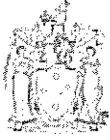


Royal Commission
into Family Violence

WITNESS STATEMENT OF ANGELINA SABIN FERNBACHER

I, Angelina Sabin Fernbacher, Project Manager and Women's Health Consultant and FaPMI Co-ordinator of 185 Cooper Street, Epping, in the State of Victoria, say as follows:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Current roles

2. I am currently the Women's Mental Health Consultant as well as Project Manager, Aboriginal Health/Clinical Engagement Project and Families where a Parent has a Mental Illness (**FaPMI**) Co-ordinator at the Northern Area Mental Health Service (**NAMHS**).

3. I also hold the position of Vice Chair of the Women's Mental Health Network Victoria (**Network**) that brings together women who have experienced mental health issues with those who work in mental health services or on women's mental health issues more broadly. The Network aims, amongst other things, to:

   3.1. provide information about the prevention and management of women's mental health issues to health professionals, service providers, carers, consumers and the public;

   3.2. promote research into women's mental health issues;

   3.3. promote opportunities for training and education in women's mental health issues;

   3.4. develop partnerships with mental health and women's organisations to promote responsiveness to women's mental health issues; and

   3.5. promote systemic change to make mental health policies and services more responsive to women's needs.

Background and qualifications

4. I have worked in the areas of family violence, mental illness and sexual assault for almost thirty years. I have a particular interest in the intersection between abuse and mental illness on an individual, systemic and policy level.

5. I hold a Bachelor of Education (Special Education), a Graduate Diploma in Gestalt Therapy, a Master of Gestalt Therapy and a Doctor of Public Health. My doctoral thesis focused on policy guidance on abuse for mental health care (title: 'Abuse and mental health policy: a (dis)connection?', La Trobe, 2009).

6. I commenced working at NAMHS in May 2000 as Women's Mental Health Consultant (**Consultant**). I have also occupied other service development roles including that of Service Development Co-ordinator 2003/2004 and FaPMI Co-ordinator since 2008. I commenced in my other current role as Project Manager in 2012 (all three roles are part-time).

7. NAMHS is a clinical mental health service providing treatment and care for adults in the cities of Darebin and Whittlesea. In my current roles as Consultant, Project Manager and FaPMI Co-ordinator, I focus on women's mental health issues, families where parents have a mental illness and Aboriginal mental health. I work on fostering systemic and cultural change within NAMHS to increase the quality of support and systemic responses for women, particularly those who have experienced abuse, and for Aboriginal people and parents with mental illnesses and their families. This entails working across various other organisations and other sectors, including sexual assault and family violence services.

8. During my work with NAMHS, I have been seconded to the Department of Health and Human Services (**DHHS**) three times to work on specific projects. During my first secondment in 2003/4 as a Senior Project Officer, I worked on the "Building partnerships between mental health, sexual assault and family violence services" project, the report of which was published by DHHS in July 2006. The project entailed a state-wide consultation process investigating the extent of partnership and collaboration between those sectors.

9. Following the above discussed project I worked on the "NAMHS Partnership Project" between 2005-2013. It involved mental health, family violence and sexual assault services in the northern region working towards improved collaboration and integration. The project also aimed at increasing support for women and their

children who experienced mental illness *and* family violence. While some gains were made during those years (such as temporarily increasing cross-sector collaboration and trialling of a secondary consultation model), the project folded in 2013 due to lack of interest by partner agencies.

10. During my second secondment to DHHS (known as the Department of Health at the time) in 2010/11, I was the Project Manager in a team that developed the "*Service Guideline on gender sensitivity and safety: promoting a holistic approach to wellbeing*" (**Service Guideline**). The Service Guideline includes guidance for organisations and practitioners on dealing with sexual assault, family violence and trauma. It touches on a range of issues around gender sensitivity and safety and provides some key messages about a range of ways to provide gender sensitive care. Attached to this statement and marked "**SF 1**" is a copy of the Service Guideline dated 2011.

11. In 2010/11, I also worked as a consultant on a collaborative project with Berry Street Family Violence Services (funded by DHHS in response to the NAMHS Partnership Project). The project examined how family violence services in the northern region worked with women and their children experiencing mental health issues. The aims of the project included the development of recommendations for the mental health and family violence sectors as well as for government for a way forward to address the needs of women and their children who experience mental illness and family violence. Whilst a report was finalised by Berry Street and provided to DHHS in 2012, it has not been published to date.

Mental health services in Victoria

12. Mental health care in Victoria presently encompasses a range of services delivered through both the private and public sector.

13. The public specialist mental health sector is broadly divided into the following categories:

    13.1. Child and adolescent mental health services (0 -18 years);

    13.2. Adult clinical mental health services (16 - 64 years);

    13.3. Aged person's mental health services (65+ years);

    13.4. State-wide and specialist services (including Forensicare, dual disability and

dual diagnosis, Mother-Baby Services, and Spectrum and Victoria's borderline personality disorder service); and

13.5. Mental Health Community Support Services being "non' clinical services';

Clinical mental health services

14. Clinical mental health services such as NAMHS generally include psychiatric inpatient units, crisis assessment and treatment (**CAT**) teams and community mental health centres. Some also operate bed-based services such as Community Care Units and Prevention and Recovery Care Services (**PARCS**). PARCS provides sub-acute residential services that are also referred to as 'step up or step down' facilities. They aim to either prevent people from being admitted to a psychiatric inpatient unit or provide support to someone who is discharged from a psychiatric inpatient unit who is not yet ready to go home.

15. Under the Mental Health Act 2014 (Vic), mental health practitioners in designated mental health services do have the power to initiate compulsory assessment and treatment under the) if necessary (clinical mental health services are 'designated mental health services').

16. Clients of clinical mental health services are generally living with mental illnesses that have a severe and persistent impact on their lives; they are more likely to endure an associated psychiatric disability. Their needs are of greater complexity than those who may access primary care services for their care such as those provided by a GP. It is more likely that those accessing clinical mental health services suffer from 'low prevalence disorders' such as bipolar disorder or schizophrenia. However, it is the level of impact on someone's every day functioning that determines whether or not they will receive care from a clinical mental health service. Someone with chronic depression or Post Natal Depression may also receive care by a clinical mental health service.

17. Clinical mental health services are provided by psychiatrists, medical registrars, psychiatric nurses, general nurses and allied health staff - occupational therapists, psychologists and social workers. The services in Victoria are under resourced and overstretched. Within an inpatient setting, clinicians are often faced with making difficult decisions about discharging patients due to demand - to make room for new admissions.

Mental Health Community Support Services

18. Mental Health Community Support Services (**MHCSS**), formerly referred to as the 'Psychiatric Disability Support Services', operate alongside clinical mental health services. As a result of the recent recommissioning process, there is now a smaller number of MHCSS in Victoria. Examples of MHCSS are MIND, Neami National and the Mental Illness Fellowship.

19. The aim of the MHCSS program is to assist eligible clients to live independently, maintain the best possible social and emotional wellbeing, meet their personal recovery goals and live satisfying lives in the community. This is achieved by providing the best rehabilitation and recovery support possible, tailored to each person's individual needs and preferences.

20. Twenty MHCSS across Victoria provide flexible support packages and new local intake services as well as some residential youth rehabilitation programs.

21. MHCSS are staffed differently to clinical mental health services. MHCSS employ community support workers; there are no psychiatrists or medical officers employed at MHCSS. MHCSS do not provide emergency or acute mental health services.

22. MHCSS do not provide clinical services, nor acute or emergency mental health services (CAT or inpatient); they do however work in collaboration with clinical mental health services when such supports are needed

23. Further, MHCSS do not have any statutory responsibilities under the *Mental Health Act 2014* (Vic).

Women with mental illness experiencing family violence – specific issues

24. Within the context of mental illness there are a number of specific ways in which perpetrators use a woman's mental illness against her as part of perpetrating violence. This is particularly challenging for women who rely on their partner as support person or carer, or where the perpetrator is another family member who is also their carer. When women with mental illness have children and experience family violence, the situation can become more complex and difficult for her and the children. Some of the issues outlined here may also be experienced by women with disabilities. However, women with mental illness are often 'forgotten' in public debate, or get subsumed into the 'women with disabilities' debate. The issues,

stigma (especially for women who are parents), lack of recognition and lack of opportunities to gain adequate support can keep women with mental illness trapped.

25. Some examples of violence using mental illness are: telling her that nobody will believe her (because she has a mental illness); telling other people that she is 'crazy' and she makes things up; threatening to tell others (family, employer etc) of her behaviour when unwell (e.g. self-harm); colluding with delusions (e.g. moving furniture around and then denying it); withholding medication or determining when medication has to be taken (to her detriment); and showing concern for her mental health towards professionals while actively undermining her mental health. Further, when children are involved, men may threaten to have the children 'taken away', because she is 'unfit' (this is a real threat for many women with mental illness who may be forced to 'prove' that they are able to care for their children due to mental illness). There is a myriad of techniques that perpetrators will use to control women with mental illness.

26. At the same time, stigma against women (and indeed all people) with mental illness prevails in society. People with mental illness frequently point out that once they are diagnosed, 'everything gets seen through the lens of mental illness' by others. Their behaviour is interpreted differently.

27. One such example is a woman who told family violence workers that she felt watched by her partner but could not substantiate her claims. Workers believed this was part of her delusion due to her mental illness. After prolonged abuse, it was found out that her partner had indeed installed cameras in the ceiling and filmed her.

28. Similarly, a normal reaction to trauma such as family violence, such as a panic attack, can be misinterpreted and pathologised by both staff in the family violence or the mental health system. One such example is a woman who has to take a train to go to a refuge; during the train ride she has a panic attack and has to get out of the train. Her distress escalates and she is attended by a mental health team. The refuge refuses to take her, as it is believed she is not capable of 'looking after herself' and live independently.

29. Family violence, including child abuse, can be a contributing or causal factor for the development of mental illness and it can exacerbate existing mental illness (Briere and Jordan, 2004; Campbell, et al 1996).

30. The needs of women with mental illness who experience family violence need to

receive greater focus and responses that adequately address their needs than has been the case to date.

31. The Royal Commission into Family Violence should closely examine the role of clinical mental health services, Mental Health Community Support Services and family violence support services in responding to family violence.

The mental health system's response to women who are experiencing family violence

32. In Victoria, the mental health system is large and its response to women who are experiencing family violence is inconsistent. There is a lack of clarity about mental health services' role and responsibility in responding to family violence.

33. While the guideline on gender sensitivity and safety (as mentioned above) goes some way towards directing mental health clinicians in responding to family violence and sexual assault, it does not go into enough detail. It also is not a binding document such as a policy statement combined with KPIs or other feed-back processes would be.

34. A high percentage of people with mental illness (accessing mental health services) have experienced family violence, including childhood (sexual) abuse. Approximately 40% of men have experienced childhood (sexual) abuse. Anywhere between 50% - 90% of women in the mental health system have experienced childhood sexual abuse or family violence (and frequently both and multiple times). When working in a mental health setting overall and particularly within acute services (psychiatric inpatient units and emergency mental health), it is safe to assume that we are working with people who have experienced some form of violence.

35. Unfortunately, interactions with the mental health system (or with other patients within the mental health system) can be re-traumatising for patients, particularly for women.

36. For example, inpatient units are often re-traumatising for patients. This issue arises in particular because men and women are in mixed wards, with other people who are very unwell and some may have poor impulse control. In a mixed inpatient ward there are many situations or behaviours that can *trigger* memories of fear and abuse for others (shouting, banging of a door or aggressive or indeed abusive behaviour). Frequently the reaction of the person experiencing such triggering (being

retraumatised) goes unnoticed and the person is left feeling unsafe.

37. One example of a particularly distressing nature told to me was when a woman witnessed a male inpatient walking around without wearing pants or underwear (disinhibited behaviour). As she had experienced abuse very similar to this as a child, she was left retraumatised.

38. Some mental illnesses can also result in hyper-sexuality which can place a person at risk of engaging in sexual behaviour that they would not engage in when well. Even if deemed 'consensual' at the time by the two people involved, it can end up being harmful and traumatic. Women report that they may form new intimate relationships very quickly during times when they are not well. When their mental health improves, they feel that they conducted themselves in a way that was inconsistent with their usual behaviour. They may also have felt coerced at the time to participate in sexual relationships, that on reflection, they did not feel they had a choice about. When this occurs within an acute or subacute setting, it occurred during a time when women were particularly vulnerable.

39. Women who are admitted to psychiatric inpatient units frequently report that they do not feel safe. Women who have experienced family violence and child abuse are particularly vulnerable to experience further abuse and report feeling retraumatised through behaviour of others. Women continue to experience violence (including sexual violence) during inpatient units stays.

40. In 2011, the Department of Health (as it was then known) issued the Service Guideline on gender sensitivity and safety for mental health services, which is a positive step. The Service Guideline addresses (amongst other things) gender-sensitive and trauma-informed care, family violence and sexual assault. It provides practical suggestions for practitioners about how to implement best practice in these areas and how to work with people who have experienced trauma, family violence and sexual assault. Equally it outlines organisational work needing to occur to assist staff in a gender sensitive and safe way.

41. The benefit of DHHS issuing guidelines is that they apply to the whole mental health service, with the potential for clinicians across the system to take note. In contrast, Chief Psychiatrist Guidelines while potentially also addressing all clinicians, are more likely to be taken note of by psychiatrists and medical staff. However, the problem with both of these types of guidelines is that while they do provide

guidance, they are not binding. There are no key performance indicators (**KPIs**) associated with guidelines of either kind and there is no clear structure for services to report back on how they are implementing the guideline.

42. Equally, implementation of guidelines is generally left up to services. DHHS went some way towards implementation of the guideline on gender sensitivity and safety by funding a train-the-trainer program for selected staff from psychiatric inpatient units. Trained staff were then responsible for local implementation in inpatient units, and services needed to provide DHHS with local implementation plans. However, there was a lack of focus on a roll-out into other parts of services and no reporting back mechanisms to DHHS about the extent of changes (policy, practical etc) or adherence to the guideline in day-to-day practice.

Recommendations for improving the way the mental health system in Victoria responds to women who have experienced family violence

Governance structures for implementing improvements in the mental health system

43. I set out below my views about the ways in which improvements can be made in both the mental health and family violence services.

44. While I identify a number of areas for improvement, there are always difficulties in implementing and embedding those improvements within the whole of the mental health system and workforce. There needs to be clear direction from the Department of Health and Human Services and a co-ordinated approach which is clear in direction-setting and allocation of responsibility.

45. In order to make sure practices are firmly embedded, we need a governance structure which involves a strategy and guidelines with associated KPIs and a resourced and staged implementation process (1-3 or 1-5 years). An overarching Departmental strategy on Trauma Informed Care (**TIC**) would outline the broad parameters and overall aims (for all staff). Furthermore a DHHS guideline is needed which outlines in greater detail roles and responsibilities for clinical and mental health community support services. This could be complemented by a related Chief Psychiatrist guideline, even if the Chief Psychiatrist guideline mostly directs people to the Departmental guideline. Additionally, psychiatrists could be directed in regards to their responsibilities and need for skill development in this area.

46. There needs to be an implementation strategy that clearly outlines expected targets over a 1-3 or 1-5 year time frame. It ought to outline responsibility for implementation and the support necessary for implementation. I suggest that such implementation needs to be resourced; this could be achieved through a statewide role that oversees and supports implementation (there are examples of this in other areas such as the FaPMI strategy and associated implementation). Regional/organisational roles (TIC co-ordinators or TIC project manager roles) are also required to work on local implementation as well as TIC specialists who work together. There also needs to be a mechanism for report-back, ongoing monitoring and refining of implementation.

47. Implementation needs to be undertaken in conjunction with workforce development (as well as policy development for mental health services). There is a need for mental health staff (clinicians and mental health community support services) to be trained in TIC, the Family Violence Risk Assessment and Risk Management Framework (also known as the Common Risk Assessment Framework (**CRAF**)) and family violence.

Trauma Informed Care (TIC)

48. Any strategy to better equip the mental health system to support women who have experienced family violence should include trauma-informed care.

49. Trauma is defined as the "personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss and/or the witnessing of violence, terrorism and/or disaster" (NASMHPD, 2004).

50. TIC is a reorientation of the way we respond to trauma which asks, "what has happened to you?" rather than "what is wrong with you?"

51. The Mental Health Coordinating Council position paper "*Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction*" by Bateman, Henderson and Kezelman provides a useful summary of the principles governing trauma-informed care:

> *[Trauma-informed care] is a practice that can be utilised to support service providers in moving from a 'caretaker to a collaborator' role. When a human service program seeks to become more trauma-informed, every part of its*

> *organisation, management, and service delivery system is assessed and modified to ensure a basic understanding of how trauma impacts the life of an individual who is seeking services. By facilitating recovery through trauma-informed care, re-victimisation can be minimised and self and community wellness and connectedness can be promoted.*

Attached to this statement and marked "**SF 2**" is a copy of this paper dated 2013.

52. Traditionally, mental health care has had a very narrow focus and frequently 'medicalises' decision-making and tends to overlook the impact of past and current trauma.

53. TIC also provides a framework for "understanding the profound neurological, biological and social effects of trauma and violence on the individual" (Jennings, 2004). TIC provides a way to understand people's reactions to trauma which may manifest in behaviour that can be pathologised if a trauma-lens is not applied (for example, someone's depression is linked to unresolved trauma experience or someone's voices are linked to their abuser – but nobody has made this connection for them). TIC does not 'medicalise' conditions and enables the person to have the space to talk about their experience, to assist in making connections between their experience and the mental health impact. It encourages the person's involvement in a more equal way, avoiding power imbalance as much as possible.

54. Many women experience a lack of attention to their family violence experience within the mental health system. While some progress has been made, a study conducted by Laing, Irwin and Toivonen found that mental health professionals often failed to ask women about or realise their experience of domestic violence:

> "*Many women commented on how general practitioners, psychiatrists and other mental health practitioners rarely inquired about their current relationships, family life or other personal and social issues, thereby not addressing the underlying reason for their mental ill health (the domestic violence).*"

A copy of this article is attached to this statement and marked "**SF 3**".

55. TIC aims to:

    55.1. ensure women do not have experiences like this in their encounters with the mental health system;

55.2. assist with making connections between abuse and mental health impact; and

55.3. take a more holistic view of mental health and illness.

55.4. promote safety

Workforce development for mental health practitioners

56. There is a need for psychiatrists, psychiatric nurses, medical and allied health staff to have greater understanding about family violence.

57. Psychiatrists in Victoria are not required to do any compulsory training in family violence.

58. Training for clinical mental health services is delivered by 'training clusters' (there are four such clusters covering the state of Victoria) and for Mental Health Community Support Services through VICSERV (peak body of Mental Health Community Support Services). Organisations may also have their own training unit or access external training. There is no mandate for mental health service staff to undertake training in sexual abuse, family violence or TIC.

59. In New South Wales, the NSW Education Centre Against Violence (ECAV, NSW Health) delivers training to the health sector, including mental health services. ECAV's training model is to:

> *"improve the emotional, social and physical wellbeing, protection and safety for victims of interpersonal violence, through holistic care that empowers victims to grow and heal whilst reducing the shame and self-blame associated with their past and present traumas.*
>
> *Understanding the current socio-political context is a critical ingredient in trauma informed work, as negative and dismissive attitudes about sexual and physical violence still remain pervasive. ECAV training provides a context for workers to reflect on their own attitudinal shifts that may be required to improve their practice and outcomes for victims."*

60. ECAV also runs a Master level subject in the continuing education program for the College of Psychiatrists in NSW about childhood sexual abuse.

61. Training and other workforce development activities need to occur in the context of

organisational change. Training individuals who then return to an organisation that does not support what they are trying to do generally does not work. Staff morale goes down, as staff find that they cannot implement their new learning without organisational support (and endorsement). They can even find themselves being discouraged from engaging with clients about either their mental health or their family violence experience, because it is 'not their job'.

Improving professional practice and relationships between mental health and family violence services

62. It can be difficult for women with mental illness to access family violence services. Likewise, it can be difficult for women experiencing family violence who also have a mental illness to access mental health services.

63. It can also be difficult for mental health workers to know the best way to deal with a client who experiences family violence. Similarly, it can be difficult for family violence workers to either detect or understand mental health problems and/or to know when to engage with mental health services.

64. A trauma reaction can be misinterpreted by both mental health and family violence staff as a mental illness. TIC can assist in rethinking and responding differently. There is a strong correlation between experiencing childhood abuse and developing mental illness. Of course, not everyone who was abused develops a mental illness, and not everyone with a mental illness has been abused. However, there is a strong correlation and mental health workers should expect that they might be dealing with people who have a history of trauma and abuse.

65. We need to ensure that both mental health workers and family violence workers understand how and when to work with complementary services. For mental health workers, we need them to expect that family violence or childhood sexual assault is part of the core business of mental health. Family violence workers need to have a basic understanding of mental illness and know when to involve and collaborate with mental health services.

66. I recall an example which illustrates the need for mental health services and domestic violence services to work more closely together. A woman had left her violent partner and needed to stay at a refuge. She was taking medication for a mental illness. When she arrived at the refuge, she realised that she had left her medication at home. The refuge would not accommodate her because they could

not organise replacement medication for her that afternoon. They were concerned that it would be dangerous for other people if she were allowed to stay and missed a dose of her medication. This woman had to stay at a motel on her own, with minimal support, even though she had just escaped a violent situation.

67. In an ideal world, the refuge would have a relationship with a mental health service (or would have contacted the woman's clinician) which could organise a script in time for the woman to stay at the refuge. However, the situation also likely arose because of fear and prejudice arising from a lack of understanding of mental health issues. In most cases, a woman missing one dose of her medication would be unlikely to be sufficient to precipitate a serious and immediate deterioration in her mental health. Conversely, a woman who needs to pick up her methadone daily would be assisted by the family violence staff to transfer her methadone in order to accommodate her in refuge.

68. I think a lot could be gained by mental health services and family violence services engaging in secondary consultations. It is one way to increase skills and expertise about mental illness and family violence respectively and to increase understanding about each others' sectors.

69. In their article, "*Women's Stories of Collaboration Between Domestic Violence and Mental Health Services*", Laing, Irwin and Toivonen refer to the "fragmented service delivery" experienced by women dealing with family violence and mental health issues and their "need for coordinated services to support them" (see annexure "**SF 3**").

70. Secondary consultation can not only provide support and up skilling of staff; it can furthermore potentially increase referral pathways and ease of access to services. It can also contribute to overcoming barriers between sectors and organisations, making inquiries, consultations and seeking assistance more easily. In particular, regular face-to-face consultation has shown benefits, increased familiarity and assisted in developing professional relationships.

71. Another related idea is to develop more multi-disciplinary hubs, such as family violence services being co-located with mental health services and others. Similar to secondary consultation, hubs could provide a structure and framework for cross-sector collaboration and engagement with other specialist services.

72. Ideally, a multi-disciplinary hub would have a full time mental health worker who could

also provide secondary consultations to others.

73. Sharing knowledge and working together through secondary consultation processes can achieve great outcomes to resource staff and build staff confidence. NAMHS has previously provided assistance to Kildonan Uniting Care (**Kildonan**) in their Family Violence Intervention Program. The male worker from Kildonan was working with a man with mental illness who was perpetrating violence against his mother, with whom he lived. The worker was concerned about how he was working with the man and uncertain about if he needed to work differently. He was able to speak with one of our clinicians who was able to provide support and guidance, and affirm the way he was working.

Improving refuge services for women with mental illness who experience family violence

74. In my experience, women who are diagnosed with a mental illness and then later experience family violence are less likely to gain access into family violence services.

75. Mental illnesses such as bipolar disorder, borderline personality disorder and schizophrenia are still very stigmatised, and I know from practice and research that there are cohorts of women with mental illness who find it more difficult to access family violence services.

76. To improve services in these cases, there is a need for collaboration between mental health and family violence services. This is not a situation where one can work without the other. This highlights the need for more secondary consultation that I discuss earlier in this statement, as well as better understanding about mental illness related issues for family violence services.

77. I can recall two examples which highlight some of the difficulties faced by women with mental illness who are trying to access family violence services, particularly refuges. The structure of the refuge system in Victoria is particularly challenging for women with a mental illness for at least two reasons.

78. Mental illness is stigmatised within society and this is likely to also occur within the family violence sector. While some women with mental illness may find it difficult to share with others, it is more likely that stigma gets in the way of accepting a woman into refuge with some workers expressing concern about the safety of other women

and children in the refuge (most likely to be unfounded and not based on reality). It is not uncommon for refuges to seek some kind of guarantee from mental health services (in particular for referrals directly from psychiatric inpatient units) regarding the woman's mental state and/or risk to others or ask questions if she is able to share with others.

79. For example, I am aware of a woman who was referred by the social worker of a psychiatric inpatient unit to a family violence refuge. The refuge would not accept the referral unless they were provided with a written statement guaranteeing that she was well enough to go into a refuge and that she did not pose any risk to herself or others. Written discharge papers sometimes take a few days to be completed and in the interim, the treating clinician had confirmed verbally that the patient did not present a risk to herself or other people. Despite this, the refuge would not take the referral.

80. I have also heard a similar story from a family violence service perspective, where the staff member pointed out that in the past they had accepted a woman and they did not feel they were equipped to provide her with the support she needed.

81. There may be several solutions to the above situation – if stronger connections existed between mental health and family violence services, trust in each other's systems, referrals and judgment would likely to be increased. If the family violence service had a working relationship with the local mental health service, they could rest assured that in case of deterioration for the woman's mental health, they could ask for mental health support. Additionally, if family violence staff had increased skills in working with women with mental illness, they would likely feel more able to accept her into their service and provide support as needed.

82. A second issue arises because of the practice of the refuge system to accommodate women away from the area in which their home is or where their supports are. This poses particular challenges for women with mental illnesses because it requires the woman to change her mental health service. Because of the way the mental health system is set up in Victoria, when you move to a different area of the state, you also have to move mental health service. That is a difficult thing to do and can be very taxing on someone's mental health, in particular at a time of crisis. You're in a new area, you do not know your way around, you are already highly anxious because you have just left domestic violence and then your mental health service works differently and is staffed by different clinicians. One of the most critical supports for

the woman, her mental health community support worker and clinicians, are changed at one of the most challenging times of her life. While having to move out of a familiar environment can be challenging for many women and their children, it may well pose even harder for women with mental illness. Routine, familiarity of supports, for children to attend their usual school and for women to engage in day-to-day activities benefit mental health and provide a sense of comfort at a time of high distress (of course if it is unsafe for a woman and her children to stay within the area, a different response is likely to be needed to ensure their safety). Providing a choice to stay within the same area (or one's own accommodation) with the same support network including mental health services could be of great benefit to women and children.

83. Equally, if women do need to leave, wish to take their children with them and need some extra support due to mental illness, a range of options could be provided. Residential services such as refuges can be organised differently (e.g. units with shared courtyard but separate living), allowing external services such as mental health to attend as necessary. Good relationships between family violence and mental health services would also increase co-working. A family violence workforce that is confident in knowing when to refer to mental health services or when to get a woman assessed would also provide higher levels of support for women with mental illness and their children.

Mentally ill perpetrators and family members who are victims of their violence

84. As the response to victim/survivors varies across mental health services, so does the response to people with a mental illness who perpetrate family violence. At the same time, it is difficult to find services that will work with men with a mental illness who perpetrate family violence (most likely toward their partner but also against other family members and more likely their mother). While some men may be ready to access Men's Behaviour Change Programs, they are not necessarily a good 'fit' for some men. One example, as briefly mentioned above, is services such as Kildonan, which provide a service to both the victim/survivor and the perpetrator of violence (including the Families @ Home program). It is worthwhile exploring a combined family violence response, in particular (but not only) for families where separation is not necessarily the aim. Within the mental illness context two cohorts which may benefit from such support are: an adolescent with emerging mental illness who is violent towards a parent (usually the mother); and a person (adult) with mental illness who is supported by their family, and perpetrates violence

against family members.

85. The mental health system relies heavily on families to care for their relatives, which can be very burdensome for families. This is particularly so when a mentally ill family member is violent.

86. As mentioned above, the pressure on the mental health system is significant and the pressure on psychiatric inpatient units is also huge. Even when people receive treatment and support from mental health services, families remain the main support for people with mental illness. At times of acute illness, this can be very challenging for families.

87. It is important that psychiatrists or mental health clinicians engage in conversations with family members and ensure that families are safe. However, there is a real challenge in this space about patient confidentiality and what can or cannot be communicated to family members who are feeling unsafe. There is a need for clear protocols and more training for mental health clinicians about balancing patient confidentiality and keeping other people safe.

Partnerships between police and mental health clinicians

88. A situation that is particularly difficult relates to women who are being abused by their adolescent or adult child with a mental illness. It presents a terrible predicament for mothers, particularly when they are faced with whether to ring the police or not.

89. In some cases, the person only perpetrates such violence when they are unwell (for example, acting on their voices). Police take out an intervention order despite the mother/family member stating that they will have their loved one back; the situation is a complex one. Police may mean well, wishing to keep the woman safe and prevent the person from returning home, and the woman may want her loved one home.

90. There has been a lot of great work done recently between police and mental health clinicians. One example is the Police Ambulance Clinician Emergency Response (**PACER**) program.

91. These programs are utilised when police are called out to someone who seems to have a mental illness and/or needs assessment (as a secondary response).

92. The model involves a joint response by Victorian Police members and a mental

health clinician. The mental health clinician performs a mental health assessment and if the person is deemed to need hospitalisation, they are brought directly into the psychiatric inpatient unit. This process circumvents long waiting times in the Emergency Department, releasing police back to their other duties. Most of all, it has proven to provide greater support to the person with mental illness as well as their family and lessens distress. Now, through programs like PACER, police and mental health clinicians attend the call together. They have become specialised in these calls. The police who are attending the calls have learned a great deal about mental health and mental illness.

93. When programs like PACER are involved in a call out, it is usually less traumatising for both the person with mental health issues and their families. It also means that emergency departments do not become clogged up.

94. The success of PACER is that fewer people are brought to hospital emergency departments because the program has direct access to the psychiatric inpatient unit.

95. The family and the individual are far less stressed because they do not go to hospital in a divisional van and they can receive more timely access to healthcare.

96. I understand that each of the 21 Area Mental Health Services in Victoria have received funding for a (now called) Mental Health and Police Response by State Government in 2014.

97. Another example of closer working relationships that have proven beneficial is the High Risk Review Conference and the Risk Assessment Management Panels (**RAMPs**). While slightly different in the way they were set up, both aim to assess family violence incidences where women and children are at high risk. Examples in the northern region (Cities of Hume and Whittlesea) include mental health clinicians on those panels. To date their involvement has provided mental health expertise, when mental illness is present, either for the perpetrator, victim/survivor or their child. Additionally, due to closer working relationships, police (one of the main key stakeholders involved) feel confident to approach the clinician to seek input or secondary advice outside of meetings. At the same time, the mental health clinician can ensure that, in instances where the mental health service was unaware of the violence or the significant level of violence, staff were made aware of this. Depending on who the mental health service works with (perpetrator or

victim/survivor or indeed with both), they can be alert to escalation of violence or any safety concerns for their client or indeed (in some cases) for themselves.

Alternatives to psychiatric inpatient facilities

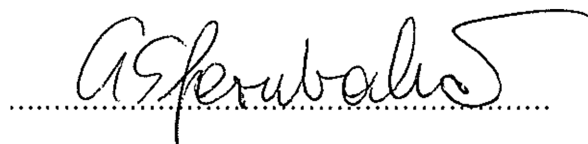
98. There has been some helpful research coming out of the United Kingdom about the benefits of using residential mental health crisis facilities as an alternative to psychiatric hospital admissions.

99. The paper titled "*Admission to Women's Crisis Houses or to Psychiatric Wards: Women's Pathways to Admission*" by Howard, Rigon, Cole, Lawlor and Johnson reports that:

> "*Women's crises houses were highly valued by service users. The women reported that their recovery was promoted by the homelike environment of the crisis house, the absence of disturbed male patients, the ready availability of staff for talking through current and past difficulties, and good support from other residents...*"

Attached to this statement and marked "**SF 4**" is a copy of this paper dated 2008.

100. Similarly to PARCS (Step up/step down facilities) it may be worthwhile to explore such alternatives for women with mental illness needing support due to family violence. Such options could be additional sources of support for women who would otherwise need to be hospitalised and would therefore be separated from their children. There would still be a need for a family violence system that works well with women with mental illness (women who do not need hospitalisation).



Angelina Sabin Fernbacher

Dated: 21st July 2015