NSW Consumer Advisory Group – Mental Health Inc.
ABN 82 549 537 349

25 May 2012

Social Issues Committee
NSW Parliament
Parliament House
Sydney NSW 2000

To the Social Issues Committee,

RE: Inquiry on Domestic Violence in NSW

Thank you to the Social Issues Committee for providing NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG) with the opportunity to appear before the Social Issues Committee on the 30th April 2012.

Violence and domestic violence can have long lasting and significant impacts on a person's mental health. Our organisation is pleased to be able to provide further information to the Committee on this topic and to respond to the question on notice, which is included in the attached submission.

Thank you for considering this submission. If you have any questions please do not hesitate to contact me on 02 9332 0200 or poshea@nswcag.org.au.

Yours sincerely,

Dr Peri O'Shea
Chief Executive Officer

NSW Consumer Advisory Group – Mental Health Inc.

Further information for Social Issues Committee on Domestic Violence and Mental Illness

May 2012

This submission was compiled on behalf of NSW CAG by:

Tara Dias, Senior Policy Officer

Acknowledgements

Thank you to the individual participants who generously shared with us their experiences and insights.

We would also like to acknowledge the staff at all agencies that gave us the opportunity to consult with the individuals accessing their services.

About NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG)

NSW CAG is an independent not for profit organisation. NSW CAG receives core and project funding from the NSW Ministry of Health.

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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 peak organisation for people with a lived experience of mental illness (consumer). We work with consumers to achieve and support systemic change.

NSW CAG's vision is for all consumers to be able to participate meaningfully in society and to experience fair access to quality and recovery focused services which reflect their needs. Participation is a fundamental human right as enshrined in Article 25 of the *International Covenant on Civil and Political Rights* (ICCPR). We work from the premise that the participation of consumers results in more effective public policy and facilitates individual recovery.

Our work is guided by six principles:

- Being person centered 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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Introduction

Violence and domestic violence can have long lasting and significant impacts on a person's mental health. We appreciate the opportunity to provide further information to the Social Issues Committee, both regarding the question on notice (information about people with mental illness as perpetrators of domestic violence) as well as further information related to policies and programs.

1. Prevalence of mental illness in perpetrators of domestic violence

The Social Issues Committee stated that they had received evidence that many perpetrators of domestic violence also have a mental illness. We are aware that:

- the NSW Auditor General's Report states that 'Repeat victims and perpetrators often have mental health, drug and alcohol problems'[1]
- one report says that men experiencing depression and post-traumatic stress disorder are at greater risk of being perpetrators of domestic violence[2]
- some research has shown that people with antisocial personality disorders may be more likely to be perpetrators of violence; this same report states that further studies are required to determine whether this is a causal relationship.[3]

We believe that this research is inconclusive. We caution the Committee from viewing this research as definitive and basing recommendations from it.

In general domestic violence is grossly underreported. Researching a hidden issue means that there are limited statistics about perpetrators of domestic violence. In addition, recent theories of violence have moved away from attributing violence to a single risk factor and acknowledge that what causes people to perpetrate violence is a complex interplay of many factors.

In the face of limited, nuanced and at times contradictory evidence, we believe it is dangerous to equate violence with mental illness. This further stigmatises consumers (people with a lived experience of mental illness), many of whom already face discrimination and battle misconceptions in their communities.

We provide the following information regarding violence and mental illness to highlight the contradictions and complexities of this area.

1.1 It is a stereotype that people with a mental illness are violent

The vast majority of people with a mental illness are not violent.[4] People with a mental illness are far more likely to be victims of violence than perpetrators of violence. In direct contradiction to evidence received by the Social Issues Committee, other evidence states that most men who abuse their partners do not have a mental illness.[5]

Research shows that most acts of violence are committed by men between the ages of 18 and 30 and are more likely to be committed by people abusing alcohol and drugs.[6] For perpetrators of domestic violence, the strongest individual risk factors are drinking habits, levels of aggression and controlling behaviours.[7]

We are concerned that we have heard of a tendency among some service providers to label people exhibiting challenging behaviours (aggression, anger, controlling behaviours) as having a mental illness even if the individual hasn't received a proper mental health assessment or isn't using or used mental health services. This label can 'stick' and follow people even if it was first applied as a hypothetical label by a community services worker who has no clinical training and is not responsible for diagnosing people. We are concerned that some of the data about perpetrators of domestic violence, including evidence provided to the Social Issues Committee, reflects this practice.

In order for our communities to respond to domestic violence, we need to have a better understanding of who perpetrates domestic violence. The data that is used to inform policy and program responses needs to be reliable and this also means having clear criteria and categories. High quality data will be able to inform the development of evidence based programs that provide effective prevention and early intervention services. Furthermore, policies and programs based on the assumption that most perpetrators have a mental illness will reinforce stereotypes and stigmas in the community, and deter people from seeking the assistance that they need.

Recommendation

One: We recommend that the Committee look at ways to improve the knowledge base of who perpetrates domestic violence. We recommend that there be measures to ensure that if someone is classified as having a mental illness, that this be based on appropriate mental health assessment.

1.2 Better access to high-quality health and human services will decrease violence in our communities.

As previously discussed, it is a stereotype that people with a mental illness are violent. The risk of people with a mental illness acting in a violent way is even further reduced when people are able to access quality support services.[8] Two key issues relating to accessing services are community information about services and having enough community based services.

We frequently hear from consumers that there isn't enough information in the community about where to go to get help and that community misunderstanding about mental illness is a barrier for people when asking for help. It is our observation that this is also the case with domestic violence. Unnecessary stigma and shame keep people from getting the help they need. We believe that there needs to be more information in the community about mental health and illness and that this will promote greater understanding of the issues and supports available. Consumers have suggested that education on mental illness should be embedded in the school curriculum. A similar approach, like the one taken by LOVE BiTES, could also be taken with regard to education on healthy relationships.

In addition to access to information, we've heard that accessing services in the community is an issue. Consumers have told us that in many parts of NSW they can only access mental health services if they are in crisis. Similarly, the domestic violence sector is tipped towards responding to people in crisis rather than investing in preventative measures. Our communities would benefit from being able access early intervention and prevention services in both sectors.

We believe that the Committee should look at ways for both sectors to improve their investment in early intervention and prevention services, including community education about mental health and respectful relationships. This will have multiple benefits for communities' health and wellbeing.

Recommendations

Two: We recommend that the Committee look at ways that it can support community education programs about mental health and healthy relationships.

Three: We recommend that the Committee review how resources are allocated across the spectrum of prevention, early intervention and crisis services, and that the Committee looks at ways to increase funding available for prevention and early intervention health and human services.

1.3 Policy makers and service providers should adopt an ecological model to understanding violence.

The Ecological Model of Violence, used by the World Health Organisation, shows that there is a complex interplay between various factors when looking at the risk of becoming a victim or perpetrator of domestic violence. These include individual factors, relationships factors (with peers, intimate partners and family), the community (formal and informal social structures) and societal values and beliefs. [9]

This model shows clearly why it is important to avoid attributing violence to any one risk factor (i.e. having a mental illness). VicHealth, a leading organisation in violence prevention activities and research in Australia, states:

> It is… important to note that a number of factors contributing to violence identified in this paper (such as alcohol, illicit drug use or childhood exposure to violence) are neither necessary nor sufficient conditions for violence to occur. That is, many men affected by these determinants are not violent and these risk factors are not salient for many men who are violent. Further, as discussed throughout this paper, many of these factors become significant primarily when they interact with broader norms pertaining to gender roles and identities.[10]

This means that even if some research identifies experiencing a mental health issue as a risk factor, it does not logically follow that a person with a mental illness will be a perpetrator of domestic violence. Other factors, such as the close relationships one has in his/her life, access to supports, and societal factors (such as gender beliefs and acceptance of violence) will all play a role in determining whether or not one perpetuates violence.

This indicates a need for multi-pronged policy responses and program development to aid prevention of domestic violence, including programs and services that aim to mitigate individual, relationship, community and societal risk factors.

Recommendation

Three: We recommend that policy recommendations are based on the Ecological Model of Violence to ensure that programs target a range of risk factors (individual, relationship, community and societal).

2. Further information on domestic violence and mental health

We would also like to take this opportunity to provide further information on domestic violence and mental illness. These include: improving screening, access to services after screening; support for people after screening; cross sectoral collaboration; and the importance of participation.

2.1 Improving screening for domestic violence

In our initial submission and while giving evidence, we endorsed the work and recommendations contained in Spangaro and Zwi's Report.[11] This report showed that screening is a complex intervention and has benefits for people health services.

We continue to endorse these recommendations, particularly those on the training required for health workers who are screening for domestic violence. Often screening occurs at the time when the individual and health professional first meet. Without screening being undertaken in a respectful, open and non-judgemental manner it is unlikely that people will disclose that they are experiencing domestic violence.

Health professionals working respectfully and collaboratively with consumers is part of a recovery-oriented and trauma-informed approach.[1] Some of the principles underpinning recovery oriented mental health services are: holistic approaches, promoting self-determination, person centred approaches, collaborative working relationships between and consumers and service providers, and fostering hope. These principles are shared by Trauma informed care. In addition, trauma informed services are aware that experiences of trauma are all too common and can have wide ranging and long lasting impacts on every part of a person's life. Trauma informed services ask people what happened to them rather than pathologising them and aim to minimise re-traumatising people. Practices such as screening for domestic violence are an important part of moving towards a trauma informed system. These approaches are recognised as best practice in mental health services.

To facilitate effective screening for domestic violence, all staff working in mental health services, and services that have a higher proportion of mental health consumers, should receive training on domestic violence and trauma informed care principles.

[1] For more information about both approaches see our website at: www.nswcag.org.au and for in-depth information about trauma informed care, please Mental Health Coordinating Council's site: http://www.mhcc.org.au/resources/trauma-informed-care-and-practice.aspx

Recommendation

Four: We recommend that Spangaro and Zwi's recommendations are implemented and that special consideration is given to the training of health professionals in undertaking screening.

2.2 Access to services after screening

Another issue of concern, briefly discussed during the hearing, is that NSW Health has processes to facilitate disclosure but there are no clear referral pathways, or as noted in the NSW Auditor-General's report, there is '…no agreement over what the role of NSW Health's mental health, drug and alcohol services should be in respect to domestic and family violence beyond routine screening.'[12]

We have heard:

- from female consumers that they have disclosed to mental health workers that they are experiencing domestic violence but they were not provided with resources (such as counselling or DV specific resources)
- that for women with mental illness, who are experiencing domestic violence, the standard response from health professionals is to prescribe medication or only discuss medication needs. This overreliance on medication as a response to domestic violence has been confirmed by recent research.[13]
- from domestic violence service providers that the services offered by health can hinder rather than help, and that they prefer to access support for their clients through schemes such as the Victim's Compensation Scheme.

People need to be able to access support services after they have disclosed experiences of domestic violence. There needs to be clear agreement about who is responsible for providing these services. Given that people may be dealing with a range of issues, these services need to be provided in a holistic and integrated manner. Services need to be evidence based, and also provide longer term (post-crisis) support.

Recommendations

Five: We recommend that the Committee should examine and clarify who is responsible for providing services for people who are recovering from domestic violence.

Six: We recommend that there is greater investment in evidence based and holistic services that meet the needs of people recovering from violence in NSW.

2.3 Cross sectoral collaboration

From our conversations with consumers who have experienced domestic violence as well as discussions with mental health and domestic violence service providers, it is apparent that there is little collaboration between community service sectors, in particular between the mental health and domestic violence sectors.

The Committee should be looking at ways to strengthen cross-sectoral understanding and collaboration. There is a great deal to be gained by working together and it is essential to improving outcomes for those experiencing domestic violence.

The Committee should review the recent research by Laing, Irwin and Toivonen, which has emerged out of a project to build greater cross sectoral collaboration in NSW[2] as well as the Victorian project on cross sectoral partnerships that aimed to improve outcomes for women with a mental illness who have experienced sexual assault and/or family violence.[3]

Recommendation

Seven: We recommend that the Committee review existing initiatives in cross-sectoral collaboration and that further funding is allocated to initiatives that are working.

2.4 Participating in solutions

We are aware that the NSW Framework to end Domestic Violence is currently under review. We believe that it is essential that time and resources are allocated to ensure that survivors of domestic violence are able to participate in this process.

We believe that working with people who have a lived experience of these issues will not only lead to effective identification of policy and services issues but also to better solutions. People accessing domestic violence and/or mental health services will be able to cut through the rhetoric and give feedback about how services are working on the ground.

Due to privacy and safety concerns of people in this group, it may be necessary for consultation to be undertaken in less traditional ways than public forums. We suggest that services and advocacy groups could play a role in supporting people to have their say.

Recommendation

Eight: We recommend that the voices of people who have experienced these issues are included in the process of revising the NSW Domestic Violence Framework and that services and agencies should play a role in supporting this process.

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2 Laing, L., Irwin, J, & Toivonen, C. (2012). Across the Divide: Using research to enhance Collaboration between mental health and domestic violence services. Australian Social Work, 65(1), 120–135. DOI:http://dx.doi.org/10.1080/031240

Laing,L., Irwin, J., and Toivonen, C. (2010). Women's Stories of Collaboration Between Domestic Violence and Mental Health Services. Communities, Children and Families, 5(2), 16–28

Laing, Lesley Toivonen, Cherie. (2010). Bridging the Gap: Evaluation of the Domestic Violence And Mental Health Pilot Project -Joan Harrison Support Services For Women, http://hdl.handle.net/2123/6118

3 Victorian Government (2006) 'Building partnerships between mental health, family violence and sexual assault services' http://www.health.vic.gov.au/mentalhealth/family-violence/partnerships0706.pdf

Conclusion

The links between violence and mental health are complex and intertwined. Policy and services responses to both issues must take into account the other and collaboration between these sectors is essential.

Thank for considering this submission and its recommendations. Please do not hesitate to contact us if you have further questions.

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1 New South Wales Auditor-General (2011) Responding to domestic and family violence: Department of Family and Community Services, Department of Family and Community Services, Department of Attorney General and Justice, Minister of Health, NSW Police: http://www.audit.nsw.gov.au/Publications/Performance-Audit-Reports/2011-Reports/Responding-to-domestic-and-family-violence , p28.

2 VicHealth (2007) Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria, http://www.vichealth.vic.gov.au/Publications/Freedom-from-violence/Preventing-violence-before-it-occurs.aspx

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4 Mental Illness Fellowship Victoria and Mental Illness Fellowship of Australia Inc. (2008) 'Understanding mental illness and violence'

5 Eastern Perth Public and Community Health Unit, Department of Health, Government of Western Australia (2001) Responding to Family & Domestic Violence, 2nd Edition.

6 SANE Australia (2010) SANE Factsheet 5: Mental Illness and violence, http://www.sane.org/information/factsheets-podcasts/209-violence-and-mental-illness

7 Mitchell, L (23 November 2011) 'Domestic violence in Australia – an overview of the issues' Social Policy Section, Parliament of Australia, Department of Parliamentary Services

8 Mental Illness Fellowship Victoria and Mental Illness Fellowship of Australia Inc. (2008) 'Understanding mental illness and violence'

9 World Health Organisation/London School of Hygiene and Tropical Medicine (2010) Preventing intimate partner and sexual violence against women: taking action and generating evidence. http://www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf

10 VicHealth (2007) Preventing violence before it occurs: A framework and background paper to

guide the primary prevention of violence against women in Victoria, http://www.vichealth.vic.gov.au/Publications/Freedom-from-violence/Preventing-violence-before-it-occurs.aspx

[11] 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

[12] New South Wales Auditor-General (2011) Responding to domestic and family violence: Department of Family and Community Services, Department of Family and Community Services, Department of Attorney General and Justice, Minister of Health, NSW Police: http://www.audit.nsw.gov.au/Publications/Performance-Audit-Reports/2011-Reports/Responding-to-domestic-and-family-violence , p28.

[13] Laing et al (2010) 'They never asked me anything about that: The Stories of Women who Experience Domestic Violence and Mental Health Concerns/Illnesses' A Report from the research project: Towards Better Practice: Enhancing collaboration between domestic violence and mental health services.' Faculty of Education and Social Work, University of Sydney.