Family Violence Implementation Monitor (Victoria)
Monitoring the Family Violence Reforms
July 2020

Improve the mental health of communities

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP Victorian Branch has almost 1700 members including around 1200 qualified psychiatrists and more than 300 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery. The RANZCP partners with people with lived experience, through the Community Collaboration Committee and our community member on the RANZCP Victorian Branch Committee. Carer and consumer representation is woven into the fabric of the RANZCP and helps to ensure the RANZCP considers the needs, values and views of the community throughout its work.

Key findings:

- Family violence is an ongoing concern in the Victorian community and has a complex relationship with mental ill health.

- Whilst there have been some improvements due to reforms from the Royal Commission into Family Violence, there is a need to ensure access to services is consistent and equitable across Victoria.

- There is a need for increased awareness within the mental health sector, and in the general public in relation to family violence.

- Increased awareness is needed with regard to at-risk communities, such as women from ethnic minority groups and migrants.

- There is a need for increased training for mental health professionals to ensure they have the necessary skills to identify and manage family violence concerns and support their patients.

- There is a need for culturally sensitive and informed practices, including education for community leaders and more mental health practitioners who speak the language of the communities they are working with.

- The benefits and pitfalls relating to the increased use of telehealth by people experiencing family violence need further consideration to inform future use of telehealth.

- The pandemic has also highlighted issues for women who are on temporary visas, who are unable to access housing and welfare support, or Medicare.

Introduction

The RANZCP welcomes the opportunity to contribute to the Family Violence Implementation Reform Monitor's ("the Monitor") consultation on Monitoring the Family Violence Reforms. The recommendations contained within this submission are based on consultation with the RANZCP Victorian Branch Committee, as well as the RANZCP Family Violence Psychiatry Network which is made up of community members and psychiatrists. [1] The network was formed to create awareness amongst psychiatrists and trainees of the mental health aspects of family violence in Australia and New Zealand. As such, the RANZCP is well positioned to provide assistance and advice about this issue due to the breadth of academic, clinical and service delivery expertise it represents.

Family violence is defined in section 5 of the *Family Violence Protection Act 2008 (Vic)* and includes physical, sexual, emotional, psychological and economic abuse as well as threatening or coercive behaviour perpetrated by a family member against another family member. The most common manifestation of this is intimate partner violence, or domestic violence, committed by men against current or former female partners. [2] Whilst family violence can be experienced by people of all genders, current statistics indicate a much higher prevalence in women. In Australia, 17 per cent of women report having experienced physical or sexual assault from a current or previous partner, compared with 6.1 per cent of men in Australia. [3]

The relationship between family violence and mental ill health is complex and bidirectional. Individuals who have experienced family violence can suffer from a variety of long-term, chronic conditions such as post-traumatic stress disorder, major depressive illness, eating disorders, problematic substance use, chronic pain, generalised anxiety disorders and panic disorder. [4] At the same time women with mental health concerns are at an increased risk of physical and sexual violence. [5] Family violence is of particular concern in certain population groups, including Aboriginal and Torres Strait Islander peoples, [6] and there is a great need to consider the relationship between family violence and suicide in the context of ethnic communities in Victoria. [7] Family violence, particularly emotional and financial abuse, experienced by a person suffering from psychotic illness may also be misinterpreted as part of their illness. This fear may prevent patients from seeking help early when they have a relapse of their illness.

Whilst there have been some improvements since the Royal Commission into Family Violence released its report in 2016, the rates of family violence incidents in Victoria have continued to show concerning trends. After a brief period of decline, family violence incidents recorded by Victoria Police increased from 76,113 in 2017-18 to 82,652 in 2018-19, with the number of Family Violence Intervention Orders also increasing. [8] Given family violence is experienced by a significant proportion of women both globally, [9] and in Australia, and is a leading cause of ill health, there is still significant room for improvement in both government and community responses. [5]

Mental healthcare professionals will often see patients who are experiencing or have experienced family violence, [10] with research suggesting a substantial proportion of psychiatric inpatients and outpatients have experienced domestic violence. [10-12] Psychiatrists are essential in multidisciplinary teams, both in public and private practice, in caring for people who are experiencing mental health issues as a result of exposure to family violence and to those who are referred for treatment because of their use of family violence. Psychiatrists have an important role in clinical leadership, as well as identification, risk assessment and referral, and treatment, [13] including for perpetrators of family violence. In addition, psychiatrists can play a key role in educating colleagues and the general public in matters relating to family violence. However, as has been pointed out earlier, there is a need for greater training for healthcare workers to identify and manage family violence issues for both victims and perpetrators. [5, 10]

1. How has the family violence service system changed since the Royal Commission?

- What are the major changes in the family violence service system since the Royal Commission into Family Violence made its final report and recommendations in 2016?

- How has the experience of accessing services and support changed since the Royal Commission for victim survivors, including children, and perpetrators of family violence?

Members tell us that whilst it may be easier to access family violence services for those who need it, the availability of services is not always consistent, especially in outer-metropolitan and rural and regional areas. In addition, anecdotal evidence suggests that for the individuals and communities affected by family violence, the experience on the ground has been largely unchanged.

2. Looking forward – what is still required in the family violence system?

- What are the most critical changes to the family violence service system that still need to occur?
- Are there any parts of the family violence reforms that have not yet progressed enough and require more attention?
- Are there any improvements that could be made to the implementation approach of the family violence reforms?

Increase awareness of family violence in the general public, and at-risk communities

Members tell us there is still a major gap in support for immigrant women and paucity of understanding around suicidality in ethnic patients, especially those who are victims of family violence. [7] Measures are needed to raise awareness of the overlap between suicide and family violence in migrant communities.

In order for services to provide evidence-based responses to family violence, there is a need for increased research to understand the needs of those with experience of family violence. O'Connor and Ibrahim [7] have raised this issue, citing the lack of culturally nuanced studies looking to understand suicidality in ethnic patients, especially those who are victims of family violence. There is a need for training for community leaders, so they can recognise family violence within their communities and raise awareness of it as an issue amongst the people they are leading. Training should be made available in the language of the community, so it can be delivered with impact. In addition, there is a great need for an increase in the number of psychiatrists and other mental health practitioners who can deliver services in the contextually-appropriate language. For some individuals, there is great fear relating to use of interpreters due to risk of misinterpretation relating to different dialects and a fear of breaches of confidentiality.

Improve availability of training

The profile of family violence as a social determinant of mental health has been raised through the Royal Commission and its reforms. However, there is still work remaining to educate mental health professionals and assist them to incorporate knowledge of coercive and controlling behaviours and unequal power relations into their clinical problem solving. Members tell us that there is still a glaring gap in education and awareness of family violence amongst psychiatrists and mental health professionals more generally.

A recent study suggested there is limited time spent in specific skills training for management of domestic violence, with increased hours spent in domestic violence training significantly correlated with greater knowledge and preparedness to manage domestic violence. [10] It was also suggested that training needs to provide details of pathways for clinicians to access additional support for patients within their communities, both for victims and perpetrators. [10] Organisations providing these additional supports in the community also require ongoing, sustained funding in order to provide effective, continuous care. [14]

3. Impact of the COVID-19 pandemic

- What has been the biggest impact of the COVID-19 pandemic on your organisation or sector? How have the services that your organisation or sector provides had to change?
- Has the COVID-19 pandemic highlighted any strengths or weaknesses in the family violence service system?
- Are there any changes resulting from the COVID-10 pandemic that you think should be continued?

The move toward provision of a greater proportion of services by telehealth during the COVID-19 pandemic has been both helpful and a source of concern for psychiatrists caring for individuals with a

history of family violence. Telepsychiatry has enabled greater reach of services for women who have experienced family violence and are separated from the perpetrator, as it removes geographical barriers to care. Members tell us there have been few cancellations of appointments by women who are separated from the perpetrator of violence. However, for those who are still living with the perpetrator of violence, there have been increased cancellations. For these women, it is likely they were in a situation where it was difficult for them to speak freely. This will need to be considered in the future if telehealth services are to account for a greater proportion of delivered services.

In addition, there is anecdotal evidence of an increase in presentations relating to family violence, including people presenting at Emergency Departments for respite from violence in the home which is more difficult to escape due to lockdown measures. Financial pressures caused by COVID-19 are also likely to escalate family violence where it was not previously an issue or increase the intensity of existing family violence. In addition, the recent hard lockdown of public housing towers in Victoria present further risk for episodes of family violence. Overcrowded conditions, coupled with anger or distress, may result in repercussions for everyone in that household. The anecdotal evidence relating to increases in drug and alcohol use and child sex abuse is also concerning. However, these early indications remain to be confirmed through data collection in the community.

The pandemic has also highlighted issues for women who are on temporary visas, who are unable to access housing and welfare support, or Medicare. This is an ongoing issue which has been highlighted due to the pandemic resulting in job losses for many individuals and has resulted in many women being unable to access the services they need to address issues relating to family violence. In addition, COVID-19 has highlighted the role of controlling behaviours and isolation which when imposed on women may exacerbate distress and symptoms of mental ill health. We have heard reports of an increase in suicides, particularly amongst South Asian women in Victoria. There should be more timely collection and reporting of suicide data in order to understand trends and intervene as early as possible where patterns are identified.

The COVID-19 pandemic has also raised the issue of point of access for individuals seeking support for their mental health who may also require family violence services. There is a greater need for co-located services so that individuals who attend a service for a mental health or family violence concern can access support services for their other health or social needs without having an additional referral or transfer. This could be in the form of Community Hubs which provide a range of services, including mental and physical healthcare, family violence and social welfare services.

4. General Comments
- The Monitor invites you to make any final general comments around the family violence service system reform.

The RANZCP Victorian Branch would like to further highlight the need for innovative funding models, and services for people who are primarily managed in the private psychiatry setting. These individuals often do not meet the threshold for shared case management in the public setting, but at the same time are unable to be case managed by a psychiatrist alone. Further thought should be given to the needs of those accessing services in the private sector, including how public and private settings and services can be better integrated.

References

1.   Royal Australian and New Zealand College of Psychiatrists. Family Violence Psychiatry Network 2020 [Available from: https://www.ranzcp.org/membership/faculties-sections-and-networks/family-violence-psychiatry-network.

2.   Royal Commission into Family Violence. Summary and Recommedations (March 2016) 2016. Available from: http://rcfv.archive.royalcommission.vic.gov.au/MediaLibraries/RCFamilyViolence/Reports/Final/RCFV-Summary.pdf.

3.   Family, domestic and sexual violence in Australia: continuing the national story [Internet]. 2019. Available from: https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-australia-2019/contents/table-of-contents.

4.   Braaf R, Meyering I B. Domestic Violence and Mental Health2013 16 June 2020. Available from: https://www.nifvs.org.au/wp-content/uploads/2015/01/Domestic-Violence-and-Mental-Health.pdf.

5.   O'Connor M, Cox J, Castle D J. What can psychiatrists do to better support victims of family violence? Australasian Psychiatry. 2015;23(1):59-62.

6.   Australian Government. Aboriginal and Torres Strait Islander: Health Performance Framework2017 16 June 2020. Available from: https://www.niaa.gov.au/sites/default/files/publications/2017-health-performance-framework-report_1.pdf.

7.   O'Connor M, Ibrahim S. Suicidality and family violence in Australian immigrant women presenting to out-patient mental health settings. Australasian Psychiatry. 2018;26(2):224-5.

8.   Crime Statistics Agency. Family incidents and related offences. In: Victorian Government, editor. Family Violence Data Portal2020.

9.   World Health Organisation. WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses2005 16 June 2020. Available from: https://www.who.int/reproductivehealth/publications/violence/24159358X/en/.

10.   Forsdike K, O'Connor M, Castle D, Hegarty K. Exploring Australian psychiatrists' and psychiatric trainees' knowledge, attitudes and preparedness in responding to adults experiencing domestic violence. Australasian Psychiatry. 2019;27(1):64-8.

11.   Oram S, Trevillion K, Feder G, Howard L. Prevalence of experiences of domestic violence among psychiatric patients: systematic review. The British Journal of Psychiatry. 2013;202(2):94-9.

12.   Oram S, Trevillion K, Khalifeh H, Feder G, Howard L. Systematic review and meta-analysis of psychiatric disorder and the perpetration of partner violence. Epidemiology and psychiatric sciences. 2014;23(4):361-76.

13.   Webster K. A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women. ANROWS Compass, 07/2016 [Internet]. 2016. Available from: https://www.anrows.org.au/publication/a-preventable-burden-measuring-and-addressing-the-prevalence-and-health-impacts-of-intimate-partner-violence-in-australian-women-key-findings-and-future-directions/.

14.   Neave AO M. Victoria's response to the Royal Commission into Family Violence: Where are we now? Alternative Law Journal. 2019;44(1):3-.