DOMESTIC VIOLENCE VICTORIA

# DV Vic Submission to Mental Health Royal Commission

5 July 2019


Domestic Violence Victoria

July 2019

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# About Domestic Violence Victoria

Domestic Violence Victoria (DV Vic) is an independent, non-government peak body organisation whose membership consists of over 80 state-wide and regional specialist family violence agencies across Victoria. DV Vic is the key stakeholder organising, advocating for, and acting on behalf of the specialist victim survivors family violence sector. In this role, DV Vic holds a central position in the Victorian family violence system and its governance structures, and is one of the key agencies with responsibility for providing family violence technical assistance, policy advice and advocacy to government and non-government partners.

DV Vic has been intricately involved in the implementation of the Royal Commission into Family Violence recommendations since the Royal Commission's final report was released. Several of these recommendations are concerned with systems integration across the community services system, including specialist family violence, alcohol and other drug (AOD) and the mental health sectors. DV Vic also has actively been involved in coordinating the Specialist Family Violence Capacity Building Project, which is designed to skill-up the mental health and AOD sectors' understanding of family violence and build capacity across these sectors to collaborate.

# A note on terminology

## Family violence and power – personal and political

Family violence is any behaviour by a person towards a family member or family-like members that seeks to control or dominate the family member and causes that person to feel fear for their safety or that of another person. Family violence can be physical, sexual, emotional, psychological, economic, spiritual and/or social and includes any behaviour that causes a child to hear, witness or be exposed to the effects of these behaviours.

Specialist family violence services understand that family violence is fundamentally an abuse of power. Power hierarchies exist in family relationships just as they do in all facets of society. These hierarchies are often related to a person's social privileges, which enables their ability to use abusive, controlling and coercive behaviours to put others into an inferior position, often with little or no consequence. While social change and developments in government, community and justice responses have had some effect on holding those who use family violence to account, the power hierarchies that make family violence possible, particularly gender inequality and other forms of interlocking oppression, continue to persist throughout society.

Conscious and unconscious bias that privileges men over women is entrenched in our social institutions and structures, including the mental health system.

Power hierarchies in our society and our social institutions can also enable perpetrators to exploit victim survivors' social marginalisation, particularly where they experience intersecting forms of oppression and discrimination (such as sexism, racism, classism, ableism, ageism, xenophobia, homophobia/biphobia, transphobia, etc.). This creates further barriers for victim survivors to get the help they need, and is compounded when they experience poor service responses, discrimination and systemic barriers that block access to support and safety that recognises and appropriately responds to trauma.

## Victim survivor

The term 'victim survivor' is used to refer to people, including adults, children, and young people, who have experienced family violence. This term acknowledges that a person subjected to family violence is both a victim of a crime and a human rights violation. They are also a survivor who should be respected for their strength and resilience. This term may not be preferred by all people who have experienced family violence and it should not be used to wholly define a person. Surviving family violence is a part of someone's life amongst many other experiences and identities.

Family violence is an abuse of power and control, and can be perpetrated by anyone against a partner, a family member or someone in a family-like relationship regardless of their background or identity. A significant driver of family violence is gender inequality, particularly within intimate partner violence contexts.

The overwhelming majority of victim survivors are women and their children.

## Perpetrator

The term 'perpetrator' is used to describe the person who uses family violence. In some cases, there may be multiple perpetrators (and multiple victim survivors) in the family. The term 'perpetrator' is used as it signifies the importance of placing responsibility with the person who chooses to use violent, abusive and controlling behaviours to intimidate, harm and cause fear in another person. It is important to acknowledge, however, that some people, including victim survivors, may not relate to this term and other expressions such as 'person using violence' might be preferred instead.

The vast majority of perpetrators are men.

# Introduction

The Victorian Royal Commission into Family Violence (the RCFV) collated a significant body of evidence demonstrating the complex relationship between mental health and family violence. The RCFV found that family violence has negative and long-lasting effects on victim survivors' mental health and that experiences of violence earlier in life can make victim survivors more susceptible to violence again in the future and increase the risk of intergenerational trauma.(State of Victoria, 2014, Vol IV p68). Family violence increases the risk of clinically significant depression and anxiety disorders, post-traumatic stress disorder, loss of self-confidence and isolation for victim survivors. In some cases family violence also leads to victim survivors' misuse of alcohol and drugs as means of coping (State of Victoria, 2014, Vol IV p65). Family violence also has a profound effect on children and adolescents. Child and adolescent victim survivors are more likely to experience depression, anxiety, low self-esteem, neurological development delays and impaired cognitive functioning/mood problems (State of Victoria, 2014, Vol II p106).

This submission does not seek to revisit the evidence produced by the RCFV. However, we do believe that the intersection of mental health and family violence is crucial for the Royal Commission into Mental Health (the Commission) to explore.

We therefore strongly encourage the Commission to review the RCFV report, particularly Volume IV as it relates to the role of the health system in responding to family violence in a way that promotes recovery, health and wellbeing for victim survivors. We also draw the Commission's attention to RCFV recommendations: 3, 38, 87, 97, 98, 99, 100, 102, 104, 105, and 179, as these recommendations are relevant to the mental health sector and the intersections with the specialist family violence system. These recommendations are currently being implemented in response to the RCFV. It is critical that recommendations made by the Commission do not conflict, but build upon the RCFV recommendations.

This submission seeks to build on the RCFV's evidence base, by:

- Articulating an understanding of mental illness from a social justice, violence-informed framework that can better identify and respond to family violence risk and the mental health needs of victim survivors of family violence;
- Presenting emerging trends and evidence from the Specialist Family Violence Advisor Capacity Building Program on challenges and successes in increasing capacity of workers in the AOD and mental health sectors to identify and respond to family violence;
- Discussing emerging issues relating to family violence and mental health, particularly the role of carers and implications for responding to elder abuse and adolescent violence; and
- Making recommendations for how to improve the mental health system's response to victim survivors of family violence.

## Methodology

Given time and capacity restraints, this submission is not able to fully discuss all the intersections between family violence and mental health and will concentrate on the following points within the Royal Commission into Mental Health Terms of Reference:

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?
4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

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

To answer these questions and for the purpose of this submission, we have chosen to focus on framing a theoretical understanding of mental health issues among victim survivors of family violence. We also have highlighted key pieces of research published post RCFV to guide the Commission's thinking in relation to mental illness among victim survivors of violence and trauma.

As part of our information gathering, we conducted a consultation with Advisors within the Specialist Family Violence Capacity Building project which has been established in response to RCFV Recommendation 98 and 99. To guide the consultation, Advisors were asked the following questions:

1. How does the framing of mental health as a medical or social model impact on treatment for individual clients who have experienced or are currently experiencing family violence?
2. What are the systemic barriers and challenges that prevent family violence and mental health service systems from working well together?
3. Do you have practice examples of where the system does not work well for clients in the intersection of family violence and mental health?
4. What have you seen work well to enhance outcomes in mental health and family violence intersection? E.g. Health Justice partnerships; secondary consult, etc.
5. What recommendations would you like to see the Commission adopt in the intersection of family violence and mental health?
6. Are there unintended consequences we should be mindful of? E.g. support for carers and families is critical to recovery but without screening for family violence, could increase risk? What else?

Feedback from Advisors was used to inform this submission and its recommendations.

We purposefully did not examine the mental health system beyond where it intersects with family violence. However, it is important to acknowledge that the intersection of mental health and family violence sits within the broader context of the historic gender bias against women in the field of mental health and psychiatry. Many of the diagnoses listed in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* and the *International Classification of Diseases: Classification of Mental and Behavioural Disorders (ICD-10)* are based on misogynistic and sexist practice and assumptions (Caplan & Cosgrove, 2004) that misidentify trauma among women and have led to a long history of institutionalised victim blaming.

There are significant gender differences in the prevalence of mental health conditions among men and women. However, the gender bias in treatment and gender specific risk factors continue to be poorly understood. For more detail on the gendered nature of mental illness and the social context for women's mental health, we commend Good Shepherd Australia New Zealand's submission to the Royal Commission.

For this submission, we have focused on enhancing the system as it applies to victim survivors of family violence, including children. However, we believe that framing mental health as a social justice issue has wider applicability to marginalised and disadvantaged groups and has the potential to enable truly preventive work in addressing the causes of mental illness.

Finally, issues relating to mental health and the perpetration of family violence were beyond the scope of this submission. However, we encourage the Commission to review No To Violence's submission for issues relating to family violence perpetration and mental health. Similarly, while briefly touching on issues of elder abuse and adolescent family violence, we have not discussed these topics in depth. We encourage the Commission to review the section of Senior Rights Victoria's submission relating to elder abuse and the Centre for Innovative Justice at RMIT on positive interventions for perpetrators of adolescent violence in the home (the PIPA project) (Campbell, 2018).

## A social justice, violence-informed approach to mental health

The need for a social model of mental health that considers the social, cultural, political and economic environment of an individual, or group of individuals, is widely acknowledged in international research (Heise, Ellsberg, & Gottemoeller, 1999) and by the World Health Organisation (WHO), as well as Australian bodies exploring mental health including the Australian Institute of Health and Welfare and the National Mental Health Commission. The influence of socio-ecological factors on mental health compared to individual characteristics like genetics, diet, physical activity and substance use continues to be examined. However, the WHO has identified social conditions as the single most important determining factor of whether an individual will experience good or ill-health, including mental health, in their lifetime (World Health Organisation and Calouste Gulbenkian Foundation, 2014).

A social model of mental health illustrates the societal, cultural, family and individual factors that give men a position of power, dominance and control over women and children and helps illuminate women's social positions which make them more prone and vulnerable to poor mental health outcomes (O'Connor, 2017). However, to understand mental illness among victim survivors of family violence, and other victim survivors of violence and oppression, we argue that a social model of mental health needs to go further in making violence visible as the cause of poor mental health among victim survivors of family violence. A social justice, violence-informed model of mental health is required.

In taking a social justice, violence-informed approach to mental illness, DV Vic recognises that not all mental illness is a result of violence, oppression, abuse or traumatic or adverse experiences. We also recognise that there is a complex relationship between family violence and mental illness and while family violence can cause victim survivors to become mentally unwell, mental illness can also increase a person's vulnerability to experiencing family violence (Hegarty et al., 2017). However, acknowledging these complexities, we argue that a significant proportion of mental illness occurs as a result of violence and oppression and that this reality has largely been erased by language that conceals violence, obscures offenders' responsibility, and pathologizes victims for their behaviour instead of recognising their strengths (Coates & Wade, 2007).

A social justice model of mental health draws on anti-oppressive, human rights, and intersectional feminist frameworks that are based on critical race, queer, woman of colour feminist, disability feminist and decolonizing theories as well as discursive analysis (Coates & Wade, 2004, 2007; Reynolds, 2018, 2019; Reynolds & White, 2012). Specifically, a social justice and violence-informed model of mental health:

1. Names the violence of social justice and human rights abuses in which people live;
2. Names the perpetrator responsible for these abuses as the cause of mental illness;

3. Recognises that individuals on the receiving end of these human rights abuses practice enormous acts of resistance in order to cope with ongoing violence and oppression and maintain a level of dignity, even if their acts of resistance do not stop the violence; and
4. Avoids pathologizing or locating the problem in the individual experiencing poor mental health by acknowledging the individual's resistance and that until injustices of violence and oppression can be addressed, the prevalence of mental illness is unlikely to be reduced (Coates & Wade, 2004, 2007).

In essence, in the same way that feminists have argued that accountability should lie with the perpetrator of family violence and not victim blame, a feminist, structural, social justice analysis needs to be extended to how we frame people experiencing mental illness within the lived experience of violence and discrimination. In the absence of this analysis, the mental health system is unlikely to be able to appropriately respond to mental illness among victim survivors of family violence because it will fail to see or acknowledge the impact of violence and trauma on individuals. Without a violence-informed approach, mental health services also risk failing to identify and respond to family violence risk, potentially leaving their patient at serious risk of harm from family violence and reinforcing power held by the perpetrator.

If we fail to recognise the constant discrimination and oppression with which these groups live, we run the risk of replicating the power imbalances that victim survivors experience and colluding with the perpetrator by painting their victims as somehow 'deficient' and 'in need of help.' We need to stop reducing victim survivors' behaviours to symptoms of being 'mentally ill' or 'addicted.' Instead, we need to recognise that a person's behaviour may be a calculated strategy employed to manage their safety or resist the acts of the perpetrator to maintain their dignity in the face of family violence. If we respond in this way, we honour the strength of victim survivors by acknowledging their acts of resistance and move one step closer to holding the perpetrator to account (Calgary Women's Emergency Shelter, 2007; Coates & Wade, 2007; Hayes, 2013; Mihelicova, Brown, & Shuman, 2018; Reynolds, 2018, 2019; Wade, 1997).

## Using a social justice lens to re-frame mental illness among victim survivors

As discussed, victim survivors of family violence are more likely to suffer from anxiety, depression and PTSD, among other mental health issues. However, the symptoms or behaviours associated with these diagnoses are often attributed to the diagnosed condition, rather than recognised as responses to violence and trauma (Mihelicova et al., 2018).

Victim survivors of family violence may present to mental health services experiencing confusion, memory loss, exhaustion, anxiety, agitation, panic attacks, poor appetite, nightmares and/or dissociation (O'Connor, 2017; Treatment (US), 2014). While these symptoms are commonly associated with PTSD and are likely to be common symptoms associated with stress, victim survivors of family violence are also more likely to exhibit behaviours of anger, fury, impulsiveness, and/or being argumentative or difficult than women who have not experienced family violence and abuse. They are also more likely to present with symptoms of personality disorders such as being avoidant, aggressive, and/or passive-aggressive (Avdibegovic, Brkic, & Sinanovic, 2017).

A social justice and violence informed model of mental health avoids pathologizing victim survivors and instead recognises these behaviours as forms of resistance. Wade (1997) defines resistance as:

> "any mental or behavioural act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose

> any form of violence or oppression (including any type of disrespect), or the options that make such acts possible."

Understood this way, acts of anger and aggression from victim survivors can be reframed as natural reactions to the repeated acts of coercion, control, violence and abuse they experience from their partner.

A social justice and violence informed understanding of mental health can also help explain systemic violence and high rates of mental illness in vulnerable populations.

There is substantial evidence documenting the high rates of mental illness and suicide among what are usually termed 'marginalised and vulnerable' groups, including Aboriginal and Torres Strait Islander Peoples, members of the LGBTIQ community, people experiencing homelessness, children and adolescents in out-of-home-care, people with disabilities and victim survivors of family violence.

The most recent ABS Census found that Aboriginal and Torres Strait Islander peoples are 2.6 times more likely to experience high or very high levels of psychological distress and almost twice as likely as non-Indigenous people to die by suicide (Australian Bureau of Statistics, 2018). Members of the LBGTIQ community experience high levels of psychological distress at twice the rate of heterosexual people and half of trans people are estimated to have attempted suicide (Rosenstreich, 2013). One in three people experiencing homelessness are estimated to have a mental health issue compared to one in five in the general population (AIHW, 2019) and children and adolescents in out-of-home-care are two to five times more likely to have a mental health issue than their peers who are not in care (Sawyer, Carbone, Searle, & Robinson, 2007). Similarly, victims of family violence are at increased risk of poor mental health and seven times more likely to suicide than people who have not experienced family violence (ANROWS, 2017). For victim survivors of family violence who experience other forms of oppression such as poverty, racism, disability and/or homophobia the rate of mental illness and suicide increases (ANROWS, 2017; Mihelicova et al., 2018; O'Connor & Ibrahim, 2018; State of Victoria, 2014).

A social justice, violence-informed analysis of mental illness extends the social model of mental health by naming the violence experienced by these communities as the reason these communities have such high rates of mental illness and naming the perpetrator/s responsible for the violence. Importantly, a perpetrator of violence is not always another person. A social justice response also recognises the structural power imbalances, discrimination, hate crimes and violence continuously perpetrated against these populations by society and the state.

An example of structural violence resulting in poor mental health outcomes is the suicide rate among Aboriginal and Torres Strait Islander youth and members of the LGBTIQ community. Instead of suicide, Reynolds and White (2012) call these deaths "hate kills," recognising that acts of suicide within these communities are not a result of individuals' experiences of depression, but a result of continuous discrimination, harassment, violence, oppression, poverty and exclusion that causes individuals in these communities to lose hope. Importantly, Reynolds and White (2012) make the point that the language of suicide holds the person responsible for killing themselves and hides the perpetrator responsible – for example, the people who relentlessly bullied and racially harassed, the person who committed the sexual assault, or the government who sanctioned the state policies which disadvantaged and excluded.

Structural violence and victim blaming also contributes to mental illness among victim survivors of family violence and sexual assault. For example, research into the relationship between rape and sexual assault disclosure and depression found that victims of sexual assault are more likely to

experience depression either when they have no one they trust to whom they can disclose the sexual assault, or when the first person to whom they disclose either dismisses their disclosure or reacts negatively. The negative experience of being dismissed or blamed was found to result in feelings of shame and isolation which increased the risk of depression. (Bhuptani, Kaufman, Messman-Moore, Gratz, & DiLillo, 2018; Hegarty et al., 2017). When discussing the cause of depression, it is important to stress that it was not only the sexual assault which caused the victim survivor to become depressed, but also the negative and dismissive reactions to their attempts at disclosure. In fact, Hegarty et al (2017) found that disclosure of sexual abuse being ignored or blamed on the victim by a family member was the factor most closely associated with all forms of common mental disorders among victim survivors, including suicidal ideation. It is not only the perpetrator of the sexual assault who is responsible for the long-term mental health consequences of the victim survivor, but also the people who compound this act of violence with victim blaming attitudes, shame and stigma.

Barriers that prevent victim survivors of family violence and sexual assault from accessing support also highlight the many ways ongoing structural violence can be perpetrated against them to the detriment of their mental health. Victim survivors of family violence frequently cite fear of authorities taking away children, immigration authorities cancelling visas, being institutionalised, shame, embarrassment, not being believed, fear of being cut off from family and support networks, self-blame, lack of financial independence, fear of losing their home and being forced into poverty, in addition to fear of the perpetrator, as barriers which prevent them from disclosing family violence and sources of significant ongoing stress which negatively impact on their mental wellbeing.

For mental health professionals working with victim survivors of family and/or sexual violence it is therefore necessary to recognise that the victim survivor is not only contending with the trauma of a sexual assault or a prolonged history of family violence and abuse from their partner or other family member, which may or may not be still happening. They are simultaneously contending with trauma from compounding instances of violence from society which are likely to be ongoing, frequent and systemic and which continuously undermine the victim survivor's ability to achieve mental and emotional wellness.

Acknowledging and understanding the context of victim survivors' lives and the ongoing violence and risk, structural discrimination, disadvantage and victim blaming that they must contend with to achieve mental wellness is critical to appropriate mental health provision for victim survivors and all highly disadvantaged and marginalised groups. A social justice approach to mental illness requires us to be able to identify and respond to family violence in ways that respect victim survivor's experiences of trauma, support victim survivors to manage their safety, address family violence risk and call out the structural forms of oppression and violence that can contribute to their mental illness. We must also insist that addressing the prevalence of mental illness in our communities requires working to eliminate structural forms of violence, oppression and human rights abuses.

**Recommendation 1:** Embed a social justice, violence-informed mental health framework across the mental health system to provide guidance to professionals to better identify and address underlying causal factors of individuals' mental illness, including experiences of family and sexual violence.

**Recommendation 2:** Modules on family violence, structural and inter-personal violence are made core subjects for all entry-level mental health training to ensure mental health clinicians have a structural understanding of the effects violence can have on a person and how the effects of violence may present as symptoms of a mental illness.

## Gaps in the system: The Specialist Family Violence Advisor Capacity Building Program and lessons learned post RCFV

The RCFV heard significant evidence about the gaps between the mental health and specialist family violence systems in appropriately responding to victim survivors of family violence.

Myths and misconceptions about the nature, impact and dynamics of family violence are prevalent among the general community and frequently reflected among mental health professionals, as are commonly held beliefs about gender and the roles of women and men in society. These attitudes and beliefs go beyond misperceptions of family violence such as 'family violence happens equally to men and women', 'family violence is a result of mental health issues, substance abuse or anger management issues on the part of the perpetrator,' or 'women can leave a violent relationship if they really wanted to' (State of Victoria, 2014 Vol IV p29). They also extend to beliefs that women are more likely to be 'hysterical,' 'hormonal,' 'prone to exaggeration,' 'over-reacting,' 'attention seeking' or 'manipulative.' These attitudes increase the risk that mental health professionals will dismiss the experiences of women and collude with the perpetrator.

Beyond negative attitudes towards women and the impact this has on victim survivors being able to access quality mental health care, the RCFV found that there were 'philosophical tensions' between the specialist family violence and mental health sectors (State of Victoria, 2014 Vol IV p35), that in some cases put victim survivors at risk. The RCFV also found that most mental health services operated from a predominately 'medical model' that focused on identifying symptoms, making a diagnosis and prescribing medication. This means that patients often are not asked what was happening, or had happened, in their lives that might be contributing to their mental illness (State of Victoria, 2014 Vol IV p 30). Finally, the RCFV found that even when mental health professionals did consider asking about family violence, they felt ill-equipped to respond in a trauma-informed way, were not confident in referring to support services, or simply did not feel they had time or capacity to provide enough support to victim survivors (State of Victoria, 2014 Vol IV p28).

In response to these findings, the Specialist Family Violence Advisor Capacity Building Program was established to strengthen the mental health and alcohol and other drug sectors' understanding of family violence and build capacity across these sectors and specialist family violence services to better coordinate service delivery.

Initially, the program was envisioned to work closely with clinicians. However, it was quickly realised that this would require Specialist Family Violence Advisors to be embedded in each mental health and AOD service across the state. Due to resource constraints this was not considered feasible and the program was re-imagined to build capacity across regions at a senior level. Specialist Family Violence Advisors are now employed in the AOD and mental health systems with an AOD and mental health advisor in each region of the state. Advisors focus on fostering relationships at senior levels across the three sectors and have established Local Area Based Implementation Committees to help drive this work.

Collaboration between the mental health, AOD and specialist family violence services has increased substantially as a result of the program. However, Advisors reported that several challenges identified by the RCFV still remain and have made recommendations for the way forward. The experience of implementing the Specialist Family Violence Capacity Building Program offers insight into some of the potential challenges and solutions in trying to integrate mental health expertise into universal services to ensure more holistic service delivery for people with mental ill-health.

## Challenges and opportunities for sector collaboration

The most persistent challenges that Advisors identified in achieving collaboration across the mental health, AOD and specialist family violence services were trying to collaborate across different practice frameworks and working within a chronically underfunded mental health system that cannot meet demand.

Advisors confirmed findings from the RCFV and other research (Hegarty et al., 2017; Mihelicova et al., 2018) that mental health services often have a very diagnostic focus that misses contributing factors such as trauma and family violence. They reported that the medical model used in services results in a diagnosis being seen as static and that once a diagnosis is made there is no further analysis of family violence risk or how changing levels of risk might affect the patient's mental health or needed treatment.

Advisors reported that mental health services do not consistently consider family violence to be their business and, as a result, there is often no investigation of safety or support as part of assessment and treatment. Advisors noted that because family violence is not seen as core business, receiving a family violence response often depends on a particular worker understanding this context and incorporating safety into a treatment plan. Without ongoing access to this worker, the onus is placed on the victim survivor to manage their safety and opportunities to provide specialist support are missed.

In other cases, Advisors noted that the medical focus often excludes consideration of family members, so even where problematic behaviour is picked up, it is not seen in the context of the whole family. Without strong family violence literacy or a focus on the whole family, Advisors reported that it is not uncommon for perpetrators to be able to manipulate the system in their favour, either by using their own mental ill-health as an excuse or rationalisation for their use of violence, or using their partner's mental ill-health as a reason to cast doubt over her experience or ability to parent.

Importantly, Advisors also critiqued the social model of mental health, noting that even where a social model is being applied, for example in community-based mental health programs, family violence literacy still can be low. This emphasises the need to adopt a social justice, violence-informed approach across the mental health sector in order to adequately respond to victim survivors of family violence.

The differences between practice models has perhaps been most keenly felt when introducing the Multi Agency Risk Assessment and Management (MARAM) framework and the Family Violence Information Sharing Scheme. The MARAM legislatively requires mental health services to take a shared responsibility in identifying family violence risk. This has prompted mental health and family violence services to come to a very clear shared understanding of each service's perspective and what each service's role is in identifying, responding and referring. The need for common language and understanding, as well as good articulation and respect for each other's specialisation, has been critical in achieving this. As one Advisor noted:

> "It is impossible for practitioners or services to be 'everything to everyone' and to do so dilutes the value that each service can bring from their area of specialist expertise. The point of collaboration is to 'value add' to each other's practice so we need to be very clear on language and on everyone's responsibilities and roles."

Implementing the Family Violence Information Sharing scheme also has required a profound shift in thinking in the mental health sector about the sector's responsibility to victim survivors and about

how the sector handles patient confidentiality when it comes to sharing information about a perpetrator of violence without consent.

Both the MARAM and Information Sharing schemes have resulted in an improved shared understanding of practice, the use of mutual language and the pooling of the known risk information related to family violence across sectors. These schemes also require a decisive shift away from purely an individualised, medical model of mental health by forcing services to consider how the patient is being impacted by their social environment, as well as how they are impacting on the social environment of others. Implementing these schemes is complex and requires considerable leadership across sectors and government departments. However, the *Responding to Family Violence Capability Framework* (the Capability Framework), a part of the *Building from Strength: A 10-Year Industry Plan for Family Violence Prevention and Response* (the Industry Plan), and the use of secondary consultations have been instrumental in getting the Specialist Family Violence Capability Project off the ground.

The Capability Framework organises the service sector into tiers according to each sector's responsibility in responding to family violence. By conceptualising the workforce in this way, services are given a clear map about how and where their area of specialisation fits within the wider service system when it comes to responding to family violence and gives services a clear idea of what their corresponding roles and responsibilities are.

Advisors also report that establishing well-defined secondary consultation processes and co-location arrangements between sectors has assisted in the rollout of the Family Violence Information Sharing scheme and the MARAM Framework. The use of secondary consultations and the Capability Framework have helped clinicians understand their respective roles in responding to family violence and enabled them to draw on each other's respective areas of expertise to ensure that clients are being offered the most appropriate response possible.

One Advisor provided the following case study:

> "We had a young woman who had presented multiple times to mental health services and had disclosed that family violence was a contributing factor to her mental illness. However, the mental health services weren't sure what to do about the family violence until an individual worker sought secondary consultation with a family violence service. The family violence service was able to advise on a complex family law matter that the client was going through. They helped the mental health service understand the reach of the perpetrator in this case and the impact that was having on the client's presentation to the mental health service. With this information, the mental health service was able to change how they were responding to the client and their approach to treatment. The family violence service was also able to help address the legal issue which helped get the client a much better mental health outcome."

One persistent gap in how mental health and AOD services identify patients experiencing family violence is the absence of a universal screening tool for family violence for mental health services. The draft MARAM Framework currently recommends only screening for family violence when 'indicators of family violence are identified.' However, this could result in the under-identifying of family violence, particularly among cohorts where there is discrimination or unconscious bias, or where indicators of family violence may be misinterpreted by clinicians as a result of mental health, AOD or 'lack of engagement.' A universal screening tool should be a set of four to five questions that provides a victim survivor an opportunity to disclose family violence but does not compel them.

Integrating such a tool into mental health services as part of existing processes would increase mental health clinicians' ability to correctly identify behaviours as possible symptoms of violence and trauma instead of mental illness and make appropriate referrals.

**Recommendation 3:** Mental health services adopt a universal screening tool to screen all patients for family violence.[1]

The use of a Mental Health Capability Framework, secondary consults and a universal screening tool for mental illness could be useful for non-mental health services in responding to clients with mental health issues. During our consultation, Advisors acknowledged that when victim survivors with unmanaged mental health issues present to specialist family violence services, these services often feel ill equipped to meet the victim survivors' needs. Unfortunately, this has resulted in a mental health presentation becoming a barrier to managing the family violence issues. Due to the traditional lack of coordination between services, this often results in women being passed between services, without receiving adequate support for either their family violence or mental health needs. Clearly there is opportunity to skill up non-mental health services' capacity to identify and respond appropriately to mental health issues. It is critical that services have a clear understanding of what their roles and responsibilities are in responding to mental health as non-specialist mental health services.

**Recommendation 4:** Implement a Mental Health Capability Framework that clearly maps different workforce's and professional's roles and responsibilities in identifying and responding to individuals with mental health needs.

**Recommendation 5:** Increase capacity across mental health and family violence services to provide secondary consults to foster service coordination and expertise across sectors.

**Recommendation 6:** Implement a universal screening tool for non-mental health services to better identify mental health needs

In addition to the challenges of working across differing practice frameworks, a severe shortage of mental health services was identified as a significant barrier that prevents optimal collaboration.

The lack of a standardised intake and assessment point for the mental health system is a significant gap in the mental health system. When a client enters the family violence system (for example through an Orange Door or directly through a specialist family violence service) a thorough family violence assessment can be undertaken and, if needed, an AOD assessment can be done through the DirectLine phone number at Turning Point. However, if a mental health assessment is needed, no such process exists. Advisors reported that a standard assessment was available in some regions through Forensicare. However, we understand that funding has recently been withdrawn as it was not connected to services and therefore was felt to be unsustainable.

**Recommendation 7:** Establish a state-wide standardised intake and assessment point for mental health services, similar to DirectLine for AOD services and the Safe Steps Family Violence Crisis Line for family violence services, to facilitate access to mental health services.

[1] Questions included in the screening tool could include: 1) Is there anyone in your family that makes you or your children feel unsafe and afraid? 2) Who is making you feel unsafe? 3) How afraid are you right now? (could include a scale of fear) 4)Would you be interested in being referred to someone to talk about your safety?

For a standardised intake and assessment point to work, mental health supports need to be available to which people can be referred. Currently, if a person needs mental health support beyond a GP referred mental health plan, there is almost no option until they become so unwell, they end up in hospital. Even after hospital there is very little, if any support upon being discharged.

As one Advisor put it:

> "Because the system does not allow for episodic check-in and light touch support, clients need to be in crisis before they can access support. Even then there is no guarantee that they will be able to work with the same person or even agency and so the continuity of care is lost. System availability drives the services response rather than the person being at the centre."

Advisors frequently listed time-poor and over-burdened mental health clinicians as a barrier to staff being able to undertake fuller assessments that might include family violence risk. For rural and regional areas this issue is compounded by even fewer services being available. Some advisors noted that, in their experience, this leads to an over-reliance on prescribing medication (e.g. anti-depressants) to manage symptoms in the absence of support services.

The "missing middle" in the Australian metal health system is a critical gap for all people needing mental health support (Meehan, Stedman, Parker, Curtis, & Jones, 2017), but it has particular significance for victim survivors of family violence and trauma who are more likely to need more extensive support than the 10 counselling sessions provided through a mental health plan, but are not so unwell they need to go to hospital. To increase the mental health sector's ability to respond to victim survivors of family violence and trauma, we need a significant increase in a variety of mental health supports that sit between a visit to a GP and presenting in an hospital emergency department.

## Finding the "missing middle" for victim survivors: the need for trauma and violence informed therapeutic interventions

For victim survivors of family violence and trauma, the "missing middle" in the mental health system is a combination of community-based, therapeutic, trauma and violence informed services and community-based, psycho-social support programs that help people 'step-up' to more intensive mental health support if their mental health takes a turn for the worse and 'step down' when someone has stabilised enough to leave hospital but needs ongoing support to prevent another down turn (Rosenberg, n.d.).

The RCFV identified the need for victim survivors to have access to therapeutic support to recover from the trauma of violence (State of Victoria, 2014 Vol IV p72). The most common form of therapeutic support is individual counselling. However, the availability of publicly funded counselling is severely limited, and many victim survivors of family violence cannot afford private sessions with a psychologist.

The RCFV found that the current 10 counselling sessions offered through Medicare Mental Health Plans are not fit for purpose when supporting victim survivors of family violence. It found that in one sense GP Mental Health Plans are being overused because some GPs use the scheme to provide the victim survivor with access to some counselling, recognising nothing else is available. On the other hand, the scheme is being underutilised because victim survivors will not always meet the GP's criteria for having a mental health disorder, leaving them ineligible for Medicare-funded counselling (State of Victoria, 2014 Vol IV p85). In response to these findings, the RCFV recommended that the

Commonwealth Government introduce a Medicare item number for family violence counselling to increase access to publicly funded counselling for victim survivors beyond 10 sessions (Recommendation 105). To date, this recommendation has not been taken up. We urge the Commission to reiterate this recommendation.

**Recommendation 8**: The Royal Commission into Mental Health urge the Commonwealth Government to implement a Medicare item number specifically for family violence to increase access to counselling for victim survivors of family violence and improve data on the impact of family violence on victim survivors' mental health.

In addition to needing increased access, counsellors' understanding of family violence and an ability to provide a structural, gendered analysis of victim survivors' experiences, is critical to victim survivors' recovery (Hegarty et al., 2017). There is no guarantee that a private psychologist will bring this understanding. The RCFV recommended that a database should be developed of psychiatrists, psychologists and other professionals with family violence expertise to assist GPs in making referrals for patients (Recommendation 100). While DHHS report that this recommendation has been implemented by creating a 'family violence' category in the National Health Service Directory, DV Vic is concerned that there are not sufficient quality control mechanisms to ensure providers listed in the directory actually are 'family violence literate' and that uptake of the directory has been low to date.

**Recommendation 9:** Review the effectiveness, quality and use of the family violence category in the National Health Service Directory to ensure that providers listed are verified as having a comprehensive understanding of family violence and their roles and responsibilities under the MARAM and Information Sharing schemes.

A significant amount of therapeutic, trauma and violence-informed counselling is provided by specialist family violence services and other community organisations. However, the RCFV found that accessing these services is difficult and that "although the WHO recommends referrals to trauma-informed mental health counselling and mother-child counselling [for victim survivors], there is a distinct lack of availability of accessibility in Australia." (State of Victoria, 2014 Vol IV p35) In response to this finding, the RCFV made Recommendation 104 calling for an expansion of peer support, group-based and individual family violence counselling (State of Victoria, 2014 Vol IV p84).

While funding for specialist family violence counselling has been increased, the huge increase in demand for family violence services means that funding continues to fall short of demand for service, leaving victim survivors reliant on other forms of non-specialist therapeutic support or without support at all.

**Recommendation 10:** Increase resourcing for individual and group therapeutic, trauma and violence informed services to be delivered by community service organisations that have a gendered, trauma and violence-informed approach to practice.

The other part of the "missing middle" that urgently needs to be increased is community-based, psycho-social mental health services that are trauma and violence-informed.

Models vary, but these services are typically provided by community organisations, that provide multi-disciplinary, community mental health teams and/or counselling and are referred to as community mental health services. Examples include the Personal Helpers and Mentors Program (PHaMs), Mental Health Community Support Services (MCHSS) and Partners in Recovery (PIR).

The Victorian Government's decision to move funding for community mental health services into the NDIS has exacerbated the chronic shortage of community mental health services available to victim survivors of family violence and all Victorians in need of some kind of mental health support between a mental health plan and a stay in hospital. Moving these services into the NDIS means that individuals who were previously able to access community mental health services regardless of the presence or nature of a diagnosis, now must meet strict eligibility criteria for the NDIS to access support. Eligibility criteria includes having a permanent disability, including a mental illness, that significantly impacts your ability to take part in daily activities.

Victim survivors are frequently pathologized as mentally ill; whereas in reality, many victim survivors are not mentally ill but are recovering from violence and trauma and in need of therapeutic support to do so. Even if they do exhibit signs of depression, anxiety, addiction, or suicidal ideations, these symptoms are unlikely to be permanent and could be addressed if the family violence risk was managed and the violence stopped. As a result, most victim survivors will never qualify for the NDIS and now have even less access to the mental health services they need to recover from violence and trauma.

For example, in our consultation with the Specialist Family Violence Advisors, one Advisor identified a client who had previously used the community mental health services PHaMs and MCHSS. This client is not eligible for the NDIS as she has no official mental health diagnosis and her illness is episodic and not severe enough to qualify. There are now no appropriate services available to her other than family violence support. The lack of mental health supports leaves the family violence service trying to manage her mental health needs when they know they do not have the requisite expertise to do so. The risk this presents to the family violence service and the client is serious.

Specialist Family Violence Advisors identified PIR as a successful program for helping people, including victim survivors of family violence, access the mental health support they need. PIR is an example of a systemic response that can support the centring of the client's experience and an appropriate systemic response to a range of needs, including family violence. This model uses a Support Facilitator to take charge of the care coordination of all the supports required by clients with multiple needs, where the core focus is on mental health.

A complete assessment across all functional life domains is conducted at the outset and over an extended period. It allows for the inclusion of families and carers in assessment and treatment with the consent of the client. Importantly, this model maintains and reinforces the specialisation of the coordinated workforces, as each workforce must have a clear idea of their roles and responsibilities in relation to the client to provide a successful response.

PIR is a federally funded program that unfortunately was defunded on 30 June 2019 as part of the NDIS rollout. It is being replaced with a less comprehensive model with some case coordination function. The primary benefit of PIR was the ability to coordinate service systems, including treating psychiatrists, engaged with the overarching case plan. PIR could easily lend itself to the inclusion of family violence response under the MARAM and Information Sharing responsibilities. As such, it has great potential to deliver a trauma and violence-informed approach to mental illness for victim survivors and other vulnerable groups.

The PHaMs program is another beneficial program for people with significant mental health needs, including victim survivors of family violence and trauma, who needed support to live in the community. The PHaMs program provided outreach (e.g. home visits) and practical support to help people manage daily tasks and living skills (e.g. taking medication, shopping, and maintaining social

contact) which enabled staff to monitor a client's mental health for signs of a down turn and help clients manage and monitor their own mental wellbeing. This program prevented people from spiralling into severe states of mental illness and needing to go to hospital. Unfortunately, this program was also discontinued when the Victorian Government moved community mental health funding into the NDIS.

To help victim survivors identify, cope with and recover from violence, Victoria needs a dramatic increase in therapeutic, trauma and violence-informed and psycho-social support services which are 'family violence literate' and have intake and assessment tools that align with the MARAM and Information Sharing frameworks.

**Recommendation 11:** Fund non-clinical, psycho-social, community-based mental health programs at a level that meets demand to support victim survivors of family violence and trauma to recover from violence and be able to live in the community

**Recommendation 12:** Expand case coordination positions to increased case coordination across the service systems, including in family violence, AOD and mental health services.

## Implementing trauma and violence-informed care

The term trauma informed care (TIC) is a common term used across health, mental health and community services, including specialist family violence services. However, there is not a common understanding of TIC, or how to implement TIC in different service settings, which causes confusion and difficulties in integrating and coordinating service delivery across sectors (Hegarty et al., 2017; Mihelicova et al., 2018).

As discussed, working from different practice frameworks has been one of the most significant challenges to overcome in implementing the Specialist Family Violence Capacity Building Project. Research suggests that practice frameworks and models vary significantly even between clinical and community mental health services (Mihelicova et al., 2018). The RCFV also found that for many mental health services, a move towards TIC would require a major shift in current practice (State of Victoria, 2014 Vol IV p41). This suggests that to appropriately respond to victim survivors of family violence and trauma who also have a mental health issue, family violence, clinical and community mental health and other associated services likely to have contact with these individuals need to have a common understanding of trauma and violence-informed care and what that means for practice.

As part of the WITH study by ANROWS, Hegarty et al (2017) provides a thorough review of academic and grey literature regarding trauma-informed care in Australia and interviewed victim survivors of sexual assault to determine the key elements of TIC they found most useful. Importantly, Hegarty et al (2017) identifies the need for trauma *and violence* informed care (TVIC) to appropriately respond to victim survivors of sexual assault and family violence.

The study examines how to implement trauma-informed practice more effectively when both sexual violence and mental health issues are present and explores how TVIC can be integrated across hospitals, sexual assault services and clinical mental health services. ANROW's full body of research on this topic, combined with lessons from the Specialist Family Violence Capacity Building Program, offer practical insights into how clinical and community mental health, family violence and other related services can develop a shared understanding of responding to mental health needs among victim survivors of violence and trauma.

Both the WITH project and the Specialist Family Violence Capacity Building program found that enacting change across services takes more time than anticipated. Secondly, the WITH project found that to successfully implement a common understanding of trauma and violence informed practice across services requires:

- relationship building across services and staff,
- integrated co-ordinated care that clearly defines roles and specialisations,
- reflexive monitoring that allows staff to give input and get feedback from management, co-workers and clients, and
- physical environments that support a TIC model

We encourage the Commission to review this body of research to inform future understandings and models of TVIC and how it can be safely and respectfully applied to victim survivors of family violence and other marginalised groups to support recovery from associated mental illness.

**Recommendation 13:** Develop a common understanding Trauma and Violence Informed Care to be implemented across mental, AOD, family violence and other associated community services.

## Additional themes for the Commission to consider

### Carer relationships when there is family violence

Families and carers are a critical, but often unrecognised and underappreciated, part of the mental health system. Across Australia, informal mental health carers provide over 100 million hours of care every year, with an estimated replacement value of over $14.3 billion per annum. More than a third of informal mental health carers provide over 40 hours of care every week (Diminic et al., 2017).

Care is highly gendered. Women are more likely to be in part time work or not in employment at all in order to balance their care and household duties. Even in instances where mothers do work full time, they tend to do more domestic work and child care than fathers (Baxter, 2014). Caring for a family member with a mental illness compounds this caring responsibility. Mind Australia found that over half of carers were women and despite most carers being of working age, nearly 40 per cent were not in the labour force (Diminic et al., 2017).

DV Vic is confident that many submissions will address the impact of providing long-term care to individuals with a mental illness and/or disability on carers' own physical and mental wellbeing and economic security. As a result, we will not discuss this in depth in this submission. The toll on carers is significant and we support all recommendations made by other individuals and organisations to provide more support to carers.

However, we do want to draw the Commission's attention to the complexities of care when there is family violence present in a carer relationship. The Mental Health Act places both individuals and carers at the centre of mental health treatment, recognising the latter's role in supporting their family member's recovery (RCVF Vol IV p30). While this is appropriate in many cases, when there is family violence, involving the carer becomes complex and could compromise either the safety of the person being cared for or the carer.

The RCFV heard evidence from victim survivors about being released back into the care of their perpetrator after being admitted to a psychiatric unit and how their perpetrator used their role as carer to continue to control and abuse their victim (State of Victoria, 2014 Vol IV p32). In addition, 'Melissa Brown's' story during the RCFV highlights the complex relationship between disability,

mental health and family violence and the difficulty women with mental health issues and/or disabilities have in leaving a violent relationship (Perkins, 2015).

Family violence in the carer relationship can also put carers at significant risk. Two areas where there is emerging evidence of this is in cases of elder abuse and adolescent family violence.

It is important to note that, as is the case with all forms of family violence, including elder abuse and adolescent family violence, mental illness is only a contributing risk factor, not a cause nor an excuse, for using violence. Understandings of elder abuse and adolescent violence as forms of family violence are new and emerging. However, research into elder abuse has found issues of mental health to be a contributing risk factor for both the perpetrator and the victim (Pillemer, Burnes, Riffin, & Lachs, 2016). Similarly, mental health issues have been identified as a common contributing factor to youth using violence (Cottrell & Monk, 2004; Fitz-Gibbon, Elliott, & Maher, 2018). Carers play a significant role both in cases of elder abuse and adolescent family violence, yet their role can often be overlooked or disregarded.

In our consultation with the Specialist Family Violence Capacity Building Program, one Advisor shared the story of an elderly woman providing care to her son with known mental health issues and a history of violence:

> "We worked with an older woman being supported for elder abuse from an adult son who had a dual diagnosis of significant mental illness and methamphetamine use. Despite being on remand for violent crime, including family violence against his parents, there was no investigation of safety or support for the family. The family requested to be part of the assessment and treatment process, but they were informed that this was impossible due to privacy concerns. No information on risk was shared with the family.
>
> A further complication was that each service wanted to focus on a single issue rather than the whole person so the mental health diagnosis, combined with problematic substance use, were treated as separate issues rather than inter-connected. The use of family violence was seen as outside the remit of the mental health and AOD treating services entirely. This meant that we missed important early risk indicators for violence which resulted in actual harm to the family."

This case study highlights the need to involve carers in mental health planning in a careful and considered way. Balancing the needs of the person needing care with the needs and safety of the carer is critical. While returning home to be supported by family is often considered the preferred option by health care professionals, when there is family violence, this is not always appropriate.

The "missing middle," or lack of therapeutic, trauma and violence-informed mental health services, is critical for families who are providing care to loved ones with a mental illness and experiencing family violence.

In both instances of elder abuse and adolescent family violence, victim survivors/carers are often reluctant to report the abuse to police and other authorities out of concern for the loved ones they are caring for and what will happen to them if the carer stops providing care or forces them to leave the home. Often victim survivors/carers try to access support for their loved ones, however the chronic lack of services means that their loved ones are likely to be deemed 'not sick enough' to justify sending a CAT team or sending them to hospital. The lack of affordable housing, low levels of income support and no community mental health services means that many people would be forced into homelessness and poverty if it were not for their careers (Brackertz, Davison, & Wilkinson,

2019). For adolescent violence, the fear of a justice response means many parents, overwhelmingly mothers, refuse to report the violence being perpetrated against them by their children.

The lack of services to support loved ones with a mental illness, can leave the carer holding all the responsibility for their loved one while simultaneously exposing themselves to risk and harm from the family violence perpetrated against them. Research into the effects of family violence on victim survivors' mental health means that carers who are experiencing violence are at high risk of developing their own mental health issues. Addressing the "missing middle" with trauma and violence-informed mental health services is therefore critical to stemming increased mental illness and reducing the intergenerational and compounding effects of violence and trauma.

## Intergenerational effects of family violence on mental health

Research into elder abuse and adolescent family violence suggest strong overlaps between mental illness and intergenerational and multi-directional violence, particularly when it comes to adolescent violence. Research suggests that one of the strongest risk factors for adolescents using violence is previous experience with childhood trauma and/or 'family conflict' (aka usually family violence) (Campo, Kaspiew, Moore, & Tayton, 2014). Similarly, the PIPA Project, currently being run by ANROWS and the RMIT Centre for Innovative Justice, found that in a significant majority of cases, young person who have come to the attention of the courts for using violence have a combination of mental health issues and cognitive or intellectual disabilities and are likely to have learned their behaviour from an adult perpetrator. This suggests that in many cases of adolescent family violence, there was likely an original perpetrator that the system had missed (Campbell, 2018).

While much about the directional relationships between mental health and family violence is still unclear, the ANRWOS WITH project found that in cases where mental health was thought to have exacerbated the risk of experiencing future sexual violence, this was only the case when prior experiences of child sexual abuse were found (Hegarty et al., 2017 p31). These findings suggest that while having a mental illness does increase vulnerability to violence, the presence of mental illness is much more likely to be a result of previous abuse than it is to be a cause of experiencing or using violence.

Less research has explored the presence of intergenerational violence in instances of elder abuse. However, anecdotal evidence suggests that victim survivors of elder abuse (predominately women) have disproportionately been victims of intimate partner or another form of family violence earlier in life. This is a theme that is worth continuing to explore.

These findings again highlight the importance of viewing mental illness with a social justice, trauma and violence-informed lens that seeks to break the intergenerational nature of violence by naming the violence the individual has experienced and the perpetrator responsible. It is only by naming the real cause of mental illness that we can begin to do truly preventative work.

## Conclusion

The Royal Commission into Mental Health is a once-in-a-lifetime opportunity to improve the mental health system for Victorians, as the Royal Commission into Family Violence was a one-in-a-lifetime opportunity to improve the response to victim survivors of family violence.

The RCFV found extensive correlations between the prevalence and experience of family violence and mental illness. This Commission has an opportunity to continue and expand on that work.

Planning and oversight of any forthcoming recommendations from this Royal Commission will be critical to ensure that recommendations do not have the unintended consequence of undoing work done since the RCFV to coordinate work between the mental health, AOD and family violence sectors.

This Royal Commission into Mental Health also has the benefit of learning from the RCFV and how to avoid potential pitfalls in implementation. Whilst the RCFV made it clear that 'family violence is everyone's business' and many of the family violence reforms have been focused on building family violence literacy and capability across non specialist health, community and education providers, this does not mean that all these professionals are expected to become family violence specialists . Rather they now have clearly prescribed roles and responsibilities in identifying and responding to family violence within the parameters of their respective specialised roles. Similarly, while everyone has a responsibility to understand mental health and support people with a mental illness, not everyone can or should be an expert in mental health.

Critical to the success of this Commission and its ability to contribute to the reduction of mental ill-health in our society is an understanding of violence and the impact it has on victim survivors.

Violence as a cause of mental ill-health extends far beyond victim survivors of family violence and affects all vulnerable and marginalised groups who experience combinations of interpersonal and systemic violence and oppression

Extending the social model of mental health to include a social justice, violence-informed framework exposes violence and names the perpetrator/s responsible, while honouring the strength of victim survivors, their resilience and acts of resistance.

Given experiences of personal and systemic violence cause mental illness, policy solutions to reduce and prevent the prevalence of mental illness are likely to sit outside the mental health sector. We must work to end systemic forms of oppression, sexism, racism, homophobia, ableism and poverty and work towards a more just and equal society in which violence is never perpetrated and no one is made mentally ill.

# Summary of recommendations

**Recommendation 1:** Embed a social justice, violence-informed mental health framework across the mental health system to provide guidance to professionals to better identify and address underlying causal factors of individuals' mental illness, including experiences of family and sexual violence.

**Recommendation 2:** Modules on family violence, structural and inter-personal violence are made core subjects for all entry-level mental health training to ensure mental health clinicians have a structural understanding of the effects violence can have on a person and how the effects of violence may present as symptoms of a mental illness.

**Recommendation 3:** Mental health services adopt a universal screening tool to screen all patients for family violence.

**Recommendation 4:** Implement a Mental Health Capability Framework that clearly maps different workforce's and professional's roles and responsibilities in identifying and responding to individuals with mental health needs.

**Recommendation 5:** Increase capacity across mental health and family violence services to provide secondary consults to foster service coordination and expertise across sectors.

**Recommendation 6:** Implement a universal screening tool for non-mental health services to better identify mental health needs.

**Recommendation 7:** Establish a state-wide standardised intake and assessment point for mental health services, similar to DirectLine for AOD services and the Safe Steps Family Violence Crisis Line for family violence services, to facilitate access to mental health services.

**Recommendation 8**: The Royal Commission into Mental Health urge the Commonwealth Government to implement a Medicare item number specifically for family violence to increase access to counselling for victim survivors of family violence and improve data on the impact of family violence on victim survivors' mental health.

**Recommendation 9:** Review the effectiveness, quality and use of the family violence category in the National Health Service Directory to ensure that providers listed are verified as having a comprehensive understanding of family violence and their roles and responsibilities under the MARAM and Information Sharing schemes.

**Recommendation 10:** Increase resourcing for individual and group therapeutic, trauma and violence informed services to be delivered by community service organisations that have a gendered, trauma and violence-informed approach to practice.

**Recommendation 11:** Fund non-clinical, psycho-social, community-based mental health programs at a level that meets demand to support victim survivors of family violence and trauma to recover from violence and be able to live in the community

**Recommendation 12:** Expand case coordination positions to increased case coordination across the service systems, including in family violence, AOD and mental health services.

**Recommendation 13:** Develop a common understanding Trauma and Violence Informed Care to be implemented across mental, AOD, family violence and other associated community services.

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