National Mental Health Commission submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Family, Domestic and Sexual Violence

Introduction

Domestic, family and sexual violence (DFSV) can have significant and long-lasting impacts on mental health and wellbeing. While DFSV can happen to anyone, this kind of violence is experienced primarily by women, in the home and perpetrated by someone they know (likely a current or ex-partner).[1] Global prevalence studies have indicated that women who have experienced intimate partner violence are almost twice as likely to experience depression and women who have experienced non-partner sexual violence are 2.6 times as likely to experience depression and anxiety.[2]

In Australia, the impacts of domestic violence contribute significantly to the overall disease burden. In 2015, the largest contributor to the disease burden due to domestic violence was mental health conditions, including; depressive disorders (43%), anxiety disorders (30%) and suicide and self-inflicted injuries (19%).[3] Aboriginal and Torres Strait Islander communities also experience DFSV at significantly higher rates than the general population.[3] Additionally, children who are exposed to DFSV are at an increased risk of developing mental health issues as well as developmental, behavioural and learning difficulties.[4]

In light of these statistics, the intersection between domestic violence and mental health is clear, with DFSV impacting on the ability to achieve public mental health objectives. Despite this, there is typically limited capability across mental health and DFSV services to effectively respond to both issues.[5] Similarly, there has been limited coordinated effort or approach at the national level in addressing the needs of women dealing with mental illness and domestic violence.[6] While partnerships or collaborations between the DFSV and mental health sectors may be occurring within pockets at the jurisdictional level[6], at the national level efforts are unclear and inconsistent.

Since its inception, the National Mental Health Commission (NMHC) has recognised the importance of social determinants as a driver for mental health (as reflected in the NMHC Contributing Lives Framework). It has emphasised the need for coordinated and combined efforts across a range of systems and from all levels of government to address the social and cultural determinants of poor mental health and suicidality, including domestic and family violence and childhood trauma.[7]

Through this lens, the NMHC acknowledges DFSV as a symptom of broader systemic sexism and gender inequality and therefore emphasises the need for a primary prevention approach as a crucial means of reducing DFSV and mental health issues. This means addressing DFSV by starting with underlying issues around gender norms and acceptability of violence against women.

Submission outline

The NMHC welcomes the opportunity to provide a submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Family, Domestic and Sexual Violence. This submission will outline an approach that encourages greater coordination and partnership between the mental health and DFSV systems and sectors at the national level, in doing so taking a whole-of-government, whole-of-life, cross-sector approach. DFSV and mental health are interrelated issues that require a joint response across sectors. This collaboration needs to be underpinned with a trauma-informed approach that does not pathologise women for experiencing adverse reactions to violence.

This submission will use the term domestic, family and sexual violence (DFSV), in line with inquiry language, as an umbrella term to broadly refer to a range of types of violence commonly used against women and children, except where using this term would misrepresent the data source cited. However, the NMHC notes that intimate partner violence is another commonly used term to describe violence used by current or ex-partners in an intimate relationship. In addition, the NMHC acknowledges that family violence is the preferred terminology for Aboriginal and Torres Strait Islander people.[3]

About the National Mental Health Commission

The National Mental Health Commission (NMHC) was established in 2012 and is an independent executive agency in the Australian Government Health Portfolio. The NMHC is a listed entity under the *Public Governance, Performance and Accountability Act 2013* with the NMHC's purpose set out in clause 15 of Schedule 1 of the *Public Governance, Performance and Accountability Rule 2014*.

The NMHC's purpose is to monitor and report on investment in mental health and suicide prevention initiatives; provide evidence-based policy advice to Government and disseminate information on ways to continuously improve Australia's mental health and suicide prevention systems; and act as a catalyst for change to achieve those improvements. This includes increasing accountability and transparency in mental health through the provision of independent reports and advice to the Australian Government and the community.

Section 1: Responding to the terms of reference

This submission will respond specifically to the below listed terms of reference:

a) Immediate and long-term measures to prevent violence against women and their children, and improve gender equality.

b) Best practice and lessons learnt from international experience, ranging from prevention to early intervention and response that could be considered in an Australian context.

c) The level and impact of coordination, accountability for, and access to services and policy responses across the Commonwealth, state and territory governments, local governments, non government and community organisations, and business.

d) The way that health, housing, access to services, including legal services, and women's economic independence impact on the ability of women to escape domestic violence.

f) The adequacy of the qualitative and quantitative evidence base around the prevalence of domestic and family violence and how to overcome limitations in the collection of nationally consistent and timely qualitative and quantitative data including, but not limited to, court, police, hospitalisation and housing.

i) The impact of natural disasters and other significant events such as COVID-19, including health requirements such as staying at home, on the prevalence of domestic violence and provision of support services.

a) Immediate and long-term measures to prevent violence against women and their children, and improve gender equality.

Prevention approach

The NMHC recognises that primary prevention is a key measure to reduce violence against women and their children, and improve gender equality. The NMHC welcomes a primary prevention focus in the Fourth Action Plan under the National Plan to Reduce Violence against Women and their Children and the National Framework for the Prevention of Violence against Women and their Children. The NMHC would like to see a scale-up of this focus across governments with greater alignment to evidence-based principles as well as the strengthened involvement of the mental health system in partnership with the DFSV and other related sectors.

The health system (including the mental health system) has been acknowledged as well placed to contribute to prevention efforts in the DFSV space.[8,9] Given the intersection of DFSV and mental health, the NMHC considers primary prevention measures as not only preventing violence and improving gender equality but as a crucial element in supporting greater mental health and wellbeing for all Australians.

Research on DFSV prevention measures has provided clear guidance on best-practice principles. A summary of these include:

- measures that are broad reaching, long term and strategic
- measures that are holistic and recognise the complexity and interplay across services, sectors and systems[8]
- a variety of prevention strategies carried out in unison, including strategies that target specific settings and groups[10]
- multisector programs that engage multiple stakeholders[11]
- monitoring and evaluation of prevention measures as essential to inform what is and isn't working[12]
- investment in new and innovative programs[8]
- research-activist collaborations[8]
- health sector leadership[8]

The Australian Government is uniquely placed to take a leadership role in primary prevention in order to ensure the consistent implementation of these principles at the national and jurisdictional level. This was recommended in the Senate Committee Report on Domestic Violence in Australia (Senate Committee)[10] in 2015, in the form of developing, funding and implementing primary prevention programs (i.e. develop best practice standards, tools and guidelines, measure progress, support design and delivery of evidence-based programs), as was a scale-up of work in this area

across governments. The report noted that a lack of evaluation of prevention programs had made it difficult to scale-up efforts and implement programs more broadly.

The report also noted a need for greater investment in primary prevention. This is in line with research demonstrating the need to match investment to the impact on health as a result of violence.[12] The tension between funding crisis and response efforts, which appear more urgent and visible, versus prevention measures, which influence change in less obvious ways, has contributed to this lack of investment. Dual investment in response and prevention measures is necessary until the demand for response services reduces. However, it is vital that while women and children continue to need response services that they are made available.[10]

The NMHC would also like to note the importance of the involvement of women's organisations in the design and implementation of prevention programs.[8] These organisations have continuously advocated for recognition of DFSV as a social and public health issue[9] and should continue to lead the way as experts in this area.

Prevention measures

A key long-term prevention measure requiring further attention is the transformation of the social systems and structures that maintain gender inequality, this includes increasing efforts to actively challenge these systems and structures.[13] The NMHC views this as a crucial measure with the effects of gender inequality having widespread impacts. These impacts are experienced beyond the family and home environment with research highlighting one example as the differential treatment received by women in mental health settings.[14]

The NMHC supports a public health approach to challenge these systems and structures. This approach takes a broader stance and is underpinned by an acknowledgment that DFSV is a result of multiple determinants that perpetuate discrimination against women such as gender roles, social norms in relation to violence against women and access to services and supports.[10] The evidence base for changing the wider social context is clear and has been established as an effective strategy in reducing violence against women and their children.[8,12]

Another prevention measure needing further attention is the investment in and development of the prevention workforce, who face significant workforce shortages.[13] The NMHC notes that this investment and development should include an emphasis on the mental health workforce, who are well placed to contribute to prevention efforts.[8]

A key segment of the mental health workforce is the peer workforce. Peer workers apply their personal lived experience of mental illness and recovery in supporting mental health consumers and carers. This includes peer workers with a lived experience of DFSV. This perspective takes a social justice stance and provides a trauma-informed alternative to the biomedical model. Research has demonstrated that compared to biomedical approaches, broader social and public health approaches are more effective in supporting women to disclose their experiences of violence.[12,15]

The peer workforce is growing significantly, and is increasingly valued across government and the community sector for contributing to better outcomes for consumers and carers.[16] Consideration should be given to what role the mental health workforce and in particular, peer workforce could play in the development of the prevention workforce as a key prevention measure.

The inclusion of the peer workforce in prevention efforts could also assist in increasing a collaborative approach across the mental health and DFSV sectors. The NMHC notes current

concerns that if a trauma-informed approach is not taken when addressing mental health in relation to circumstances of DFSV, there is a risk of pathologising women. This can significantly impact on a women's perceived credibility as well as her standing in relation to child custody rights.[5,6] The utilisation of the peer workforce could work to mitigate some of these risks, as would taking a trauma-informed approach in general.

Social workers form another key segment of the mental health workforce and are often employed across domestic violence and mental health services.[17] Similarly, this workforce also emphasises trauma-informed care.[18] Investment in this workforce's capability would further mitigate risks and assist in prevention efforts across sectors.

b) Best practice and lessons learnt from international experience, ranging from prevention to early intervention and response, that could be considered in an Australian context.

Research has demonstrated that best practice should combine multiple approaches across multiple sectors.[8] There are a number of examples of collaborations between the mental health and DFSV sectors, both locally in Australia[6] and internationally,[19] that could be examined for adaptability to the broader Australian context.

The Domestic Violence and Mental Health Policy Initiative (DVMHPI) is one innovative example. DVMHPI was first established in Chicago, Illinois in 1997 and has since expanded its efforts nationwide, setting up the National Center on Domestic Violence, Trauma and Mental Health through a grant provided to the project. The primary objective of the DVMHPI project was to develop models that integrate clinical and advocacy concerns collaboratively across a network of community based mental health, domestic violence, substance use and other social service agencies and government officials with an emphasis on the impact of trauma.[5]

Evaluation of the DVMHPI project does not appear to be publicly available. Nonetheless, the projects expansion into a national center, along with the sizable number of cross sector organisations involved[19], suggest this is an innovative example offering insight into what such a collaboration between the mental health and DFSV sectors could look like.

An Australian state based initiative; the Building Partnerships between Mental Health Services, Family Violence and Sexual Assault Services project (Partnerships Project) was conducted by the Mental Health Branch of the Department of Human Services (now Department of Health and Human Services Victoria). The Partnerships Project aimed to inform collaborative and integrated partnerships between sectors in particular at the service level. The project consulted across DFSV and mental health services resulting in a number of recommendations to increase coordination and collaboration including the development of local cross-sector protocols, tools and processes and increased cross staff forums and training.[6] This initiative could be used as the foundation to conduct further consultations to inform what is currently happening across jurisdictions and how best to increase collaboration at the national level.

A more recent initiative is the 'Nurturing Non-violence' research project by Sydney University commissioned by NSW Health. The project currently underway will examine the benefits of a multi-disciplinary wrap-around approach, involving the coordination of multiple services with survivors of domestic violence. The outcomes of this research project will provide a valuable example to further inform cross-sector collaboration in the DFSV space.

c) The level and impact of coordination, accountability for, and access to services and policy responses across the Commonwealth, state and territory governments, local governments, non government and community organisations, and business.

As previously stated, an integrated, cross-government, cross-sector response is needed to address DFSV. This will require a sustained effort at all levels of government as well as non-government and community managed organisations and business.

The NMHC has previously recommended the creation of a single central government agency to coordinate and oversee a cross-portfolio and whole-of -government approach to mental health policy.[7,20] A coordinated cross-portfolio approach to mental health is essential to adequately address the impacts of the social determinants of mental health, and ensure mental health promotion and prevention is effective across government portfolios, including social policy and services, employment, education, housing and justice. Such an approach could include a focus on the DFSV sector and could bolster efforts towards a joint response to DFSV and mental health.

While the National Plan to Reduce Violence Against Women and their Children works towards coordination and accountability across levels of government, it does not detail best practice for collaboration beyond the government sector such as non-government, community managed organisations and businesses who play a vital role in responding to DFSV. Nor does it detail how partnerships across these levels could be best leveraged.

It is clear that further attention to the level of coordination and accountability across governments is required, as well as clarity around integration of efforts at the community level. In addition, greater focus on implementation, evaluation and coordination as well as a shift in emphasis towards outcomes in order to understand impact and effectiveness is required. Many of these concerns could be addressed through a coordinated, collaborative approach across governments and the broader sectors that intersect with DFSV including mental health. This could include linkage agreements, consultation arrangements and the development of protocols or standards.

The NMHC is interested to further discuss what contributions it could make in its monitoring and reporting capacity to inform impact and effectiveness in relation to DFSV and mental health outcomes in the next National Plan to Reduce Violence Against Women and their Children.

d) The way that health, housing, access to services, including legal services, and women's economic independence impact on the ability of women to escape domestic violence.

These factors and sectors impact on the ability of women to escape domestic violence. Given this complexity, holistic strategies that target different levels of social and political structures and recognise the interplay between the two are required.[8] For example, policies that work to increase women's economic independence (such as; parental pay and leave, childcare support, political and corporate gender quotas and targets) not only work to increase women's economic independence (and therefore ability to escape violence) but they start to unpick the social and political structures that perpetuate gender inequality and violence in the first place.

Housing is a crucial factor that impacts on women's ability to escape domestic violence. In 2017-18, 42% of clients who accessed specialist homelessness services had experienced family or domestic

violence. Of these clients aged over 10 years of age, one in three had a mental health issue and/or problematic substance use.[3] Women and children experiencing domestic violence have been made a priority group in the National Housing and Homelessness Agreement, providing an example of a joint response across sectors. Despite this however, further work is required to actualise the prioritisation of women and children in social housing eligibility criteria, and further investment is needed in social infrastructure like social housing to meet the demand for women and children fleeing DFSV.

Trauma-informed approach and frameworks

The NMHC recognises the importance of a trauma-informed approach across sectors that intersect with DFSV as a measure to increase women's ability to escape from domestic violence. A trauma-informed approach creates an environment of safety and open and genuine collaboration, without judgement, where women can feel comfortable to disclose their experiences of violence and are empowered to make choices that maximise their recovery.[21]

A trauma-informed approach also recognises the impact that exposure to DFSV has on children's mental health and wellbeing. It provides a contextual understanding to explain the presence of psychosocial and behavioural symptoms in children as a result of trauma. These symptoms are often misdiagnosed as behavioural symptoms of other childhood conditions such as ADHD and ADD in the absence of knowledge of exposure to violence. This can be harmful when children are prescribed medications for these disorders that exacerbate existing symptoms.[22]

The mental health system has a way to go in appropriately responding to the impact of violence and trauma, with interim findings from the Victorian Royal Commission into Mental Health citing the need for a common understanding of trauma and violence informed care. This speaks to the current models of health care that neglect to take into consideration the family and social context surrounding an individual and any co-existing issues. For example, treating mental health and substance use issues in isolation of the impact of DFSV (despite the crossover of service users), is treating only the symptoms not the underlying cause of mental health and substance use issues i.e. violence.[12]

Although limited in their evaluation, there are promising frameworks that have the potential to address the issues of inadequacy to respond appropriately to DFSV in the health and mental health systems and form a common understanding of trauma and violence informed care.

The Health Systems Implementation Trauma and Violence-Informed Model was developed by the Australia's National Research Organisation for Women's Safety.[23] Input for the model was sought from women with lived experience of DFSV, staff working in hospitals, sexual assault centres and a clinical mental health service as well as conducting a literature review of similar or related existing evidence-based models. This framework underpins both a woman centred care approach and a practitioner or staff-centred service approach, where women are empowered and receive a holistic response and practitioners and staff are supported and provided with the necessary education and resources to provide appropriate care.

Insights can also be garnered from the Women with Co-occurring Disorders and Violence Study that generated a wealth of knowledge regarding the effectiveness of comprehensive, integrated and trauma-informed service models for women with co-occurring histories of violence and mental health issues.[21] For a detailed understanding of the neurobiological impact of trauma on the body 'The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma' by Bessel van der Kolk is a valuable resource.

Service delivery and integration

The NMHC has highlighted the need for creating pathways to care and integrating services in its National Mental Health and Wellbeing Pandemic Response Plan (Pandemic Response Plan) in addressing DFSV. This includes ensuring warm referrals between sectors such as alcohol and drug use, domestic violence, homelessness, unemployment, disability support, education and family welfare and enabling functional integration of responses to mental health, substance use, family and domestic violence. Although these measures have been recommended in response to the COVID-19 pandemic, they should be continuously prioritised post the pandemic response. These recommendations are grounded in the evidence-base that indicates an increased likelihood of disclosure of intimate partner violence when services are linked in with specialist support and/or advocacy services.[24,25]

In addition to this, the need for individually tailored supports and services for women and children experiencing DFSV should be noted. Mainstreaming approaches and supports runs the risk of failing to recognise intersectional discrimination based on sex, race, disability and sexuality as well as taking into consideration the specific needs of Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse communities, and women with disability.[26] This applies for both DFSV and mental health service delivery.

In response to outcomes of the Victorian Royal Commission into Family Violence, the Victorian Department of Health and Human Services has implemented a number of specialist family advisor roles in major mental health, drug and alcohol services. This is in order to increase access to specialist family violence skills across Victoria. The department is also encouraging increased collaboration between these services by resourcing and promoting shared casework models. These provide examples of integrated service delivery across sectors addressing the needs of women experiencing both DFSV and mental health issues.

Another opportunity is to provide professional development training for the general mental health workforce on domestic violence awareness, in particular on its impacts on mental health.

f) The adequacy of the qualitative and quantitative evidence base around the prevalence of domestic and family violence and how to overcome limitations in the collection of nationally consistent and timely qualitative and quantitative data including, but not limited to, court, police, hospitalisation and housing.

Currently there are no nationally consistent data collection methods for primary health care and psychological support in Australia.[27] This, along with the understandable reluctance to report DFSV, means we are limited in our ability to form a complete understanding of the prevalence of co-occurring DFSV and mental health.

There are however, a number of national data sets that collect information on services that intersect with populations who have experienced DFSV. Mental health related data sets include the National Residential Mental Health Care Database and the National Community Mental Health Care Database. An opportunity exists to use these established data sets to capture or identify women and children experiencing DFSV in order to inform a greater understanding of the prevalence of co-occurring DFSV and mental health prevalence.

Ensuring that this additional capture of information is done as sensitively as possible will require further attention and workforce training.

The NMHC also encourages additional research regarding the intersection between mental health and DFSV services, with particular focus on the lived experience of women and children who have experienced both DFSV and mental health issues. This would inform an understanding of existing gaps in meeting the needs of women and their children.

i) The impact of natural disasters and other significant events such as COVID-19, including health requirements such as staying at home, on the prevalence of domestic violence and provision of support services.

Natural disasters and other significant events such as the COVID-19 pandemic can impact on the prevalence of DFSV. Stay at home and physical distancing measures during the COVID-19 pandemic have exacerbated existing DFSV issues, with reports of domestic and family violence increasing around the world in the wake of COVID-19 isolation measures.[28,29,30]

Female dominated industries have been heavily impacted by the effects of the pandemic in various ways, including increased employment instability of female dominated industries and increased child care needs.[31] These impacts both highlight and exacerbate existing issues of gender equality in Australia and around the world. This is concerning given gender inequality is a known driver of violence against women[8], and demonstrates the need for further progress in this area. It also lends support to the scale-up of primary prevention approaches that target the drivers of violence against women.

The NMHC highlighted in its Pandemic Response Plan the need for domestic violence services to take into account the restrictions faced in accessing help and any surge in violence as a consequence. Maintaining clear and consistent communication that help remains available is vital and that services are taking precautions to ensure they can continue to support people while complying with social distancing and health practices. These principals should apply during any natural disaster or other significant events.

The NMHC also highlighted the need to integrate learnings from the COVID-19 DFSV response to proactively address the known driver of violence against women – systemic sexism and gender inequality – and ensure this experience informs the next National Plan to Reduce Violence Against Women and their Children and other related policy initiatives.

Conclusion

DFSV can have significant and long-lasting impacts on mental health and wellbeing. Yet, historically, there has been limited coordinated effort or approach at the national level in addressing the needs of women dealing with both mental illness and domestic violence.[5,6]

The NMHC has outlined an approach that encourages greater coordination and partnership between the mental health and DFSV systems and sectors at the national level. In doing so taking a whole-of-government, whole-of-life, cross-sector approach, pertinent to which is the underpinning of a trauma-informed lens. Existing issues regarding coordination, evaluation and data have been highlighted as well as an up-scale of work needed in regards to a trauma-informed approach and a primary prevention focus.

DFSV and mental health are intersecting issues that require a joint response across sectors. A critical opportunity exists for governments to consider how a strengthened partnership or collaboration between the DFSV and mental health sectors could increase efforts towards both reduction of violence against women and their children and mental health issues.

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