

Senate Community Affairs Committee
Commonwealth Funding and Administration of Mental Health Services

29/7/2011

Dear Senators,

Please find a submission with Appendices A & B prepared for the Senate Affairs Committee Inquiry into Commonwealth Funding and Administration of Mental Health Services prepared on behalf of ASCA (Adults Surviving Child Abuse)

For further comment or any additional information please contact Dr. Cathy Kezelman on 0425 812 1976 or by email on ckeelman@asca.org.au

Yours sincerely,

Dr. Cathy Kezelman, ASCA director

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Inquiry: Senate Community Affairs Committee into Commonwealth Funding and Administration of Mental Health Services

In releasing the budget announcements for mental health earlier this year the express focus was on *“providing more intensive support services, and better co-ordinating those services, for people with severe and persistent mental illness who have complex care needs; Targeting support to areas and communities that need it most, such as Indigenous communities and socioeconomically disadvantaged areas that are underserved by the current system.”*

In response to items listed in the terms of reference

- a) Adults traumatised by interpersonal violence/neglect in childhood often have severe and persistent mental health, as well as health, behavioural, social and/or substance abuse problems and there is copious research, national and international to support these findings.

Australia’s mental health system has a poor record in recognising the well-documented relationship between trauma and mental health issues, in general, but complex trauma in particular. There has been a lack of policy focus as to how this knowledge can be incorporated into service delivery. In fact as a group, the more than 2 million Australian adult survivors of childhood trauma have repeatedly been ignored in mental health policy reform and funding considerations and the recent mental health budget initiatives are no different.

While the express focus on mental health and increased investment committed this year are to be lauded, the needs of this group have once again been ignored. Adult survivors as a community ‘need it most’ and are chronically disadvantaged and substantially “underserved by the current system”. The continued failure to acknowledge and address the core issues of these Australians’ trauma comes at enormous cost. (See Appendix B)

The majority of the community of survivors cannot access and/or afford to sustain the holistic support they need to work towards recovery.

- b) ii) The recent change to the Better access initiative with rationalisation of allied treatment sessions further reduces access for adult survivors to skilled practitioners who can provide the often long-term expert care adult survivors with complex needs require. The capping of these services at 10 sessions/annum is blatantly inadequate for this group. Neither the additional provision of up to 50 Medicare Benefits Schedule consultant psychiatrist services per annum, nor the services offered by the specialised mental health system in each State or Territory fill that gap.

Psychiatrists approach patients with the medical model of pathology, diagnosis and treatment. That treatment often focuses on medication rather than on a therapeutic process, informed by an awareness and understanding of trauma. Specialist mental health systems similarly fail to operate from a trauma informed perspective.

- c) The provision of additional services under the Access to Allied Psychological Services program has failed to identify people with complex care needs secondary to childhood trauma as a vulnerable and hard to reach group. This group whose complex needs are often compounded by co-morbidity differs

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from those on which the system currently focuses i.e. those experiencing psychosis and mood disorders. Failure to identify the group, per say, and their particular needs means that their needs stay chronically unmet.

- d) In the case of adult survivors of childhood trauma many who have severe mental illness as a result of their trauma there is a pervasive lack of understanding about the impacts of trauma on their mental health at the core of the presentations and failure of services and systems to approach their care from a trauma informed perspective.
- e) Even though knowledge about the understanding of the biological and interpersonal consequences of childhood trauma has exploded over the past two decades, many training and treatment programs have not yet integrated the new information. Mental health training, in psychiatry, psychology, medicine, social work, counselling, nursing or other human services disciplines often does not adequately prepare health professionals to work effectively with adult survivors of childhood trauma with complex needs.
- f) Services provided within the current system for adult survivors of childhood trauma – a profoundly disadvantaged group many of who have complex needs is patently inadequate. The system often provides for short term and crisis intervention only rather than the longer term care needed for protracted recovery and is frequently re-victimising and re-traumatising

Appendix A

Prevalence of childhood trauma:

According to ABS (2005) 10% of women and 9.4% of men experienced physical abuse before age of 15. 12% of women reported that they had been sexually abused before the age of 15 compared to 4.5% of men.ⁱ

A 2007 Australian University-initiated study of over 21 thousand older Australians found that over 13% of those surveyed reported having been either sexually or physically abused in childhood or both. N.B. These figures do not include those who have been emotionally abused or neglected or forced to live in domestic violence situations.ⁱⁱ

Prevalence of mental health issues associated with childhood trauma:

In 2007 child sexual abuse was responsible for 0.9% of the burden of disease and injury in Australia in 2003.ⁱⁱⁱ N.B. These statistics relate to child sexual abuse only and do not include physical abuse, emotional abuse, neglect or the impacts of living with or witnessing domestic violence.

76% of adults reporting child physical abuse and neglect experience at least one psychiatric disorder in their lifetime and nearly 50% have three or more **psychiatric disorders**.^{iv}

Survivors of child sexual abuse accounted for 34% of all presentations across the mental health sector in 1998. (NSW Health (1998))

35% to 70% of female mental health patients self-report, if asked, a childhood history of abuse. (Briere 2004)

Background:

All trauma can invoke fear, helplessness, and horror, and overwhelm a person's resources for coping. However the trauma caused by all forms of abuse - sexual, physical and emotional including neglect and witnessing or experiencing violence is especially damaging. Often victims of abuse experience several forms of trauma concurrently. Policy and funding historically and the recent budget announcements have not/do not reflect this.

During childhood the brain grows and develops rapidly and trauma can and does impact fundamental neuro-chemical processes, and these in turn can affect the growth, structure, and functioning of the brain.

The trauma of child abuse is rarely an isolated incident. Childhood trauma is commonly repeated, prolonged and extreme, characterized by a series of traumatic events starting at a young age and disrupting the earliest of attachments. Its effects are all the more pervasive because children are young, vulnerable and developmentally immature.

Childhood trauma is interpersonal i.e. perpetrated by one human being on another, is most commonly perpetrated by adults on whom the child depends and trusts, the very adults charged with the child's care. The trauma perpetrated is also generally intentional, differentiating it from the trauma of natural disasters and separation, death and loss. For all these reasons childhood trauma is more prone to cause global consequences than trauma which is experienced in adulthood.

Complex trauma:

A diagnosis of PTSD features the triad of intrusive re-experiencing of traumatic memories, emotional numbing, including memory loss, and hyperarousal. The characterization of the impacts of childhood trauma in terms of PTSD alone and service responses based solely on the diagnosis fail to capture the often pervasive impacts of childhood trauma.

Ongoing trauma exposure in childhood and the developmental impact of such exposure typifies *complex trauma*, which features an additional array of traumatic stress challenges and can lead to lifetime patterns of fear and mistrust, impacts on personal identity and self-worth, relationships with others and with the world, emotional regulation, self-soothing and stress management, body symptoms and chronic feelings of hopelessness.

Many survivors have developed extreme coping strategies as ways of managing the impacts of overwhelming traumatic stress. Many of these strategies are adopted in childhood but persist into adult life. They include suicidality, substance abuse and addictions, self-harming behaviours such as cutting and burning, dissociation, and re-enactments such as abusive relationships.

Our service system responses need to reflect the complexity and diversity of mental health issues related to abuse (See Appendix) including to dissociation (during which one feels detached from one's mental processes or body), lack of capacity to regulate emotions and the interpersonal challenges which can arise.

Challenges of meeting the complex needs of adult survivors of childhood trauma:

Meeting the needs of adult survivors can be challenging because of the deep feelings of insecurity, sensitivity of criticism, shame and self-blame, low self-esteem, difficulties with trust and interpersonal relationships, substance abuse, self-harming, suicidal and risk-taking behaviours with which many survivors struggle.

Even though survivors may want to talk about their feelings, their own shame as well as fear of how others will respond can stop them from doing so. Child abuse, at its core, is about being and feeling unsafe and survivors try to protect themselves from being hurt again. Hence survivors will tend to withdraw, isolate themselves and not seek help. Strategies such as these combined with the symptoms of hyper-arousal or avoidance that accompany PTSD, can make it particularly hard for survivors to seek help and engage in and sustain treatment.

Fortunately survivors can and do recover. They can learn how to trust, to feel safe and relate to others, how to self-regulate. Neuroscience tells us that neural pathways can repair themselves but survivors need support, empathy, understanding and respect. Relationships are crucial to the process of recovery but the nature of those relationships that is vital. As the relationships which caused the original trauma were disempowering and controlling, relationships of care and support must challenge the beliefs created by the original trauma.

Failures of current system:

The complex needs of adult survivors are not often met by mainstream services and few specialist services exist. Survivors characteristically experience ineffective, fragmented service provision by multiple agencies over a long period of time, with frequent of oft-repeated presentations with responses which are often crisis-driven and re-traumatising. There is a systemic lack of expert long-term affordable counselling/therapy and/or appropriate groups/workshops and workforce deficiencies in both skills and capacity, with a particular lack of rural, regional, outreach services.

Survivors experience long waiting periods in the public system, lack of affordability in the private system with few community managed services available as a result of funding deficiencies. There are failures in access and equity across the board. As a result survivors currently seek help from a diversity of government, non-government and private services unable to access the skilled services they need for sustained recovery.

In recent years, cognitive-behaviour therapy, exposure and cognitive restructuring have been used extensively as evidence-based responses to PTSD. However the application of such techniques to those who have experienced complex trauma especially prior to the establishment of safety can be fraught. Working through the compounded impacts of complex trauma can take a long time and involves a number of stages including establishing safety, stabilisation, establishing a therapeutic relationship, education and skill building, processing and integration.^v The failure of practitioners, systems and governments to appreciate these complexities means that many survivors of childhood trauma do not find the care and support they need to reclaim their health and wellbeing.

Trauma survivors with complex needs often experience co-morbid mental health and substance abuse problems and a range of life burdens. These findings are supported by extensive research evidence. That is - the majority of clients presenting to mental health and AOD services have trauma histories integrally intertwined with their substance abuse and/or mental health challenges. Yet despite it being patently obvious that all three issues should be addressed in an integrated way, this rarely happens. Care for survivors with co-morbidity is often fragmented and fails to respond to their multiple needs which can include unemployment, welfare dependency, homelessness and social exclusion. A holistic approach to care and support is needed and yet to date we see little to no co-ordination between services along with poor referral and follow-up pathways.

ASCA's experience:

Every day ASCA receives calls from child abuse survivors who cannot find or afford the care and support they need. They report having experienced a health care professional who has been disempowering, re-victimising or otherwise unhelpful; a GP who was uninformed, who didn't inquire about trauma despite symptoms which were highly suggestive. A worker who didn't know how to respond to a disclosure, a counsellor, psychologist or psychiatrist they felt had minimized or dismissed their feelings and experiences rather than listening empathically and validating them.

It is staggering how often survivors are told by those in health care environments things like "It happened such a long-time ago; there's no value in talking about it. What does it matter? Stop whingeing about it." These attitudes parallel the survivor's experience of being told to keep quiet about their abuse or, on disclosure, being ignored or vilified. Some workers believe that talking about past traumas is irrelevant and self-pitying or imply that the trauma was the person's fault, that he/she is carrying on about nothing, making things up, exaggerating, or has a personality disorder.

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Reasons for failures of current response to adult survivors with complex trauma:

The current mental health system is based entirely on a medical model of pathology, diagnosis and treatment while failing to explore, acknowledge and address the underlying causes. The spectrum of presentations which occur as a result of trauma do not fit comfortably within such a model.

The research evidence in responses to complex trauma stresses the importance of understanding of what happened to the person rather than focussing on what is wrong with them. Research has also shown that recognition and integration of past trauma is fundamental to the recovery process and yet the current mental system and the bulk of health practitioners within it fail to focus on the trauma or approach individuals from a trauma informed perspective.

Frequently the possibility of underlying trauma is not on a health professional's radar at all or if known about, is not viewed as pivotal. Often it is invalidated, negated or dismissed. Such responses come at a huge cost, not just to individuals but to families and communities. ASCA witnesses that cost every day in its work.

Trauma informed care and practice:

Trauma-Informed Care and Practice is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.^{vi}

It involves a cultural and philosophical shift which changes assumptions about how we organise and provide mental health and allied services. The approach is holistic, personal, collaborative and therapeutic and incorporates a model of recovery-orientated practice

Becoming trauma-informed requires every aspect of the system and service delivery to be incorporate a basic understanding of how trauma impacts the life of individuals. Based on an understanding of the particular vulnerabilities and/or triggers that trauma survivors experience (that traditional service delivery approaches may exacerbate), these services and programs can be more supportive, effective and avoid re-traumatisation.^{vii} For adult survivors of childhood trauma who have complex needs, a trauma informed approach to care has the potential to produce markedly improved outcomes.

USA reports of a Trauma informed approach have proven them to be cost effective and to include a decrease in psychiatric symptoms, substance abuse, trauma symptoms, hospitalisation and crisis care, as well as improvement in survivors' daily functioning.^{viii}

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Appendix B – Childhood abuse – the costs

Impacts:

National and international research has demonstrated a number of adverse impacts of child abuse and neglect, many of which are associated with significant financial costs for individuals and the communities in which they live^{ix}. These include:

- future drug and alcohol abuse;
- mental illness;
- poor health;
- homelessness;
- juvenile offending;
- criminality; and
- incarceration

Social and health costs:

A 2007 Australian University-initiated study of over 21 thousand older Australians found that over 13% of those surveyed reported having been either sexually or physically abused in childhood or both. These figures do not include those who have been emotionally abused or neglected or forced to live in domestic violence situations. This study found child abuse survivors are almost two and a half times as likely to have **poor mental health outcomes, four times more likely to be unhappy** even in much later life, **more likely to have poor physical health**.

Childhood physical and sexual abuse increases the risk of having **three or more medical diseases**, including cardiovascular events in women, causes a **higher prevalence of broken relationships**, lower rates of marriage in late life, cause **lower levels of social support** and an **increased risk of living alone**, an increased likelihood of **smoking, substance abuse, and physical inactivity**^x

A 2001 study with 384 survivors of childhood abuse found that survivors of child abuse tended to be **depressed**, have **low-self esteem** and have **problems with family functioning**.^{xi}

76% of adults reporting child physical abuse and neglect experience at least one psychiatric disorder in their lifetime and nearly 50% have three or more **psychiatric disorders**.^{xii}

- **Depression:** Child sexual abuse fosters the conditions for the development of mental illness especially anxiety and depression. The most frequent symptom is depression. Adult survivors are 3-5 times more likely than non victims to experience a major depressive episode during their life

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- **Anxiety:** High levels of anxiety can result on self-medicating behaviours, such as alcoholism and drug abuse.
- **Alcohol and substance abuse:** Childhood abuse has been associated with increased risk of alcohol related problems in multiple studies. Sexually abused females in crisis centres were four times more likely to have a history of substance abuse and twice as likely to be alcoholic, than those who hadn't been abused.^{xiii}
- **Drug abuse/crime:** In one study, "Eighty-seven per cent of incarcerated women were victims of sexual, physical or emotional abuse in either childhood (63 %) or adulthood (78 %). The majority were victims of multiple forms of abuse; childhood and adult abuse were correlated with drug dependency and involvement in the sex trade."^{xiv}
- **Criminality:** One study found that 80 - 85% of women in Australian gaols have been victims of incest or other forms of abuse.^{xv} Another NSW study found that 65% of male and female prisoners were victims of child sexual abuse and physical assault.^{xvi}
- **Suicide:** young Australian survivors of child sexual abuse have a suicide rate 10.7 to 13.0 times those nationally.^{xvii} A 2010 Victorian study found that victims of child sexual assault are 18 times more likely to commit suicide than non-victims.^{xviii}
- **Self-harm:** Self-mutilation is consistently described among survivors.^{xix} (Lindberg et al., 1995) In one study, 70% of survivors with a history of CSA who suffered from anorexia or bulimia had self-harmed by overdosing, poisoning, cutting or burning themselves or by headbanging.^{xx}
- **Homelessness:** 45% of homeless young people reported sexual or physical abuse to be a major factor in leaving home.^{xxi}
- **Eating disorders:** Eating disorders, particularly bingeing and purging, has been linked to childhood sexual abuse and PTSD.^{xxii} Nearly one-half of eating disordered patients in an Australian clinic reported a history of child sexual abuse and one-quarter reported child physical abuse^{xxiii}
- **Physical health problems:** survivors of child maltreatment are at increased risk of hepatitis, diabetes, heart disease, cancer, stroke are more likely to have surgery and are at increased risk of having one or more chronic pain symptoms^{xxiv}.
- **Violence:** child maltreatment is associated with adolescent violence, adult violence toward non-familial individuals, and violence toward romantic partners.^{xxv} Interspousal violence is not only predicted by a history of physical abuse, but also by witnessing domestic violence and experiencing sexual abuse and neglect in childhood^{xxvi}
- **Intergeneration transmission:** Approximately 30 per cent of maltreated children (with a plus or minus 5 per cent error) will go on to maltreat children in some way when they are adults^{xxvii}

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- **Dissociative symptoms** have been found in adults with a history of CSA.^{xxxviii} Several studies established that 60 -83% of patients with DID have a history of sexual abuse, and in many cases, physical abuse as well.^{xxxix}
- **PTSD:** Data from a large-scale study in the USA suggests that the experience of a CSA and SA (male and female) may be more likely to lead to Post Traumatic Stress (PTS) and PTSD than other types of traumatic events. This percentage was significantly higher at 54% than the 38.8% diagnosed in men who have experienced combat (Kessler et al., 1995).^{xxx}
- **Complex PTSD:** Clinicians and researchers have suggested that a diagnosis of PTSD does not reflect the severe psychological harm that occurs as a result of the protracted, repeated trauma frequently experienced by survivors of CSA.^{xxxi} Chronic trauma can alter the victim's concept of 'self' and affect how they adapt to stressful events. Herman (2001) suggests a new diagnosis, Complex PTSD (CPTSD) to describe the symptoms of long term trauma, particularly applicable to survivors of CSA.^{xxxii}
- **BPD:** Borderline personality disorder (BPD) is characterised by distressing emotional states, difficulty in relating to other people and self-harming behaviour. Some researchers have estimated that up to 75% of individuals with BPD have experienced some degree of sexual abuse in childhood.^{xxxiii}

Economic costs:

Taylor et al.^{xxxiv} (2008) estimated that the annual cost of child abuse and neglect for all people ever abused in Australia was \$4 billion in 2007, while the value of the burden of disease (a measure of lifetime costs of fear, mental anguish and pain relating to child abuse and neglect) represented a further \$6.7 billion and could be as high as \$30.1 billion.

The report also estimated that the lifetime costs for the population of children reportedly abused for the first time in 2007 would be \$6 billion, with the burden of disease representing a further \$7.7 billion and could be as high as \$38.7 billion, including the monetary value of the pain and suffering that survivors' experience.

(N.B. This is the projected cost for children being abused in 2007 for the first time and needs to be applied to each new group each year.)

Child sexual abuse was responsible for 0.9% of the total burden of disease and injury in Australia in 2003. Ninety-four per cent of this burden was due to anxiety and depression; suicide and self-inflicted injuries and alcohol abuse.^{xxxv}

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