Senate Select Committee on Mental Health

– Joint Submission by the Centre Against Sexual Assault – CASA House and Women's Social Support Services (Social Work) at the Royal Women's Hospital, Melb. VIC.
May 2005

1) Background information:

This submission is made by the Women's Social Support Services and CASA House (Centre Against Sexual Assault), departments of the Royal Women's Hospital. The submission presents what the two departments hear from women who are victim/survivors of violence have told us about their experiences of the mental health system.

1.1 The Royal Women's Hospital

The RWH cares for the health of women and newborn babies and responds to the social and cultural diversity of all the communities we serve. Our role extends beyond the provision of clinical services to advocating changes that will improve women's health and well being.

Our Values:

- Excellence in care
- Our people
- Our women and babies
- A women's centred approach to women's health care
- Social justice
- Learning

The work of RWH

In 2003/04 RWH provided 82,000 days of care, 40% of which were in maternity care and 24% in complex neonatal care. Gynaecology accounted for 12% of care days and cancer services for 6% of care days.

RWH is the third largest provider of outpatient services in Victoria and the largest provider of public Obstetric, Gynaecology, Family Planning, Dysplasia and Reproductive Biology Services. In 2003/04 RWH provided nearly 250,000 outpatient attendances. This included Medical Outpatient appointments, allied health, education session and attendances at the Emergency Department. 36% of attendances were for an Obstetric appointment, 15% for attendance at the Emergency Department and 15% for allied Health.

Women;s Social Support Services see approximately 175 women per week. These women are attending or are inpatients in all areas fo the hospital.

CASA House has contact with thousands of victim/survivors of sexual assault each year through calls to the counseling and support telephone line, provision of crsis intervention and care at the time of immediate crisis following sexual assault and the provision of ongoing support, counseling and advocacy to victim/survivors of recent and past sexual assault.

2) Definition of Violence to be used in this submission:

The World Health Organisation's (WHO's) definition of violence is to be used:

> *"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or a community, that either results in injury, death, psychological harm, maldevelopment or deprivation."*
> (WHO, 1996 as quoted in WHO 2002:4)

The types of violence being referred to include:

- Intimate Partner Violence (also referred to as Domestic Violence)
- Family Violence
- Child Sexual Assault
- Adult Sexual Assault
- Torture and Trauma
- Trafficking

It is acknowledged that *any* experience of violence can be experienced as a traumatic event.

3) In regard to the terms of reference we would like to submit the following information for the consideration of the Committee:

3.1. Link between trauma and mental health/illness:

A number of issues have been identified in the work that both CASA & WSSS undertakes with individuals who have experienced any sort of violence, and who may also experience difficulties with their mental health. Significantly, the possible link between the **trauma** that has been experienced and the possible **impact** on the individual's mental health is often not identified, or minimised, by the mental health services involved.

There is also much anecdotal evidence which questions the capacity of some of those who work in the mental health system to be able to identify and/or assess and discuss trauma and its possible impact on the individual.

This includes, for example, individuals who are refugees and/or asylum seekers who may have experienced torture and trauma in their country of origin; women who are victim/survivors of domestic/family violence; women and men who are victim/survivors of either child or adult sexual assault; and/or women/girls who have been trafficked for the purposes of prostitution.

There has been significant research linking mental health issues to childhood abuse (see for example Herman, 1992; Brier 1992; Salter, 1995; Van der Kolk, McFarlane, Weisaeth, 1996), despite difficulty in accounting for the causal relationship between the two (Hawthorne, McKenzie, Dawson, 1996). *"In the clinical literature, depression is the symptom most commonly reported among adults molested as children"* (Browne and Finkelhor, 1986, in Briere, 1992, p. 29).

Most psychiatric disorders among women arise during the childbearing years (Austin & Mitchell, 1998). The specific issues for pregnant women with a mental illness are complex and little is documented about working with these women during pregnancy to ensure that they have the support needed. The increased likelihood of post-natal depression when a woman has a history of trauma is often over-looked. There appears to be a lack of acknowledgment that trauma and/or mental illness will potentially be triggered by any medical procedure or consultation.

There are numerous examples of research which indicates the increased likelihood of women who have experienced violence experiencing symptoms of depression. For example, research undertaken in Australia in 1999 demonstrates the prevalence of depression amongst women who have experienced abuse. It was found that just under half (47.6%) of the women in these studies suffered from clinical depression, as compared to 10-20per cent of women in the general community. "*Abused women were three times as likely as non-abused women overall to be diagnosed as depressed."* (Taft, 2003:7)

Through our work at both CASA House and WSSS we have worked with many clients who have been labelled with a variety of mental health diagnoses. According to Herman (1992), *"The mental health system is filled with survivors of prolonged, repeated childhood trauma. This is true even though most people who have been abused in childhood never come to psychiatric attention"* (pg.122).

In many cases, clients report to us that they have attempted to disclose to professionals in the mental health system the sexual assault which has been perpetrated against them in childhood and adulthood. Many have stated that the impacts of abuse have not been acknowledged or taken seriously by mental health professionals, and their experiences have been minimised and/or are seen as irrelevant by workers in the mental health system.

The anecdotal information we present to you has been reflected in recent Australian studies which focused on the experiences of women who had experienced abuse and been linked into the mental health system (Davidson, 1997; Hawthorne, McKenzie & Dawson, 1996; Graham, 1994). These studies were undertaken predominantly in mental health services. Only one of these studies included women from a sexual assault service and they formed less than a third of the sample (Graham, 1994).

We have come into contact with victim/survivors who have expressed that they have been previously unable to talk of the abuse they have experienced. This has been explained academically because, *"certain violations are too terrible to utter aloud"* (Herman, cited in, Breckenridge 1999; 6). Further, it has been our experience as sexual assault workers, that victims are also silenced by professions, "*in relation to domestic and sexual violence, subjugation occur(s) when professional 'knowledge', and their ways of talking about violences…, are privileged over the knowledge that the victims hold about their experience"* (Breckenridge, 1999;7/8).

Victim/survivors who have accessed both services have in many cases, either had an extensive history in the mental health system and/or may be currently linked into the mental health system. There are a myriad of diagnoses that these victim/survivors have listed including: depression; post traumatic stress disorder; eating disorders; schizophrenia; borderline personality disorder; anxiety disorder; and dissociative disorder. The impact of childhood sexual abuse can be complicated by the responses that individuals receive from the mental health system. According to Herman (1992), *"Survivors of childhood abuse, like other traumatized people, are frequently misdagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete"* (pg.123).

According to Herman (1992), 'empowerment' is the first principle of recovery from trauma, and, *"No intervention that takes power away from the survivor can possible foster her recovery, no matter how much it appears to be in her immediate best interests "* (Herman, 1992; 133).

- **Some examples of practices in the mental health system that undermines victim/survivors control over the situation and/or ability to deal with the impact of the assault:**

Victim/survivors have talked to counsellor/advocates and/or social workers about admissions to the mental health system which have involved them being "held down and physically restrained". Women have told of how this has triggered flashbacks of previous abuse and hence their behaviour as a consequence, has been construed as extreme by the health professionals involved, intensifying the inappropriate response provided.

Often it is the case that victim/survivors who have experienced sexual abuse, or violence *per se*, have not been offered information regarding their legal and/or medical options. According to these women this has been because it has been thought by the mental health practitioners involved that they were 'psychotic' and therefore the abuse must not have occurred.

In some cases women have described instances whereby mental health practitioners have tried to force victims of recent assault to have a medical to 'check' if they've been abused. This level of disbelief and questioning of the woman is not acceptable. If a victim/survivor who is a patient is unable to give consent – due to the impact of the trauma - or does not consent to a medical check up, yet is forced to do so, this is potentially going to be experienced as another form of assault.

Many of these actions are viewed as a violation of individual human rights and dignity.

3.2. Particular Areas of Concern include responses provided to:

- **Culturally and Linguistically Diverse Communities**

The Australian health system has largely failed to adequately understand and respond to the needs of CALD communities, with major problems identifying and treating mental illness among Australians from non majority cultures (Pitscitelli, 2004).

CALD groups are often under represented in prevention programs and over represented in crisis services including having longer stays in hospital and more involuntary admissions into mental health services. The recent controversy surrounding the deportation on an Australian Citizen who was born overseas who was mentally unwell at the time, highlights the often total lack of understanding and/or appropriate responses being provided. The use of fully qualified interpreters is vital in being to communicate effectively with people whose 1st language isn't English. This highlights the need for system changes and models of care that incorporate diversity.

- **Indigenous Community**

Indigenous women continue to be over represented in all risk groups with high levels of unmet need. While data is generally inadequate, available evidence indicates that Aboriginal people suffermental health problems such as depression at a much higher rate compared to non Aboriginal people, that rates of self harm and suicide are higher, and that substance abuse, domestic violence, child abuse and disadvantage contribute additional risk factors (P. Swan & B. Raphael, 1995 Ways Forward, Commonwealth of Australia).

Resources are required to ensure service models are responsive and culturally appropriate for this community, which includes self determination and Aboriginal control over service development and provision.

- **Individuals with a Disability**

It is important to note that women with disabilities are not a homogenous group and that within this 'grouping' of women there are women of all sorts of backgrounds and experiences, as with women generally in society. It is necessary to note that the needs of women with an intellectual disability or an acquired brain injury are likely to be different than those of women with sensory, physical or multiple disabilities. Women who have chronic health problems, such as terminal cancer, for example, also have specific needs as identified by the NHMRC in their publication Clinical Practice Guidelines For The Psychosocial Care Of Adults With Cancer .

In 2003 the report, '*Triple Disadvantage – Out of Sight, Out of mind,* produced by the Domestic Violence and Incest Resource Centre (DVIRC) referred to the '***triple disadvantage'*** of being a woman, having a disability and of being a survivor of violence. (Jennings, 2003) The report highlights that women with disabilities are often viewed as 'just the disability' on medical grounds, and that they are often discriminated against on the basis of their gender as well as their disability i.e.: a '*double disadvantage'* . (ibid) In one case recently a woman who identified as deaf, told of being an inpatient for 10years and of being treated appalling re: her experiences of sexual assault.

It is noted that violence against women with disabilities can be both 'individual and systemic' with some forms of abuse occurring exclusively against women with disabilities. This is identified as including forced sterilisation or forced abortion; withholding access to necessary aides, such as a wheelchair; and failing to provide sex education. (ibid) According to the report, this '*failure to provide'* places the woman in an increased position of vulnerability by limiting her access to the right 'language' to identify the abuse and describe what has happened to her. The situation is further compounded by the myth that women with disabilities are asexual.

3.3. Model of Service Delivery:

We would argue that the appropriate model of service delivery for women with mental health needs is a rights-based, social model of health which allows interventions on a continuum from provision of practical support to secure housing or other needs, counseling and advocacy, therapeutic approaches such as group work through to psychiatric interventions and medication. The current Western model of service delivery is not easily accessible or appropriate for Indigenous communities or many CALD communities.

We would advocate that accountability is paramount, and that transparency in processes is vital. The safety of women is also of primary concern due to the increased likelihood of women being re-traumatised in the current system.

There is often a lack of communication and collaborative work between organizations involved in individual's care. For example, often psycho-social services in the field are not aware of the plan of the mental health case-manager, who often has also not communicated this to the hospital. There have been cases recently where the responsibility for discharge planning of womenis left with the hospital Social Worker, as opposed to being a joint collaborative effort of all involved. The result of this, on occasion, has been the woman ending up in a crisis, and a child protection notification being required postnatally.

An example of where collaborative working relationships have been effective is the relationship between the Royal Womens' hospital and the Royal Melbourne hospital in regard to sexual assault. Recently RMH inpatient psychiatric services called CASA when a woman, who had been a victim/survivor of recent sexual assault and had experienced a psychotic episode as a result, was well enough to be seen. A CASA counselor/advocate was able to do an outreach visit to see the woman and provide here with information around her rights/options after she had received the appropriate medical required. This is an example of collaboration which is too rarely seen.

3.4. Issues with Mental health facilities:

Currently there is no option of female only psychiatric wards. Given the prevalence of women who are psychiatric inpatients, who may also have been sexually assaulted at some point in their lives, this issue is viewed as being a major priority. As it is recognised, that the vast majority of perpetrators are male, it makes sense that these women would not feel safe in a ward with both genders.

The situation in regard to women's safety being compromised when inpatients is compounded by the fact that toilets and showers are often shared in psychiatric facilities/wards. This is viewed as highly disrespectful, as even in primary schools children have separate facilities. In addition currently there is no choice available to women in the public system with regard to the gender of their treating doctor,
psychologist or case worker.

The 'fish bowel' lay-out of most common areas in psychiatric facilities whereby staff are encased in glass offices looking out, 'monitoring' inpatients, is viewed as being totally unacceptable and a violation of individual human rights and dignity.

To date there has been little research on these issues and the impact that this has on women. At the moment we have only the valuable anecdotal evidence from the numbers of women who have shared their stories with us.

3.5. Rights of Consumers of Mental Health Services:

The majority of women worked with at CASA and WSSS have described experiences within the mental health system that we view as a violation of individual human rights and dignity. There needs to be an increase in the funding provided to the Mental Health Legal Service and other community advocacy/rights-based services, including consumer/advocates.

3.6. Training and education

Increased training needs to be provided specifically on the links between violence, trauma and mental health issues to all health professionals who work in the field. This could be done on a collaborative arrangement with services with expertise in responding to violence sharing their experience and learning from mental health professionals.

Training and education is one possible way of enhancing communications between the different sectors and encouraging a collaborative and planned approach to ensure that those who have experienced the trauma of violence are provided with a safe environment in which to seek support receive an appropriate response to disclosures.

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on behalf of Maria Vucko, Helen Makregiorgos, Sam Clavant and Maura Bevilacqua.