SUBMISSION TO THE ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Dr Sabin Fernbacher

Consultant

I acknowledge the Traditional Owners of the country that I live and work on, the Wurundjeri people of the Kulin Nation. They are the original custodians and caretakers of this land. I wish to acknowledge and pay my respect to their Elders, past and present.

I want to acknowledge people with Lived Experience of mental health challenges of all kinds. I acknowledge your resilience, strength and generosity in teaching me and others about the need for an inclusive society that busts myths, works against stigma and towards a kinder society for all. It is you who I dedicate my submission to. Thank you.

Contents

Background

I have worked in a range of sectors over the past 35 years relevant to mental health/illness. Since the mid-90s I have worked within the mental health sector, initially in a community organisation, then in clinical mental health services and State Government and more recently in primary health.

Since 2000 my roles have predominately focused on service development; community development; inter-organisational and inter-sectorial collaboration; policy and guideline development (State Government); research and evaluation; and project management.

The areas I have worked in include sexual assault; family violence; homelessness; Families where a Parent has a Mental Illness (FaPMI); Aboriginal and Torres Strait Islander mental health & Social Emotional Wellbeing; women's mental health; gender and sexual safety; Trauma Informed Care and Practice; and collaboration with people with Lived Experience.

My most recent role in the Victorian State Government was as Principal Policy Adviser Family Violence in the Mental Health Branch. I was responsible for the implementation of recommendations from the Royal Commission into Family Violence. As part of this role I developed the Chief Psychiatrist's guideline and practice guide: family violence (Department of Health and Human Services 2018)[1].

In previous roles with Victorian State Government, I developed the 'Service guideline on gender sensitivity and safety. Promoting a holistic approach to wellbeing' (Department of Health 2011)[2], I project managed and produced the report on 'building partnerships between mental health, family violence and sexual assault services (Department of Human Services 2006)[3]. Following this publication, I managed a project that sought to implement the recommendations across a clinical mental health, family violence and sexual assault services in the northern region of Melbourne.

In my doctoral thesis I undertook a policy study, investigating mental health policy guidance regarding abuse (family violence and sexual assault) in Australia, Victoria and NSW (Fernbacher 2008).

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[1] https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/family-violence-guideline-practice-resource

[2] https://www2.health.vic.gov.au/about/publications/policiesandguidelines/service-guideline-for-gender-sensitivity-and-safety

[3] https://www.nifvs.org.au/wp-content/uploads/2015/01/partnerships-mh-fv-sa.pdf

I provide this background information to give the commission some context to my submission. While there are many areas of mental health service provision that I would like to comment on, I will predominately focus on the issues of interpersonal trauma (sexual assault and family violence); Trauma Informed Care and Practice; and gender sensitivity and safety in the context of mental health care.

Connection between trauma and mental health

Current and previous trauma, including childhood (sexual) abuse and family violence (including intimate partner violence) can cause, contribute and/or exacerbate current mental health problems and mental illness (Department of Health and Human Services 2018). While abuse might not be the only reason why a person develops mental health problems, a strong link between abuse and its impact on mental health has been established.

The impact of interpersonal trauma, in particular childhood (sexual) assault spans many areas of a person's live including health and mental health (Anda, Felitti et al. 2005, Campbell, Dworkin et al. 2009). Equally, the impact of family violence on mental health has been established (Department of Health and Human Services 2018).

Childhood trauma, in particular sexual assault, has been linked to most if not all types of mental illness diagnoses[4]: depression and anxiety (Briere 1994); suicide attempts and suicide (Cutajar M, Mullen P et al. 2010, Kezelman 2019); Borderline Personality Disorder (Cutajar M, Mullen P et al. 2010, Rao and Beatson 2019); schizophrenia (Read, Perry et al. 2001, Read, Mosher et al. 2004); Multiple Personality Disorder (Krawitz and Watson 2000); Eating Disorders (Everett and Gallop 2001); Dissociative Identity Disorder (Middleton, Dorahy et al. 2008); Post Traumatic Stress Disorder (Gearon, Kaltman et al. 2003); complex trauma/complex post-traumatic stress disorder (Kezelman and Stavropoulos 2012); psychotic symptoms or psychosis (Read, Agar et al. 2003); self-harm (Kezelman 2019).

Family violence has been linked with a range of mental health impacts, including anxiety, depression, and Post Traumatic Stress (Disorder) (WHO 2013). A link between intimate partner violence and postnatal depression has also been identified (Kezelman and Stavropoulos 2012).

[4] Mental illness diagnosis is problematic and changes constantly; while being gay, for example, was once categorised as a mental illness, it is no longer seen as mental illness. I use the terminology of the current mental illness paradigm in this submission, while acknowledging that the terminology is problematic and limiting.

Prevalence of trauma

The level of interpersonal violence, including sexual assault and family violence in the general population is high (Department of Health 2009, WHO 2013, Family Safety Victoria 2018). The prevalence of such violence and abuse in the Australian context has been highlighted in recent years through the Royal Commission into Institutional Responses to Child Sexual Abuse and the Royal Commission into Family Violence (Victoria).

While prevalence rates are alarmingly high in the general population, they are even higher for people who have mental illness diagnoses and those who access mental health services.

Rates vary and depend on a range of variables (definitions, age ranges). Some studies show that between 51%-98% of those accessing public mental health services and who have a diagnosis of 'severe mental illness' have a history of childhood abuse (sexual, physical or both) (Cusack, Frueh et al. 2003). An Australian study showed that up to 92% of women who were in a psychiatric inpatient unit had experienced childhood abuse, family violence, and often both (Mouzos and Makkai 2004).

People who experience schizophrenia, bi-polar and psychotic symptoms show high rates of abuse, and often multiple forms of abuse (Khalihef, P. et al. 2014). Up to 85% of those diagnosed with Borderline Personality Disorder (mostly women) have experienced trauma, usually during childhood (Rao and Beatson 2019).

A Victorian study shows a link between family violence and suicidality (MacIsaac, Bugeja et al. 2017). It found that one third of people who suicided in Victoria had history of 'exposure to interpersonal violence'. Women, unsurprisingly, were more likely to have been victims and men more likely to have been the perpetrators of the violence.

Specific Issues

Both above mentioned Royal Commissions highlighted the impact of abuse on mental health; the often catastrophic impact when survivors of abuse are not believed and supported; the mental health impact and toll on peoples' lives; the role of institutions; the need for health and mental health services to provide better responses to trauma; and the need for change.

The recent report by the Victorian Mental Health Complaints Commissioner outlined the lack of sexual safety for people accessing acute psychiatric inpatient units (Mental Health Complaints Commissioner 2018). It also discussed the impact on a person's mental health, when they are sexually assaulted in a place such as an inpatient unit, where they ought to

be safe. Often, people, and mostly women, who are assaulted, have previously experienced sexual assault. Being re-traumatised in an inpatient unit can have significant impact on the person. While the Victorian Government issued guidelines on sexual safety (Department of Health 2009), it has become apparent that people, and in particular women, are still not safe in psychiatric inpatient units. This is echoed by the statement of the Victorian Women's Mental Health Network's submission to this Royal Commission.

People who have experienced trauma come into contact with mental health services earlier, more frequently, access emergency mental health and emergency departments more frequently, experience longer and more frequent hospitalisations and spend more time in seclusion (Read, Harper et al. 2018)

The Adverse Childhood Experience Study (ACE) found that people with high levels of abuse were 10 times more likely to be prescribed antipsychotic medication and 17 times more likely to be prescribed antidepressants than those who had not experienced abuse (Anda, Brown et al. 2007)

It has been established that mental health services have not been at the forefront of understanding trauma and its impact on mental health, with some exceptions (Adults Surviving Child Abuse 2012). Frequently the issues of trauma and mental illness are seen as separate. Equally, the far-reaching impact of trauma on a person's life, including their housing/homelessness status, drug or alcohol consumption or intergenerational trauma, have not been well understood (Benjamin, Haliburn et al. 2019).

While there are a range of frameworks that can assist in understanding the connection between trauma and mental health problems, they have not been implemented consistently in Victoria. I briefly outline two of these in the next section.

Trauma Informed Care and Practice

Trauma Informed Care and Practice (TICP) provides a framework for understanding, responding and providing services that are sensitive to trauma and aim to avoid re-traumatisation. An organisational approach, TICP seeks to provide guidance on the work that needs to occur to fundamentally change how organisations and clinicians (staff) respond to trauma (Kezelman and Stavropoulos 2012). It provides key principles that need to be applied to policy, procedures and (clinical) practice in order to re-orientate services to become 'trauma sensitive' (SAMHSA 2014, Mental Health Coordinating Council 2018).

The key principles of TICP are

- **Understanding of trauma:** understanding of the prevalence of trauma, its impact on child development and long-term impacts
- **Safety:** providing environments that are safe, ensuring cultural safety and interpersonal safety;
- **Minimise re-traumatisation:** practice in a way that minimise re-traumatisation; follow-up if -traumatisation has occurred;
- **Service culture:** adopt cultures and practices that acknowledge trauma, avoid re-traumatisation and support recovery
- **Trustworthiness:** focused on building of trust, decisions are made with clarity;
- **Peer support:** peer support is valued and offered
- **Empowerment:** people's strengths are validated;
- **Choice:** strengthening choice for the person;
- **Cultural, historical and gender issues:** openly address these; ensure policy and practice align;
- **Staff skills:** staff are supported to gain TICP skills, enact them and receive adequate supervision
- **Diversity and intersectionality:** acknowledge types of trauma and population groups who experience trauma; including historical and institutional trauma;
- **Towards cultural competency:** acknowledgment of historical violence and Australia's treatment of Aboriginal and Torres Strait Islander people; and the impact of Government policies including child removals.

Within a TICP framework behaviour that has traditionally been interpreted as a symptom of mental illness or drug and alcohol addiction can be reframed as responses to trauma, its effect and ways of coping. Equally, some diagnoses can be reframed as responses to trauma, such as behavior associated with Borderline Personality Disorder can be understood as a response to 'complex trauma' (Kezelman and Stavropoulos 2012, Herman 2017).

Problematic drug or alcohol use, self-harm or 'risky behaviour', can be understood as coping strategies, the person is trying to cope with the impact of trauma and of triggers as best as they can. Within mental health care such behavior is rarely understood as a person coping the best they can, even if their coping strategies have become unhelpful for them on some levels (Bloom 2019).

While there are pockets of good work relating to TICP, there is no state-wide approach to its implementation. There are, of course, challenges in implementing TICP within a system in which people are held against their will, through the application of the mental health act. However, it should still be possible to respond to individuals within a TICP framework.

There is a need for statewide guidance on TICP for all services that work with people who have experienced trauma. This is one of the uniting factors or human service provision that cuts across many sectors including mental health, homelessness/housing, family and sexual violence, health, AOD, disability, CALD, Aboriginal services and so on. Many people who

would access those services would have experienced both trauma and mental health challenges.

The Power Threat Meaning Framework

The Power Threat Meaning Framework ('the framework') was developed in the UK by the Division of Clinical Psychology (Johnstone, Boyle et al. 2018). It provides a way to understand how distress, social injustice and inequity impacts on people. It takes the concepts of TICP further, when it calls into question the common assumption that biology is the (Cozolino 2002)primary cause of mental ill health after reviewing the evidence. While they reaffirmed that there is a connection between brain and human experience, the authors established that it is not a monodirectional relationship. They provide evidence that it is not biology that directs responses, but that human experiences also impact on biology. Similarly, researchers in the area of neurobiological impact of trauma have established the interaction between brain functions and human experience also (Cozolino 2002).

The framework provides a way to unpack how power has impacted on a person, to identify patterns of distress, how this manifest and the meaning the person makes of this experience. The framework proposes a de-medicalising of people's distress and a therapeutic way to support people's strengths.

I suggest strongly that the Commission needs to review the Power Threat Meaning Framework and engage with its authors. They have much to offer in a way of understanding people's distress, the impact of trauma and abuse of power and ways forward towards creating a different type of mental health support system.

In order to review the current mental health system in Victoria, there is a need to draw on other models and frameworks beyond the current system, otherwise it is just doing more of the same. While this framework may seem 'radical' to some, the eminent psychologists that developed it, are world-known leaders in this area of work.

Connection with the Royal Commission into Family Violence

While State Government has been working on implementing the recommendations of the RCFV, including the DHHS/Mental Health Branch, more work needs to be done at the intersection of family violence and mental health and sexual assault and mental health sectors.

The implementation of recommendation 98, the creation of Family Violence Adviser Roles in mental health and AOD services can go some way towards increasing the capacity of mental

health services to respond to family violence. It is, however, not enough to influence change in such a large system.

Recommendation 102 of the RCFV aimed to increase the skills of psychiatrists and psychologists through establishing learning agendas on family violence. It is only once these learning agendas are implemented, professional development is routinely delivered, that changes in skills and abilities will follow.

GPs are often the first point of contact for people with mental health concerns, with family violence concerns or who have been sexually assaulted. GPs juggle a myriad of issues in small time fractions available through appointments. While upskilling them in the areas of family violence and sexual assault will go some way, other solutions need to be found to support GP practices. Primary Health Networks are ideally placed to develop systems and commission programs that can support GPs' work, if the Commonwealth was to fund such initiatives. There is a need for state and Commonwealth to work together on these solutions.

Mental Health Services' response to trauma

Mental health services have been slow to understand the connection between trauma and mental health problems/mental illness (Sampson and Read 2017). Frequently the issues are still seen as separate, leaving people with lived experience exposed to a system that 'treats their mental illness' but does not engage with issues such as trauma. When it does engage with it, trauma is often seen as secondary, when in fact it can be THE factor to someone's current mental health problems. A New Zealand study found that childhood sexual abuse was a greater predictor than current depression for suicidality (Read, McGregor et al. 2006). It is studies of this kind that need to be translated into real change within any type of mental health care, no matter where it is provided.

Peer Support

Peer support has been proven to be just as beneficial as clinical mental health treatment. Equally, peer support is one of the cornerstones of TICP frameworks.

While there are great initiatives occurring in Victoria to increase peer support and other Lived Experience roles, more needs to be done. Internationally, there are examples of peer support and peer-run services and its benefits. The evidence is clear – peer support works and is of great benefit.

There is a need for a concerted effort to increase all aspects of peer support to enable greater numbers of peer support positions across the state. These should be available on each service (clinical or non-clinical).

Mental Health Services

Clinical mental health services are tertiary services, they see a very limited number of people. People have to be 'sick enough' to gain access. At the same time, there is a lack of support for people who are 'not yet sick enough' or those who may 'never get that sick'.

The vast majority of people with mental health problems will never access a clinical mental health service. It is often unclear what they access or if they actually get the support they need.

The Stepped Care Model by the Commonwealth Government seeks to match the need of the person with the service they receive, according to need. It spans prevention, early intervention, support for people with mild to moderate and 'severe' mental illness. Commonwealth funding is commissioned through Primary Health Networks (PHNs) throughout Australia. More planning is necessary to ensure that services commissioned by PHNs provide mental health care that complements clinical mental health services (in their current or future way they will be provided, following the RCVMHS).

The mental health system has undergone a huge change in the past few years through the roll-out of the NDIS. It is well known that the NDIS has been problematic for people with mental illness and that many fail to gain access to NDIS services or find it difficult to negotiate them.

There is an urgent need to review how the NDIS has impacted on people with mental illness and their level and type of support they receive.

Recommendations

1. **People with Lived Experience**

    - People with Lived Experience of mental health problems/illness need to be at the centre of all recommendations of the Commission.
    - All changes to the mental health system need to have people with Lived Experience at its core.
    - People with Lived Experience need to be part of governance groups, advisory bodies and decision making about changes to the mental health system.

2. Addressing the lack of safety in mental health services

- There is an urgent need to increase safety in psychiatric inpatient units and other bed-based services (such as Community Care Units and Prevention and Recovery Care Services) for all genders, including transgender people.
- Women should not have to share inpatient units with men. The current policy of 'women's corridors' has had mixed results. Many women are still not safe. There is a need to review women's corridors and find other solutions through environmental changes to established inpatient units.
- Women's-only wards ought to be a priority and need to be funded in future developments.
- Women's PARCS need to be established.

3. Review of current systems and broadening scope

- Broaden the scope of the type of services, the type of responses and support provided.
- Develop prevention and early response services to support people earlier in their distress.
- Broaden the scope of the mental health system, to include primary care.
- Replicate this in State Government (expand the Mental Health Branch's function or integrate with primary care).
- Take a population health approach to all service system designs.

4. Development of new types of services

- Develop new services that operate within a TICP framework (within the scope of the 'mental health system'5).
- Develop new services that are trauma-specific services (within the scope of the 'mental health system').

5. Integration of services

- Creation of services that are integrated or integration of current services, which address a range of needs and provide a holistic service6.
- Integrate mental health workers into a wide range of other service providers.
    - Including (but not limited to) Support and Safety Hubs; specialist family violence services; sexual assault services; Child Protection; homelessness services; child, youth and family services.

6. Create new initiatives

- Create alternatives to inpatient units.

[5] This would mean that the future mental health system does not look like it does today and links with my earlier statement about the need for review and change.

- Create PARCS type services that address trauma and provide a holistic service7.
- Review the evidence of initiatives such as the Women's Crisis Houses in the UK (Howard, Rigon et al. 2008).
- Create new types of mental health services that provide a more holistic service.
- Ensure peer support is part of any new service initiatives; ensure this is adequately funded.

7. Extend the recommendations of the RCFV

- Review the current state of the recommendations and the real change that is occurring.
- Allocate funding to State Government (Mental Health Branch) to continue to implement recommendations proactively.
- Enshrine into service agreements, that Mental Health Services need to provide services that address family violence issues as a priority (ensure evaluation is possible).
- Build on the roles of the Family Violence Advisers in mental health services to increase coverage.
- Increase funding for family violence related programs and initiatives within mental health services (that support the work of the FV Advisers).

8. Trauma Informed Care and Practice

- Publish a statewide Trauma Informed Care and Practice Guidance.
- Attach implementation to the guidance.
- Fund those initiatives both in State Government and in mental health services.
- Any established and new mental health services (clinical, community, primary care) need to be implement TICP. To implement TICP, State Government needs to provide direction and guidance on TICP across all human service sectors, including but not limited to mental health, child protection, housing and homelessness, AOD, child and adolescent services, schools, counselling, community health, primary care.

[7] Review the evidence of initiatives such as the Women's Crisis Houses in the UK Howard, L., E. Rigon, L. Cole, C. Lawlor and S. Johnson (2008). "Admission to women's crisis houses or to psychiatric wards: women's pathways to admission." Psychiatric Services 59(12): 1443-1449.

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