission into Family Violence, Professor Ogloff (2015) noted the influence of mental disorder – both personality disorder and mental illness – in the perpetration of family violence, and the lack of attention paid to these conditions in existing family violence services responding to perpetrators.

Professor Ogloff identifies personality disorder as dysfunctional characteristics or traits of the person that tend to be pervasive over time and across situations, and mental illness as group of disorders with a range of symptoms that affect one's cognition, emotion, behaviour and relationships with others and that vary in their nature and severity. He further identifies that personality disorders can make an individual vulnerable to mental illness and the two tend to co-occur.

Professor Ogloff asserts that personality disorders are a significant underlying component of family violence, with primary examples being borderline personality disorder and antisocial personality disorder; however, Victorian services have paid little attention to the assessment and treatment of personality disorders. With respect to mental illness, Professor Ogloff identifies three groups of people with mental illness who engage in violence:

1. People where a mental illness is a necessary and sufficient explanation of their behavior. These people lead normal lives, become unwell for a period and engage in violence when unwell; for example, in response to developing paranoid delusions associated with a psychotic episode. This is the smallest group.
2. The largest group are those who experience mental illness and other problems, such as personality disorder, substance abuse, and problems with anger and aggression.
3. The final group are those who develop antisocial attitudes and behaviours, independent of their mental illness or mental state.

As such, Professor Ogloff asserts that the relationship between mental illness and family violence is variable, and can involve a range of other risk factors. Therefore, these factors need to be identified and treated on a case by case basis via risk assessment and risk management. Risk assessment refers to the process of identifying risk factors that are present and increase the likelihood of violent behavior occurring. The preferred method – structured professional judgment – utilises a systematic framework to assess evidence-based and theoretically relevant risk factors to assist in the case formulation, and the use of a validated risk assessment measure.

Professor Ogloff highlights that existing programs for family violence perpetrators in Victoria do not reflect best practice in offender treatment or rehabilitation. They do not subscribe to the principles of the Risk Needs Responsivity model or other principles of evidence-based practice that have been shown to reduce recidivism. A one size fits all approach is provided, rather than attempting to match an individual offender's assessed needs to the focus of treatment and treatment intensity. Professor Ogloff asserts that "we must improve provision of specialist interventions to those with complex and serious mental, personality and substance abuse disorders". He further asserts that "better integration and communication between mental health services, drug and alcohol services, and offence-specific program providers" is needed.

Summary

In summary, family violence can have significant impacts upon the mental health of female adult victims, with anxiety, depression and PTSD identified as prominent experiences (Ayre et al., 2016; Lagdon et al., 2014; Trevillion et al., 2012). The risk for mental illness has been shown to increase in response to multiple forms family violence and repeat victimisation (Garcia-Moreno et al., 2005; Rees et al., 2011), although sexual abuse appears to have the greatest impact on victims' mental health (Bennice et al., 2003; Temple et al., 2007)

Mental disorder – both in the form of personality disorder and mental illness – has also been associated with the perpetration of family violence (Askeland & Heir, 2014; Shorey et al., 2012; Stuart et al., 2008), with an estimated 70% of perpetrators presenting with at least one psychiatric

disorder (Askeland & Heir, 2014). In addition, research has found high rates of co-morbidity of mental health problems and substance use among perpetrators of family violence (Askeland & Heir, 2014; Davoren et al., 2017; Siegel, 2013). Ogloff (2015) suggests that existing service responses to perpetrators in Victoria do not adequately assess and treat mental disorders in this population, and that greater service integration between perpetrator programs, mental health services and drug and alcohol services is needed.

Bethany Family Violence Services

The Bethany Men's Family Violence Intervention Centre aims to provide coordinated responses to male perpetrators of family violence across the Barwon area. Services offered at the Centre include Men's Behaviour Change Programs, Men's Case Management (shirt and long term), the Cross Sector Coordination trial and an adapted Men's Behaviour Change program for men with a cognitive impairment. The Men's Behaviour Change Program is a group-based intervention program for adult men who have used violent or controlling behaviour, with the aim of assisting men in making changes towards developing safe and respectful relationships with their partners and children. Bethany Men's Case Management provides support and assistance to men who have used family violence against their partner and/or children and have been excluded from the family home. The service aims to assist men in stabilising their lives, whilst addressing their use of family violence. The Cross Sector Coordination trial provides specialist case coordination support to men who have used family violence and who present with multiple dynamic risk factors that may include concurrent mental health concerns, substance use issues, homelessness, problem gambling and unemployment. The services offered at the Centre complement and work in close partnership with other family violence services and resources offered in the area.

The Bethany Men's Family Violence Intervention Centre host co-located alcohol and drug services provided by Barwon Health and Salvation Army, in addition to a homelessness response from the Salvation Army. This model is designed to provide complementary treatment of a man's use of violence in addition to presenting risk factors, such as problematic substance use.

The Barwon Orange Door, a key initiative of the Victorian Government's Royal Commission into Family Violence provide a primary intake point for adult men who reside across the Barwon area that perpetrate family violence. Bethany are funded to provide this service and currently manage a team of six practitioners within this environment. A focused approach for this team has been to better understand some of the presenting mental health needs for the men who are referred to the Barwon Orange Door, and facilitate appropriate referrals to clinical and community based mental health services.

In addition to being the sole provider of male perpetrators services for the Barwon area, Bethany offer a suite of specialist responses to adult and child victims of family violence. These include intensive case management support, therapeutic counselling, evidence informed group based programs and the coordination of the Risk assessment Management Panel (RAMP), Personal Safety Initiative and Court Support 4 Kids.

The following sections detail consultations with service providers, with a specific focus on their experience of working with victims and perpetrators presenting with mental health concerns.

Consultation with Specialist Women's and Children's Services

The Specialist Women's and Children's Services at Bethany Community Support provide crisis and case management support to women and children experiencing family violence, in addition to some therapeutic groups to support attachment and bonding between women and their children experiencing family violence. In this consultation, practitioners discussed their experience of working with women and children experiencing family violence and presenting with a mental illness.

Anecdotally speaking, practitioners suggested that the majority of their clients present with mental health concerns. The mental health concerns could be diagnosed or self-reported, though practitioners rely on women's self-report rather than having access to formal records of diagnosis. Nevertheless, they reported that GP Mental Health Care Plans were commonly held by women presenting to the service, and that the main mental health concerns tend to relate to depression, anxiety, and trauma-related symptoms for both women and children, and some issues of ADHD for children.

Practitioners reported that they find it difficult to distinguish whether the mental health concerns preceded the family violence or are a result of the family violence. They noted that the family violence situation can be very stressful and, as such, symptoms of mental illness can be an expected response to this stress. In addition, practitioners noted that women experiencing family violence tend to be dealing with parallel stressors involving the navigation of multiple systems, such as housing services, court processes, child protection, etc. As such, in their practice, practitioners tend to normalise the stressful nature of family violence and the responses that women and children may be having to the stressors they are facing.

Practitioners noted that system responses to women experiencing mental illness can be problematic, in that these women may be stigmatised, be less likely to be believed, and be less likely to receive a family violence response because the problem is seen as "the woman's problem and not family violence". This is similar to observations made by practitioners who work with perpetrators, in that mental illness among victims and perpetrators is perceived differently – the former as the 'reason' and the latter as the 'excuse'.

In their work with women and children experiencing family violence, practitioners reported that they predominantly provide crisis and case management support, family violence education, and some generalist counselling, but would refer to alternative services for intensive mental health or trauma support that is beyond their expertise, such as the Family and Relationships Services at Bethany Community Support, the Sexual Assault and Family Violence Centre, or a psychologist via a GP supported Mental Health Care Plan. Practitioners advised that these services were not integrated with the Specialist Women's and Children's Services per se, but greater service integration or coordination could be achieved when the outsourced service was internal to Bethany (i.e., the Family and Relationships Service), or when they had established informal relationships with workers in the related sectors or services. They further suggested that reforms to information sharing had assisted the process of collaboration with other services.

Practitioners felt that they lacked service integration with mental health services and with drug and alcohol services, and advised that it is difficult for clients to access these services in the public system. They advised that clients "need to be suicidal or high risk" to be accepted into the public mental health or drug and alcohol services, that waitlists tend to be long, and that there is "not a consistent, easy pathway" to entry. Practitioners further advised that service links to family violence services following discharge from mental health or drug and alcohol services were largely absent.

Practitioners felt that having a specialist mental health practitioner co-located within their team would enhance their responses to women and children experiencing family violence and presenting with a mental illness, as this could provide a point of secondary consultation and aid in warm referrals to mental health services. Practitioners referenced the cross-sector program that exists at the Men's Centre at Bethany Community Support, in terms of having co-located specialist mental health and drug and alcohol workers for men perpetrating family violence; however, practitioners felt that, due to the high number of women and children presenting with a mental health concern, "we all need to be cross-sector workers", meaning that all practitioners need to be trained in how to respond to mental health needs. Practitioners further spoke of responding to drug and alcohol needs and the need for related training in this area also.

As such, it is recommended that the Royal Commission consider the need for specialist mental health and drug and alcohol workers to be co-located with family violence services for women and children.

When discussing service development, practitioners overwhelmingly spoke of the need for co-located housing services, suggesting that housing needs are a common theme for women presenting to family violence services and that mental health concerns could be reduced, alleviated or prioritised if housing concerns were resolved quickly.

Practitioners felt that client feedback would be useful in further informing service development needs when responding to the combination of family violence and mental health concerns.

Consultation with The Orange Door Men's Family Violence Intake Practitioners

The Specialist Men's Family Violence Service at The Orange Door (Barwon) responds to men who have perpetrated family violence. In this consultation, practitioners discussed working with men who perpetrate family violence and present with a mental illness.

Practitioners suggested that, although practitioners hold a gendered understanding of family violence, other dynamic risk factors for family violence, such as mental illness, can present as an important or primary consideration in the understanding of an individual case. There is a distinct need to consider the complexity and interplay of multiple and dynamic risk factors and to tailor intervention responses to these, rather than adopting a 'one size fits all' approach, such as the Men's Behaviour Change Program (MBCP).

Practitioners noted the need for an integrated or coordinated response with mental health services when responding to men who present with a mental illness. They identified that there is a lack of service connection to existing mental health services and that these services are limited, in that they only respond to crisis-driven or acute cases of mental illness. Often, men will not meet criteria for these services as they present with high prevalence mental illnesses (e.g., depression, anxiety) of mild to moderate levels. These men are eligible for mental health services on a private basis (such as via the Better Access Program), but are not always able to fund this privately, and these services operate separately to the family violence services.

Therefore, it is recommended that the Royal Commission review the affordability and accessibility of private mental health services under the Better Access Program.

Practitioners suggested that men are, at times, well versed in their diagnoses, in terms of knowing their diagnosis and associated symptoms (e.g., "I have anxiety"), but are rarely versed in strategies to manage these symptoms. At other times, men have a vague understanding of their diagnosis or of potential mental health concerns and may be supported to reconsider this as their narrative

unfolds. Some men self-diagnose issues of mental illness, but have not received a formal diagnosis. Further, practitioners advised that men may not be able to distinguish between symptoms of mental illness and 'escalation' of their bodily sensations that precede violence, such as those of anxiety. Practitioners did, however, identify that men can usually speak of a pattern of behaviour regarding their mental illness and/or violence; for example, they may speak of not being able to sleep, worrying that they may not be able to work, using substances to assist their sleep-wake cycle, becoming increasingly agitated, etc.

Practitioners spoke of the complexity of holding conversations with men who present with a mental illness specifically, identifying the need to acknowledge and discuss this dynamic risk factor, whilst being careful not to attribute it as the primary or sole cause of violence in the majority of cases. Practitioners noted that, often, mental illness is viewed as an 'excuse' for men's violence by other services (e.g., police, courts, and media); whereas, when women present with mental illness it is viewed as a 'reason' for the violence perpetrated against them.

Practitioners discussed the sensitive balance that exists between engaging men and holding them accountable in the conversations held with them. Practitioners suggested that engagement of men is a priority, as men are otherwise unlikely to engage in the process of change, and that viewing the entirety of the man's life and functioning, rather than focusing on specific incidents of violence, is helpful in this regard. Practitioners also identified that engagement strategies may differ according to the presentation; for example, men presenting with personality disorders may require a different approach.

In terms of training for the workforce, practitioners reported that training in responses to mental health would be of use, such as mental health first aid, the Applied Suicide Intervention Skills Training (ASIST) program, and responses to immediate, crisis-based situations. Practitioners suggested that learning more about the types of mental illnesses and their defining features would be of use, so that these features can be recognised when working with men. Practitioners further identified that training in personality disorders and their relationship to violent behaviours, such as stalking and sexual jealousy, would be beneficial also. In addition, practitioners requested training in alcohol and other drugs as this tends to co-occur with mental illness, in their observations.

Therefore, it is recommended that practitioners working in family violence be trained in how to identify and respond to mental health, personality disorder and substance use concerns.

Practitioners with a counselling background reported that the medical model approach to managing mental illness is limiting and does not serve to empower people to manage their mental illness beyond compliance to medication. Practitioners also distinguished between mental illness and mental health, suggesting that existing models or theoretical frameworks emphasise deficits, or the illness, rather than the concept of mental health, or the presence of psychosocial wellbeing.

Practitioners agreed that training in offender rehabilitation programs would also be useful, as would training in responding to men with neurological differences (ABI, ID, or autism spectrum disorders).

Practitioners re-asserted the need for mental health services to be integrated or coordinated with family violence services, in order to work together to address the needs of men who present with a mental illness and perpetrate family violence.

Consultation with the Specialist Men's Services at the Men's Centre

The Specialist Men's Services at the Men's Centre provide specialist assessment and intervention services to men who have perpetrated family violence, including the Men's Behaviour Change

Program and the Cross Sector Coordination trial (which provides specialist case coordination support to men presenting with mental health and drug and alcohol concerns). In this consultation, practitioners discussed their experience of working with men who have perpetrated family violence and who present with a mental illness.

Practitioners advised that a total of 333 men were referred to the Centre between the period of July 2018 to May 2019, with 29% of these men identified as having a mental illness and 22% identified as having a drug and/or alcohol concern. However, in certain programs, such as the Cross Sector Coordination trial, 100% of men referred presented with a diagnosed or suspected mental illness.

Practitioners identified a subset of men who present with an acute mental illness (e.g., psychosis), for whom mental health intervention is prioritized from the outset. Practitioners estimated that such acute cases of mental illness present approximately once per week and practitioners are somewhat versed in responses to them, which involve consultation with local Mental Health Services and/or emergency services, and the development of a safety plan with the client.

Practitioners identified that high prevalence mental illnesses (e.g., depression, anxiety) are commonly reported by men presenting to the service, and that an underlying mental health or drug and alcohol concern applies to "nearly all" men presenting to the service. Practitioners also reported that a history of mental illness or undiagnosed mental illness tends to be identified in the assessment process (e.g., childhood ADHD). Practitioners further identified a subset of men who present with indicators of personality disorder, although practitioners are not formally trained in assessment and treatment of these conditions.

Practitioners reported that, although they collaborate with the local clinical Mental Health Services, there are times when the referral is not accepted as it does not meet threshold or times when the service is unable to intervene as the client is not engaging with mental health services. Short-term case management at the Men's Centre (which can be extended depending on client need) is available to men presenting with a mental health or drug and alcohol concern, with the view to prepare these men for family violence specific intervention (i.e., the Men's Behaviour Change Program). The Cross Sector Coordination trial allows for a relatively rapid response to men presenting with a mental health or drug and alcohol concerns.

Practitioners spoke of the difficulty they experienced in discerning whether the behaviours of men who perpetrate family violence and present with a mental illness was due to their mental illness or a tactic of family violence. They identified that for acute cases of mental illness, such as psychosis, the man's capacity for personal choice or control is severely limited and the impact of the mental illness is clear. However, for the majority of cases which involve high prevalence disorders, the impact of the mental illness on men's choices and behaviour is less clear, and may influence men's emotion regulation and resilience, among other things. Nevertheless, when working with men who present with a mental illness and attribute their family violence to their mental illness, practitioners generally encourage these men to assume more responsibility for managing their mental illness, such as engaging with mental health services and being compliant to medication. In addition, they encourage men to understand the risk of family violence when mental illness is not managed.

Practitioners discussed the way in which mental illness is understood by men who perpetrate family violence and by the women to whom the violence is directed. Practitioners identified that women "feel they have to save him" and that "his mental illness is the reason he is abusing her". Practitioners also spoke of men's expectation that they are nurtured and cared for by their female partners, or that their partners are responsible for their mental health and wellbeing.

Practitioners understand mental illness as a dynamic risk factor, though not necessarily a driver of the family violence. Practitioners reported that they would gradually introduce conversations about gender-based drivers of family violence, suggesting that men are not usually receptive to these conversations at the early stages of engagement, or change, and that the focus in early stages of intervention is on building rapport. Practitioners further advised that the priority is on managing risk of escalation when challenging men about their gender-based beliefs.

Practitioners suggested that mental health professionals are trained in assessing and treating mental health concerns, but are not necessarily versed in family violence or assessing family violence risk to women and children. With respect to their own training needs, practitioners felt that they need regular training in mental health and responding to mental health concerns. Practitioners nominated training such as mental health first aid training and the Applied Suicide Intervention Skills Training (ASIST).

Practitioners identified the need to develop trauma-informed practice, given that men may present with a history of childhood trauma relating to exposure to family violence and/or the intergenerational trauma affecting Aboriginal and Torres Strait Islander people.

Case Study

Mr Smith[1], a 28-year-old Anglo-Australian man, self-referred to the Bethany Men's Behaviour Change Program upon the recommendation of his psychologist and his current partner, who was threatening to leave their relationship if his behaviour did not change. He did not present with a formal history of family violence, in terms of an absence of police reports or intervention orders; however, an incident of family violence was reported to child protection some years ago, in relation to a former partner and child. Mr Smith has been involved in a relationship with his current partner for 18 months and they have an infant child together.

Initial Assessment

- Mr Smith disclosed two recent incidents of family violence, in which he damaged property while his partner and young child were in the house; these incidents were not reported to police and he did not recognise them as family violence as such. He conceded to engaging in controlling behaviours towards his partner that were aimed at restricting her movement. He regarded his partner as his 'saviour', who helped him to manage his mental health; as such, he did not want their relationship to end and felt threatened by this possibility.
- Mr Smith disclosed recent involvement with local mental health services for psychosis and polysubstance use. He was prescribed antipsychotics but reported non-compliance to medication and disengaged from the service due to distrust of the mental health professionals who were involved in his care. He described ongoing psychotic symptoms, in the form of auditory hallucinations and persecutory ideas, and advised that he carries weapons as a preemptive measure against possible attack.
- Mr Smith reported experiencing suicidal ideation and admitted that he frequently threatens suicide to his partner. He described himself as extremely sensitive to criticism and as experiencing fears of abandonment and persistent feelings of shame. He further described experiences of intense and unstable moods that he struggles to regulate and, in particular, acute anxiety and difficulty controlling his impulses. Mr Smith disclosed escalating drug and alcohol use as a means of self-medication.

[1] Name, age and details have been changed to maintain anonymity.

- Mr Smith reported that he remains engaged with his private psychologist, who suggested that Mr Smith presents with traits of borderline personality disorder.

Service Responses to Initial Assessment

- Mr Smith was assessed as being at imminent risk of family violence, as per the Common Risk Assessment Framework (CRAF) and concerns for the safety of his partner and child were immediately raised.
- A referral was made to the Men's Behaviour Change Family Safety Contact Worker, who contacted Mr Smith's partner and referred her to Specialist Women's Family Violence Case Management. The referral was immediately accepted and Mr Smith's partner was supported to leave the premises with her child and a plan put in place for their safety.
- Mr Smith's partner advised that his mental health had rapidly declined within months of his non-compliance to antipsychotic medication and self-medication with alcohol and methamphetamine. She advised that she 'felt sorry' for Mr Smith and wanted to 'help him', and would often try to help him calm down and manage his moods; she wanted him to get help and stop using violence. She further advised that, when she threatened to leave Mr Smith if he did not get the help he needed and address his behaviour, he would react with violent outbursts and increase his risk-taking behaviour.
- With Mr Smith's consent, mental health services were contacted to advise of concerns for his deteriorating mental health and associated risk for violence. Mental health services agreed to contact Mr Smith and attempt to re-engage him.
- Mr Smith was referred to the Cross Sector Coordination trial for case coordination around his family violence and mental health concerns.
- A notification was made to Child Protection, which prompted an investigation.
- Within two days of the assessment, Mr Smith perpetrated further family violence against his partner and in the presence of their child.
- When consulted, Mr Smith advised that his auditory and visual hallucinations were worsening and that he was engaging in daily methamphetamine use. He remained reluctant to re-engage with mental health services, but accepted the referral to the Cross Sector Coordination trial, which provided him with rental assistance, made an appointment for a mental health review, and referred him to counselling for alcohol and other drugs.

Summary of Consultations

In summary, specialist family violence practitioners who work with women and children anecdotally report that many of the women presenting to their service identify mental health concerns – namely, depression, anxiety and trauma symptoms – and this is consistent with research findings (Ayre et al., 2016; Lagdon et al., 2014; Trevillion et al., 2012). Practitioners note that the family violence itself and accompanying stressors associated with the family violence experience may make women and children vulnerable to mental illness, and that housing stress is a particular area of need. Practitioners suggest that women who experience family violence and mental illness may be stigmatised or blamed for their experience of family violence, which may present as a barrier to receiving appropriate services.

Practitioners advise that women are more likely to access mental health services via private psychologists (GP Mental Health Care Plans) and access to public mental health services is limited to severe or crisis cases. Practitioners further advise that specialist family violence services are not integrated with mental health services, but some collaboration or coordination occurs via the

establishment of professional relationships (as opposed to established systems) and that services internal to Bethany are more accessible for secondary consultation and warm referral. Practitioners noted that, due to the number of women presenting with mental health concerns, this is an area of need for practitioners' professional development and competence.

Specialist family violence practitioners at the Orange Door and at the Bethany Men's Family Violence Intervention Centre who respond to men perpetrating family violence identify mental illness as a risk factor for family violence, and that the main presentation tends to involve depression and/or anxiety. Practitioners noted that most men do not meet criteria for public mental health services as they tend not to present with severe cases of mental illness, and that their service is not coordinated with these mental health services. Men can access psychologists on a private basis, but this is not always an affordable option.

Practitioners advised that, in practice, they may assist men to identify links between symptoms of mental illness and family violence behaviour in the process of engaging men in conversations about their behaviour, whilst being careful not to conceptualise mental illness as an excuse for their violence and managing men's expectations of their partners to manage their mental illness and behaviour. Practitioners identified a need for training in mental health and, in particular, mental illness, personality disorder, suicide prevention, childhood trauma, and cognitive impairment, which they link to perpetration of family violence, and training in offender rehabilitation frameworks.

Data provided by specialist family violence practitioners at the Bethany Men's Centre who respond to men perpetrating family violence identifies over one quarter (29%) of men presenting with a mental illness and approximately one in five men (22%) presenting with a substance use issue. However, anecdotally speaking, practitioners estimate a higher proportion of men presenting with mental illness that may not be identified in the initial assessment process. Practitioners identify a subset of men who present with acute mental illness (e.g., psychosis) and personality disorder.

The case study presented shows the severity of mental illness that clients can present with to family violence services, and the complexity of service integration with mental health services, particularly when the client is non-engaging and non-compliant to medication. This speaks to the need for specialist family violence practitioners to be trained in understanding and responding to mental health concerns, and to have access to close collaboration with mental health professionals via co-located services or integration with external services.

Themes and Recommendations

Mental Health and Family Violence

Understanding of the relationship between mental illness and family violence is relatively limited, particularly with respect to the relationship between mental illness and the perpetration of family violence, and the nature of this association. However, emerging empirical and anecdotal evidence suggests that this is a pressing issue and more research is needed to understand the phenomena.

Specialist family violence services for both women and children experiencing family violence, and men perpetrating family violence report that a significant proportion of their clients present with mental health concerns. Those working with women identify issues of anxiety, depression and PTSD, whilst those working with men identify a broader range of mental health concerns in addition to depression and anxiety, including psychosis, personality disorder, and substance use.

Recommendation:

- That the Royal Commission support and commission further research into the area of family violence and mental illness.
- Family violence services to employ record keeping practices that accurately capture data regarding the prevalence of mental illness among clients presenting to specialist family violence services, to better understand the needs of this population and to inform enhanced responses, such as service integration with mental health services.

Family Violence Practitioners Working with Mental Health

Practitioners rely on collaboration with mental health services to work with clients presenting with mental health concerns. For clients presenting with acute mental illness, consultation and collaboration with public mental health services is prioritised; however, the majority of clients do not meet criteria for public mental health services and this service tends to be short-lived, working to stabilise acute symptoms of mental illness via medication. Private psychological services are available via the Better Access Program; however, this is not always an affordable option for clients. As such, clients presenting with mental health concerns are not always engaged with mental health services, and monitoring and management of mental health concerns may rest with the family violence service.

Practitioners identified training in mental health as an area of need in the family violence sector. Bethany's Cross-Sector Coordination trial at the Men's Centre provides a means of service integration with mental health responses that offers relatively rapid assessment and case management responses to men who present with a mental illness and/or substance use concerns; however, an equivalent service is not available to women's and children's services at this stage.

Recommendation:

- That the Royal Commission review the affordability and accessibility of private psychological services under the Better Access Program.
- Specialist family violence practitioners require training in mental disorder – mental illness and personality disorder – and ways to assess and respond to mental health concerns that clients present with to their service.
- As demonstrated by the Cross Sector Program, specialist family violence practitioners benefit from having close working relationships with mental health services to support their ability to manage risk for family violence posed by the mental illness. This needs to be developed in the form of greater service integration with mental health services.
- Specialist family violence practitioners may further benefit from training in offender rehabilitation frameworks and practices to inform risk and tailor individual intervention pathways to address identified needs, including mental illness.

Gendered Experience of Mental Health

Practitioners identify gendered responses to women's and men's experience of mental illness, with women's mental illness identified as a source of blame for the violence perpetrated against them and men's mental illness identified as a potential excuse for their use of violence. In addition, both men and women appear to hold gendered expectations that women assume responsibility for assisting men to manage their mental illness and related behaviours – in particular, emotional regulation.

Recommendation:

- That the gendered experience of mental illness among female victims and male perpetrators be considered in service responses, and in particular, the tendency for women to assume responsibility for managing their partner's symptoms and their partner's expectations of the same. This may pose additional risks to women, in terms of reinforcing issues of gender-based power and control in the dynamic.

Mental Health vs. Tactic of Family Violence

Practitioners spoke of the need to carefully manage the issue of responsibility-taking when working with men who present with a mental illness, whilst acknowledging the mental illness as a dynamic risk factor. Practitioners further spoke of the difficulty in distinguishing behaviours associated with mental illness from tactics of family violence when working with men who perpetrate family violence, in cases where the mental illness is not clearly linked to the family violence.

Recommendation:

- Further research is needed to determine the nature of associations between mental illness and family violence, and to distinguish mental illness from tactics of family violence, which can inform practice development when working with men who present with these concerns.

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