NSW Consumer Advisory Group – Mental Health Inc. and Dr Sue Webster

Submission on Domestic violence: trends and issues in NSW Legislative Council Standing Committee on Social Issues

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NSW Consumer Advisory Group - Mental Health Inc.

NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG) is the independent, state-wide organisation representing the views of people with a lived experience of mental illness at a policy level, working to achieve and support systemic change.

NSW CAG exists to ensure that policy makers hear the perspectives of mental health consumers across NSW. We work from the premise that the participation of mental health consumers in systemic advocacy leads to the development of more effective public policy in the area of mental health. Participation is a fundamental human right as enshrined in Article 25 of the *International Covenant on Civil and Political Rights* (ICCPR).

NSW CAG's vision is for all mental health consumers to be able to participate meaningfully in society and to experience fair access to quality and recovery focused services which reflect their needs. Our work is guided by six principles:

- Being person centred and empowering consumers in the interests of consumers;
- Adopting a recovery approach to building positive futures;
- Promoting positive images and reducing stigma and discrimination;
- Enhancing best practice and building understanding of effective approaches to consumer participation;
- Capacity building of our organisation, consumers and services; and
- Promoting professionalism and continuous improvement in our ways of working.

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Dr Sue Webster

Dr Sue Webster is a Senior Lecturer, clinician, an Accredited Mental Health Practitioner/Provider, and researcher with several national and International grants.

She is the Transcultural Mental Health Clinical Consultant for Thai and Laos groups. Her research has focused on mental health issues, education and public health targeting both migrants and youth in primary care.

Dr Webster has also undertaken specific research in domestic violence, focusing on the prevalent and incidence in emergency departments in NSW.

Introduction

We welcome the opportunity to provide comment to the Social Issues Committee on domestic violence trends and issues in NSW.

This submission provides comment on these areas:

- issues for women with mental illness
- issues for women of culturally and linguistically diverse backgrounds
- issues relating to children who have been exposed to domestic violence.

From NSW CAG's consultations with mental health consumers and Dr Webster's research in this area, we are aware that these groups are vulnerable when it comes to domestic violence, in terms of accessing appropriate services and support.

Issues for women with mental illness

From NSW CAG's consultations with people with a lived experience of mental illness (consumers), we are aware that experiences of violence and trauma are all too common.

The issue of violence and mental illness is complex and intertwined. While it is well known that exposure to violence impacts on physical health, the effects on one's mental health are less visible. Domestic violence is linked to a wide range of mental health problems including post-traumatic stress disorder (PTSD) and complex trauma, anxiety, depression and problems with alcohol and other drug use (Laing 2003). Recent research shows that the experience of having lived with a violent partner is linked to having a diagnosed psychological disorder, recent experiences of depression and anxiety and overall decreased psychological wellbeing (Loxton et al 2006). In addition, another Australian study found that experiencing gender based violence was significantly associated with mental health disorder, dysfunction and disability (Rees et al 2011). Furthermore, a high percentage of individuals using the mental health system have experienced multiple traumas (NETI 2005).

We are aware of several issues for women with mental illness who are experiencing domestic violence including:

- for women who have a mental illness, their claims of abuse are often seen as less credible and not taken seriously (Laing et al 2010)
- women are more likely to seek care for the injuries they have sustained and the mental health symptoms (depression, anxiety) that are caused by experiences of violence (Laing 2003) and less likely to see help for abuse
- health professionals, due to time constraints, are quick to prescribe medication for symptoms of violence and abuse (depression and anxiety) which means that women may not have access to information and supports.

One solution is to review and strengthen screening for domestic violence. Screening consists of asking all individuals at a particular health service whether or not they have experienced domestic violence. Screening is explained as

> …a complex intervention by assisting women who are screened in diverse ways, that include provision of opportunities for first disclosure, provision for information about abuse, and after six months, evidence of increased awareness about abuse and reduced abuse as well as reduced isolation and being prompted to evaluate the situation. (Spangaro and Zwi 2010)

In NSW, mental health services, antenatal, early childhood and drug and alcohol services have had routine screening for domestic violence since 2003. With some women in mental health services, there may be issues around women being unwell upon admittance and

being unable to be screened. There also may be issues around inconsistencies between health districts due to attitudes and skills of those undertaking screenings.

An evaluative study of NSW Health's domestic violence screening process and policy was undertaken by the School of Public Health and Community Medicine at the University of NSW (Spangaro and Zwi 2010). The study made numerous policy proposals as a result of this study to improve screening for domestic violence in NSW (see Appendix A for a full list of the recommendations).

We recommend that the Social Issues Committee review and recommend implementation of the policy proposals put forward in this document. Of particular interest to NSW CAG are recommendations concerning:

- Extending mandated screening to areas where individuals are likely to experience domestic violence (i.e. post-natal wards, gynaecology and sexual health)
- Routine screening should be introduced to private services, including private mental health services
- Inclusion of time alone for patients with health providers in NSW Health's over-arching privacy policy
- That the screening protocol is revised to include a requirement for repeat screening of all individuals and for those using inpatient mental health services this should happen prior to discharge
- That future versions of Mental Health Outcomes and Assessment Tool (MH-OAT) should have screening questions around domestic violence embedded within it.

In addition, Spangaro and Zwi make recommendations around how health services staff undertake screening. They note that women will be more likely to disclose abuse to those they view as being respectful, caring and competent. NSW CAG believes that these recommendations align with models of trauma informed care and practice, a way of working with people who have experienced trauma that supports their recovery. For more information about trauma informed care and practice, please see Appendix B.

Recommendation
That the Committee review and recommend implementation of the policy proposals put forward in 'After the Questions: Impact of Routine screening for Domestic Violence in NSW Health Services'.

Issues for women from culturally and linguistically diverse (CALD) backgrounds

It is well documented that women of non-English speaking backgrounds are greatly disadvantaged in accessing information, services and justice (for more information about Australian CALD demographics please see Appendix C).

Although there is limited research on the incidence of domestic violence experienced by women from culturally and linguistically diverse communities, Easteal's study indicates that there is evidence that women from immigrant and refugee backgrounds are more likely than non-immigrant women to be murdered in domestic violence, and are less likely to access services, or to receive appropriate support from those services, when they seek to leave a violent relationship (Easteal 1996: 6, 10, 11). Her study was supported by Cunneen & Stubbs 2002 that Filipino women living in Australia are almost six times over-represented as victims of homicide, compared to other women.

For women from non-English speaking backgrounds, the hierarchy of status that gives the dominant culture greater power, influence and control over all other cultural groups, results in living with a triple disadvantage. The gender-based violence endured is reinforced and exacerbated through racial violence, discriminatory practices, and lack of culturally inclusive service delivery by significant numbers of government and non-government organizations (Easteal 2008).

In Dr Webster's experience of working with Thai and Laos groups, domestic violence was prevalent in 24.4% in the sample of 104 women (Webster 2009). In these groups the perception of domestic violence as part of the "deal" due to fear of retaliation from the perpetrator i.e. further violence, firing, blacklisting or withholding of basic needs and pay (Webster, et al 2011). Experiencing violence impacted the women's lives, their health – including their emotional, psychological and mental health.

To provide more effective support to women from CALD backgrounds who experience domestic violence, it is necessary to:

- Undertake further research about the prevalence of violence in CALD communities and to refine research methodologies and how they categorise violence[1] and develop a more comprehensive and systematic approach to the collection of data concerning family violence
- Further develop services, information and supports that address the barriers that arise from issues of ethnicity, race, class, immigration and/or refugee experiences and that are culturally effective; this include and go beyond the use of interpreters in working with women who have experienced domestic violence
- Strengthen domestic violence screening processes so they are more effective in supporting women from CALD backgrounds.

It is not that culture and race cause women of non-English speaking backgrounds to become victims of domestic violence, but culture and race impact on a woman's access to appropriate assistance with domestic violence (Pillar et al 2010; Webster et al 2011). Women from CALD backgrounds require additional supports from the community and health sectors to recover from domestic violence.

Recommendations

We recommend that:

- The Committee advocate for further research is undertaken about the incidence of domestic and family violence in CALD communities
- Investigate ways to improve information made available to women from culturally and linguistically diverse backgrounds about domestic violence and abuse and the legal protections that are available to them
- That interpreters are made available to women during screening processes and that care is taken in ensuring the privacy and confidentiality when working with those from relatively smaller ethnic/cultural communities; further those undertaking screening processes need to be able to undertake further screening in working effectively with individuals from CALD backgrounds.

[1] Criticism has also been levelled at research methodologies that narrowly categorise domestic violence. For example, studies using one of the most commonly used research tools, the Conflict Tactics Scale (CTS) (Straus 1995), have been criticised for a number of reasons. Bagshaw and Chung (2000) argue that the CTS give no consideration to the meaning or intent of acts of violence and make no distinction between attack and defence.

Needs of children affected by domestic violence

From NSW CAG's consultations, we are aware that some mental health consumers attributed their mental health issues to witnessing domestic violence in childhood or adolescence. Consumers have described these experiences on having long lasting and far reaching impacts, and have explained experiences of youth homelessness, academic underachievement and abusive adult relationships on being exposed to domestic violence.

Recent research supports these narratives and has found that children who are affected by domestic violence experience significant negative impacts on physical, psychological, emotional, social, behavioural, developmental and cognitive well-being and functioning (Australian Domestic and Family Violence Clearinghouse, 2011).

It is necessary to keep in mind that the figures of children affected by domestic violence are probably higher than official figures due to underreporting of DV; as research with children and young people indicates that they have a higher level of awareness of the violence than their mothers had reported. In addition to exposure to domestic violence, it is estimated that in 30% to 60% of families where domestic violence is a factor, child abuse is also occurring (Edleson 1999).

Spangaro and Zwi note that women identified that they wanted information about the way that exposure to domestic violence impacts their children in the long and short term; they also wanted information about how to support their children to recover from DV.

Recommendation
We recommend that the Committee review and consider the information available to women on the impacts of domestic violence on their children and how to support their child's recovery from domestic violence.

Conclusion

We commend the Committee for their attention to this important issue; we know that domestic violence can have devastating immediate and long term impacts for women and their children.

While domestic violence can happen to anyone, we thank the Committee for their attention to the needs of women with mental illness, women from CALD backgrounds and children who are affected by domestic violence. These three groups face particular issues and barriers in accessing services and recovering from domestic violence.

Appendix A: Spangaro and Zwi's policy proposals

The full list of policy proposals taken from Spangaro, J & Zwi, A (2010) 'After the Questions: Impact of Routine Screening for Domestic Violence in NSW Health Services' UNSW School of Public Health and Community Medicine. To see the full document and rationale for each proposal, see:
http://www.health.nsw.gov.au/resources/nswkids/pdf/dvrs_doh_report_after_the.pdf

Context for undertaking screening

Proposal 1: Mandated screening should continue in the four programs and consideration be given to extending mandated screening for DV to additional programs including post-natal wards, gynaecology, sexual health and oral health clinics.

Proposal 2: Routine screening for DV should also be introduced in private antenatal, mental health and substance abuse clinics.

Proposal 3: Provision needs to be made in the over-arching NSW Health privacy policy that all episodes of care of adults should automatically include time alone with the health provider.

Proposal 4: The brief screening tool comprising two questions and embedded into assessment schedules should be sustained and the preamble positioned prominently in the tool and emphasised in training.

Proposal 5: Minor amendment of the questions should be considered and tested, to include choking, controlling behaviour and actions that create fear.

Proposal 6: An information resource needs to continue to be provided to all women who are screened and systems should be established so that renewal of supplies of the resource to sites, occurs on an automatic basis.

Proposal 7: The protocol should be revised to include a requirement for repeat screening of all patients at a specified interval. Among mental health patients this should occur prior to discharge and among long term D&A patients this should be annually at least.

Proposal 8: Statewide policy should be amended to introduce assessment of new patients in all antenatal and D&A services as a split process, over two sessions, provided by the same health care worker. The DV screening questions and other sensitive questions will be asked at the second visit.

Proposal 9: In any revision of the protocol, consideration should be given to the presence, influence and needs of partners who are abusive.

Proposal 10: The screening protocol should be amended to direct that disclosures of current abuse in response to screening should be responded to with a formalised risk assessment process.

Proposal 11: Dedicated social work positions with capacity to respond at the point of disclosure need to be attached to all public antenatal clinics.

Proposal 12: Antenatal clinics need to provide case management for all women where abuse is identified by screening so that intervention by eg D&A, mental health and child protection services is managed as a coordinated, single site response.

Proposal 13: Hospital based DV Clinical Improvement positions are required in all hospital facilities over 200 beds in order to provide staff consultation, training, and practice improvement.

Monitoring the policy

Proposal 14: The annual one month snapshot should continue, with reporting back to AHS within six months of data collection. Consideration should to be given to extending the monitoring to include training coverage.

Proposal 15: All hospitals should ensure that staffing in all antenatal clinics follows a model where continuity of care is provided, so that patients are seen by a one or at two midwives only through the course of their antenatal care.

Proposal 16: Area Health Service protocols should be reviewed to ensure consistency with the statewide policy and screening protocol.

Practice Proposals

Proposal 17: All women need to be asked and responded to in ways that that are respectful, caring, promote choice and minimise shame, without making assumptions.

Proposal 18: The screening information card needs to be given to and also discussed with all women who are asked the screening questions, regardless of disclosure

Proposal 19: Referrals need to be actively facilitated, in order to promote uptake

Proposal 20: Referrals should also be offered to women no longer experiencing current abuse.

Proposal 21: Reports to Community Services need to be based on assessment of risk rather than presumed as automatically indicated when DV is disclosed and women informed that a report has been made unless this is not possible.

Proposal 22: All health workers who ask the domestic violence routine screening questions need to complete at least four hours of screening training in order to undertake screening without error.

Training Proposals

Proposal 23: Each Area Health Service should establish area-wide strategies to ensure that all new staff attend the training course within six months of commencement of their role.

Proposal 24: Each Area Health Service should establish a process for monitoring completion and currency of staff training in screening for DV.

Proposal 25: Training courses need to alert health workers to the importance of asking and responding in ways that that are respectful, caring,promote choice and minimise shame,

without making assumptions and the need for practice to respond to the implications of disclosures of abuse.

Proposal 26: Training courses need to present more complex stories about women's experiences of abuse reflecting the diversity of their situations.

Proposal 27: Staff undertaking screening should renew their training every three years and NSW Health should pursue the option of including training on DV screening as an element of accreditation for nurses, psychiatrists, medical officers and social workers.

Proposal 28: Staff undertaking screening should have access to expert consultation on responding to DV.

Appendix B: Trauma informed care and practice

Trauma

Trauma can be defined as the experience of interpersonal violence (physical abuse, sexual abuse, severe neglect and or the witnessing of violence, terrorism and/or disasters. It can be any event which makes a person feel intense fear, helplessness or horror.

Many people with mental illness have experienced trauma; often these experiences are treated as additional problems rather the cause of problems.

Trauma informed care and practice

The Mental Health Coordinating Council says that trauma informed care and practice is

> …grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and interpersonal violence and the prevalence of these experiences in persons who receive mental health services…When a human service program seeks to become trauma-informed, every part of its organisation, management, and service delivery system is assessed and modified to ensure a basic understanding of an individual who is seeking services.

In a practical sense, this means creating service environments that help individuals to feel safe, respected and free from shame and/or humiliation. It means moving from a medical model of assessing symptoms to asking why a person is the way they are. A trauma informed approach places the mental health consumer at the centre, and responds to their needs in a holistic and respectful manner.

Key features of trauma informed care systems include (NETI 2005):

- Recognition that health and human services environments can cause trauma or can re-traumatise individuals
- That staff need to be trained to recognise trauma and to work with people in a way that supports recovery
- Values the consumer in all aspects of care
- Uses objective and supportive language
- Supports individually tailored and holistic care
- Avoids shaming and humiliation at all times
- Provide support and infrastructure to staff working in these environments to prevent them from becoming burnt or dehumanised from vicarious trauma.

For more information on trauma informed care, please see: Mental Health Coordinating Council's portal at: http://www.mhcc.org.au/TICP/default.aspx

Appendix C: Statistics regarding CALD communities in Australia

According to the 2006 Census, in descending order of population size, the main CALD groups in Australia are from Italy, China, Vietnam, India Thailand and the Philippines. However, between 1996 and 2006, increasing proportions of new arrivals came from Sudan (an average increase of 28% per year), Afghanistan (12%) and Iraq (10%; see Baur 2006).

Most CALD communities in Australia, especially Asian communities, are concentrated in urban areas (Sawrikar & Katz 2008).

The CALD communities may face a range of complex issues, including discrimination and prejudice, social isolation and disenfranchisement, and difficulties in assimilating within the broader Australian culture and/or in maintaining a sense of identification with the culture of origin.

References

Australian Bureau of Statistics (ABS) 2010a. *Migration, Australia 2008–09*. cat. no. 3412.0. Canberra: ABS. http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/3A3EB923A8CBB55CCA25776E001762A6/$File/34120_2008-09.pd

Australian Institute of Health and Welfare 2000, *SAAP National Data Collection Annual Report 1999-2000 Australia*, AIHW Cat. No. HOU 50,

Australian Bureau of Statistics [ABS] 1996, *Women's Safety Australia*, Catalogue No. 4128.0, Australian Bureau of Statistics, Canberra.

Bagshaw, D. & Chung, D. 2000, *Women, Men and Domestic Violence*, Partnerships Against Domestic Violence, Canberra.

Baur J. 2006, *Future migration and policing: Examining assumptions*. Australasian Centre for Policing Research Issues no. 5. Canberra: Australasian Centre for Policing Research. http://anzpaa.org.au/anzpire/acpr-publications

Boufous, S., Silove, D., Bauman, A., Steel, Z. 2005. Disability and health service utilization associated with psychological distress: The influence of ethnicity. *Mental Health Services Research.* 7(3): 171-179.

Cunneen, C. & Stubbs, J. 2002, 'Migration, political economy and violence against women: the post immigration experiences of Filipino women in Australia', in J. D. Freilich, G. Newman, S. G. Shoham & M.

Easteal, P. 2008. 'Teaching about the Nexus between Law and Society: From Pedagogy to Andragogy' 18 (1 & 2) *Legal Education Review* pp 163–172.

Edleson, J. L. 1999, 'The overlap between child maltreatment and woman battering', *Violence Against Women*, vol. 5, no. 2, pp. 134-154.

Keys, Young 1998, *Against the Odds: How Women Survive Domestic Violence: The Needs of Women Experiencing Domestic Violence who do not Use Domestic Violence and Crisis Related Services*, Office of the Status of Women, Department of the Prime Minister and Cabinet, Canberra.

Hopper, E, Bassuk, E and Olivet, J. 2010 'Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings', *The Open Health Services and Policy Journal*, Vol 3.

Laing, L, Toivonen, C, Irwin, J and Napier, L, 2010, "They never asked me about that": Stories of Women who experience Domestic Violence and Mental Health Concerns/Illness, A report from the research project: Towards Better Practice: Enhancing Collaboration between domestic violence and mental health services. University of Sydney, Faculty of Education and Social Work. http://ses.library.usyd.edu.au/bitstream/2123/6535/1/They%20never%20asked%20me.pdf

Loxton, D, Schofield, M and Hussain, R, 2006, Psychological Health in Midlife Among Women Who Have Ever Lived with A Violent Partner or Spouse' Journal of Interpersonal Violence 21, 1092.

Mouzos, J. 1999, 'Homicidal Encounters: a study of homicide in Australia 1989-1999', *Australian Institute of Criminology Research and Public Policy Series No. 28*, Australian Institute of Criminology, Canberra.

National Executive Training Institute (NETI), 2005, Training curriculum for reduction of seclusion and restraint. Draft curriculum manual. Alexandra, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental Health Planning (NTAC).

National Institute for Clinical Excellence, *Post-traumatic Stress Disorder (PTSD): the treatment of PTSD in adults and children*, March 2005, http://www.traumaclinic.org.uk/info.html

Piller, Ingrid, & Takahashi, Kimie, 2010, Language, Migration, and Human Rights *Wodak, Ruth, Paul Kerswill and Barbara Johnstone. Eds. Handbook of Sociolinguistics. London: Sage*

Rees et al, August 2011, 'Lifetime Prevalence of Gender-Based Violence in Women and the Relationship with Mental Disorders and Psychosocial Function' Journal of the American Medical Association Vol 306, No 5.

Spangaro, J & Zwi, A, 2010, 'After the Questions: Impact of Routine Screening for Domestic Violence in NSW Health Services' UNSW School of Public Health and Community Medicine http://www.health.nsw.gov.au/resources/nswkids/pdf/dvrs_doh_report_after_the.pdf

Straus, M.A. 1995. *Manual for the Conflict Tactics Scales*. Durham, NH: Family Research Laboratory, University of New Hampshire.

Sawrikar P & Katz I, 2008, *Enhancing family and relationship service accessibility and delivery to culturally and linguistically diverse families in Australia*. AFRC Issues no. 3. Melbourne: Australian Institute of Family Studies. http://www.aifs.gov.au/afrc/pubs/issues/issues3/issues3.pdf

Victorian Community Council Against Violence 2002, *Victorian Family Violence database: First Report*, Victorian Community Council Against Violence, Melbourne.

Webster, S. and Lopez, V, 2011, Using the Thai translated of 42-item Depression Anxiety and Stress Scales (DASS-42) in Thai women Community sample. Accepted for publication in Public Health Asia and Pacific Journal (in press)

Webster, S. 2009, Study presented at Diversity Conference 2008 of the first NSW Thai women study of clinical presentations to Transcultural Mental Health from 2001-2005.

Webster, S., Sweet, S. & Stolz, T. A. 1994, 'Domestic violence in pregnancy: a prevalence study', *The Medical Journal of Australia*, vol. 161, pp. 466-470