The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Department of Social Services

Consultation on the Second Action Plan under the National Plan to End Violence Against Women and Children 2022-2032

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RANZCP Feedback on the 2nd Action Plan

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Royal Australian and New Zealand College of Psychiatrists submission

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for training, educating and representing psychiatrists in Australia and New Zealand. RANZCP has more than 9000 members, including around 6500 qualified psychiatrists.

Recommendations

RANZCP recommends that the Second Action Plan:

- Prioritises the safety, health and wellbeing of victim-survivors at all times.
- Forefronts mental health as a priority for addressing domestic, family and sexual violence.
- Integrates training to identify and appropriately respond to domestic, family and sexual violence across all levels of the frontline workforce and contact systems.
- Commits the Government to developing and publicly funding specialised DFSV mental health services that recognise the gendered nature of violence.
- Improves availability and equitability of community mental health services to early intervention avenues and ongoing support to victim-survivors.
- Acknowledge that any child who is exposed to DFSV should be treated as a victim-survivor and ensure that they receive age-appropriate support.
- That culturally safe services codesigned and coproduced with Aboriginal and Torres Strait Islander communities and stakeholders are available across the lifespan.
- Develops community mental health services to address the use of violence driven or exacerbated by mental ill health.
- Establish psychosocial supports to address the sociocultural drivers of male violence.
- Commit to enhancing holistic support by co-locating services and working to guide the development and implementation of multi-agency risk assessment and monitoring tools across the States and Territories.

Introduction

Domestic, family and sexual violence (DFSV) has a proven impact on acute and long-term mental health. Mental health needs to be at the forefront of the Action Plan and integrated into every level of implementation. Identifying the mental health impact of DFSV and providing effective, ongoing supports should be central to all DFSV responses.

Victim-survivors can experience mental health impacts such as suicidality, post-traumatic stress disorder, major depressive disorder, eating disorders, problematic substance use, chronic pain, generalised anxiety disorders and panic disorder.[1-3] These impacts can be felt across the lifespan.[4]

DFSV can impact anyone but it is an inherently gendered issue, with most victim-survivors being women, and most users of violence being men.[1] Certain communities have increased vulnerabilities, such as Aboriginal and Torres Strait Islander peoples, LGBTQIA+ individuals, members of multicultural communities, young people, and those with mental and physical disabilities.[1]

Because of the extensive mental health impacts of DFSV it is crucial that specialised mental health supports are developed for, and available to, victim-survivors. It is important that these services are designed to provide trauma-informed care which minimises the chance of re-traumatisation and promotes

recovery by embedding sensitivity to the unique requirements of victim-survivors at all service levels.[5] Currently, service responses are largely focussed on symptom reduction and distress alleviation in the acute phase.[6] Long term services to help victim-survivors navigate the ongoing impacts of DFSV need further research and investment. Furthermore, ongoing supports are largely provided via the private sector which reduces the equitability of access.

Prevalence and data gathering

One of the key activities from the First Action Plan is to develop a nationally consistent process for information sharing, monitoring and data gathering regarding DFSV services, and prevalence data is openly available via the Australian Institute of Health and Welfare.[7, 8] However, there is an over emphasis on the results of the Australian Bureau of Statistics' Personal Safety Survey (PSS) through our national DFSV data processes which distorts the landscape of DFSV.

The 2021-2022 PSS results show a consistent longitudinal downward trend in instances of DFSV. However, more recent data does not support this trend, and instead shows an increase in violence. New South Wales' BOSCAR data shows an increase in instances of violence and women murdered by partners, Western Australian police note an increase in DFSV reports, and the Australian Institute of Criminology reports show a general increase in women killed by their partners in the last few years.[9-11] Our members have also reported an increase in DFSV related clinical interactions.

Whilst there is an overarching downward trend in DFSV over the past 30 years, current data shows Australia is in a concerning spike. This spike is not addressed in the consultation paper due to its reliance on the PSS data from 2021-2022, and any developed Action Plan should clearly address this immediate trend.

The College also has additional concerns regarding the PSS, due to its smaller sample size and changed methodology from the previous survey. Furthermore, it was undertaken during and immediately after the COVID-19 pandemic, forcing respondents to answer while in close and/or inescapable proximity with the people that may have been abusing them. As such the results should be understood in the context of these methodological concerns.

Priority area 1: Victim-survivors

All actions to address domestic, family and sexual violence must have the safety, health, and wellbeing of victim-survivors as the paramount concern and priority.

Currently, victim-survivors are more likely to seek health services such as community health, emergency departments, or frontline medical help (such as through GPs) as opposed to specialised mental or DFSV support services.[12, 13] Evidence shows that dedicated mental health support services uptake is low amongst victim-survivors – with fears about disclosure and lack of holistic support, as well as cost and confidentiality being barriers.[12] To improve ongoing victim-survivor recovery and wellbeing the Action Plan needs to address the low uptake of specialist mental health support. RANZCP recommends two key actions to address this low uptake.

Increased integration of mental health supports across systems.

The Action Plan should support governments to provide frontline workers with training to identify and respond to the mental health impacts of DFSV as early as possible. The World Health Organisation's

LIVES framework provides an evidence-based approach for recognising and responding to DFSV, including risks of self-harm and suicide.[14]

Develop and provide specialised DFSV mental health services.

The Action Plan should commit to developing and publicly funding specialised, trauma-informed mental health services for victim-survivors of DFSV. These services must be culturally safe, integrated with other support services, accessible to all who need them, and supported by funding arrangements that enable effective long-term care.

Priority area 2: Prevention and early intervention

Early intervention depends on strengthening frontline capacity to identify and respond appropriately to DFSV. Initial contact between victim-survivors and service providers can significantly influence whether people access ongoing support.[15] When health, social and justice services can recognise people experiencing, or at risk of experiencing, DFSV, they can provide information and support at first contact. Training that builds effective listening skills, reduces stigma, judgement and isolation, and addresses immediate safety concerns can help victim-survivors access support that meets their needs and reduces barriers to help-seeking.[14] RANZCP supports the use of the WHO's LIVES principles as a framework for engaging with victim-survivors.

Community health services play a vital role in prevention, early intervention and responding to DFSV. People experiencing DFSV may feel isolated, ashamed, or unsure whether what they are experiencing is abuse, making it harder to seek help. These factors can also affect whether a person acknowledges that they are experiencing DFSV by creating circumstances where abuser's perspectives dominate.[16] Accessible community health services, with staff appropriately trained to identify and respond to DFSV, and with integrated mental health supports, can reduce the impact of these factors, and help to provide information for available support services.

The Action Plan must integrate these mental health focussed initiatives to effectively advance prevention and early intervention efforts.

Priority area 3: Children and young people in their own right

The impact of DFSV on children and young people's mental health is well established.[17, 18] There is also growing evidence of the intergenerational transmission of violence, with children who grow up experiencing DFSV having an increased risk of experiencing it in adulthood, or developing into a user of violence.[15] The acute and ongoing impacts of DFSV within a child's immediate environment make children a victim-survivor in their own right, rather than simply a witness or bystander. The Action Plan should clearly acknowledge that any child who is exposed to DFSV should be treated as a victim-survivor and receive the appropriate support.

The key to the Action Plan improving outcomes for children and young people is to ensure that support services and systems developed for adult victim-survivors are appropriately adapted to their needs. Health, social, education, and justice services must ensure that age-appropriate services are provided to children both as part of a broader familial care plan, but also for them as individuals separate from any other victim-survivors.[19]

Care must be taken in the development of any plans to address DFSV related to Aboriginal and Torres Strait Islander children and young people. The legacy of the Stolen Generations increases the likelihood of trauma, and First Nations children and families are overrepresented in out of home care and Child Protection statistics.[15] Any services designed for First Nations children must be codesigned and co-developed with Aboriginal and Torres Strait Islander communities and stakeholder organisations.

Priority area 4: People who use violence

While mental ill health is not always a primary cause of DFSV, many users of violence may experience mental health conditions, substance use issues, or suicidal ideation that requires appropriate intervention. Although prevalence data varies across research, one study found that in perpetrators of domestic and family violence homicides, there was a history of mental health issues (33.3%), problematic substance use (50.4%), suicidal ideation (17.1%) and suicide attempts (13%).[20, 21]

Effectively treating and managing these mental health conditions may be an important but often overlooked way to help prevent violence and offending.[22] Expanding community mental health services to increase accessibility for those at risk of using violence may help to reduce use of violence. Increasing community mental health services is an important part of mitigating the individual psychological drivers of DFSV but efforts are also needed to address the socio-cultural and economic drivers of offending.

Many intervention opportunities are only able to reach those who have already used violence and are in contact with the justice system or social services.[15] Direct help seeking is rare.[15] Increasing training for frontline service providers to identify those at risk of using violence and appropriately intervening can help to alter trajectories. However, whole-of-population primary prevention activities which address harmful forms of masculinity, misinformation, and stigma or provide positive opportunities for social inclusion are the most promising way to prevent the use of violence.[15] The Action Plan must include actions to develop these psychosocial interventions.

Priority area 5: System integration and workforce

Services are currently fragmentary and siloed, and do not collaborate effectively to provide holistic DFSV support. Improved reporting, information sharing, and referral pathways are required in every jurisdiction at every level. DFSV is often associated with social isolation, economic distress, and housing instability which all drive negative mental health impacts in victim-survivors. One clear solution, outlined in the literature, and which the RANZCP supports wholeheartedly, is the co-location of services.[12, 14, 23] Reducing the physical and organisational burden for victim-survivors to receive holistic wrap-around supports increases effective responses and increases service usage.[14] The Action Plan should contain a clear commitment and roadmap for Federal Government guidance and a commitment to dedicated funding arrangements for States and Territories to develop these co-located integrated services.

Service collaboration and integration can be improved by advancing the development and rollout of multi-service DFSV risk and management systems. Systems such as Victoria's Multi-Agency Risk Assessment and Management (MARAM) and South Australia's Multi- Agency Protection Service (MAPS) facilitate ongoing monitoring and intervention efforts. As part of the Action Plan, a review and assessment of the efficacy of these systems can provide a much-needed understanding of how to ensure that victim-survivors are being appropriately identified and supported throughout the various support services. The results of this review can be used to develop clear Federal guidance for the design and implementation of these kinds of systems in all jurisdictions.

Conclusion

Addressing DFSV is a complex and ongoing process, and the above recommendations are just some of the priority ways RANZCP believes the Action Plan can have an impact. The details and recommendations in this submission were developed in close consultation with RANZCP members and committees, such as the Family Violence Psychiatry Network Committee and Faculty of Forensic Psychiatry Committee. These members have clinical and academic experience and expertise related to DFSV and mental health.

RANZCP welcomes the opportunity to further engage directly with the Department of Social Services and the Australian Federal Government. If you have any questions about the details in this submission or would like to engage the College to provide more in-depth consultation, please contact Felicity Loxton, Executive Director of Policy and Advocacy, via policy@ranzcp.org.

Selected RANZCP DFSV resources

RANZCP has numerous resources publicly available regarding the interaction between domestic, family and sexual violence (DFSV) and mental health. Further resources are available via our publication library.

- Family and Domestic Violence information page
- Position Statement 102: Family violence and mental health
- Submission to the Inquiry into the relationship between domestic, family and sexual violence and suicide
- Submission to the Inquiry into Family Violence Orders
- Submission to the South Australian Royal Commission into Domestic, Family and Sexual Violence
- Submission to the Victorian Inquiry into Capturing Data on Family Violence Perpetrators in Victoria.

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