IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

STATEMENT OF DR MARK OAKLEY BROWNE

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I, MARK OAKLEY BROWNE, Chief Psychiatrist, SAY AS FOLLOWS:

1. I am the Victorian Chief Psychiatrist appointed under the *Mental Health Act 2014* (Vic.) (**Act**). I have held this position since March 2013.

2. As Chief Psychiatrist, my responsibilities include the provision of clinical leadership and the promotion of continuous improvement in the quality and safety of mental health services. This includes promoting the rights of people receiving mental health treatment in public mental health services, developing guidelines, undertaking clinical reviews, audits and investigations and having statutory responsibility for the monitoring of restrictive practices, electroconvulsive therapy and reportable deaths. As Chief Psychiatrist, I also provide advice to the Minister for Mental Health and the Secretary for the Department of Health and Human Services (**Department**) about the provision of mental health services.

3. As part of my role as Chief Psychiatrist for Victoria (and previously as Chief Psychiatrist for Tasmania), I sit on the Safety and Quality Partnerships Standing Committee which is a Standing Committee of the Mental Health, Drug and Alcohol Principal Committee (see paragraph 88 below). In this capacity I assisted in the development of the National Standards for Mental Health Services, which were issued in 2010.

4. It is in my capacity as the Chief Psychiatrist that I make this statement.

5. Prior to my current appointment, from February 2009 I was Tasmania's Chief Psychiatrist and Statewide Clinical Director of Statewide and Mental Health Services for the Tasmanian Department of Health and Human Services. Throughout my career I have held a variety of positions in academic and clinical settings. I have also had roles on a variety boards and committees and I continue to do so.

6. I graduated as a medical graduate of the University of Otago, New Zealand (BSc 1975, MB ChB 1979) and I am a consultant psychiatrist and Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP, 1987). I completed further postgraduate training in administration in healthcare management (Master of Health Administration, University of New South Wales 2004) and I am an Associate Fellow of the Royal Australasian College of Medical Administrators (MRACMA, 2008). I also hold a Graduate Diploma in Clinical Epidemiology (Newcastle, 1998) and a research doctorate (PhD, Otago, 1983).

7. I attach my curriculum vitae as **Attachment MOB-1**.

8. I have received a notice from the Royal Commission into Family Violence pursuant to s 17(1)(d) of the *Inquiries Act 2014* (Vic.) requiring me to attend to give evidence at the Royal Commission and to provide a written witness statement.

SCOPE OF STATEMENT

9. In this statement I respond to a request by the Royal Commission for information regarding Module 8 (Mental Health).

10. I understand that the Royal Commission is interested in:

    10.1 the role of mental health as a factor leading to perpetrators engaging in family violence;

    10.2 the impact of family violence on the mental health of victims;

    10.3 how victims are best supported to deal with the mental health burden of family violence; and

    10.4 the guidelines available for mental health workers regarding family violence, the way mental health workers and the Mental Health Tribunal deal with the risk of harm posed by a patient to family members, the way privacy laws impact on how mental health workers can respond and the nature of support services available for family members living with persons with mental illness in order to protect them from risks of harm.

11. The academic literature, studies and reports, referred to in this statement are referred to on the list which is attached to this statement at **Attachment MOB-2**. Where relevant throughout my statement, I provide citations for these sources by referring to the author and year of publication.

12. I have also canvassed the views of Chief Psychiatrists from other Australian States and Territories and New Zealand, including:

    12.1 Associate Professor John Allan, Chief Psychiatrist, Queensland;

    12.2 Dr Nathan Gibson, Chief Psychiatrist, Western Australia;

    12.3 Dr Ed Heffernan, Chief Psychiatrist, Queensland;

    12.4 Dr Murray Wright, Chief Psychiatrist, New South Wales;

    12.5 Dr Aaron Groves, Chief Psychiatrist, South Australia;

    12.6 Dr Denise Riordan, Acting Chief Psychiatrist, ACT; and

    12.7 Dr John Crawshaw, Director and Chief Advisor of Mental Health, Ministry of Health, New Zealand.

13. I have also spoken with the following persons because of their expertise in relation to family violence and mental health service provision:

    13.1 Dr Ruth Vine, Executive Director, NorthWestern Mental Health Melbourne Health;

    13.2 Dr Sabin Fernbacher, Project Manager Aboriginal Health/Clinical Engagement Project, Women's Mental Health Consultant, FaPMI Co-ordinator, Northern Area Mental Health Service; and

    13.3 Professor Jim Ogloff, Professor of Forensic Behavioural Science, Director of the Centre for Forensic Behavioural Science, Swinburne University of Technology.

14. All opinions expressed in this statement are my own.

THE ROLE OF THE CHIEF PSYCHIATRIST

15. Pursuant to s 120 of the Act, my role is to:

    15.1 provide clinical leadership and expert clinical advice to mental health service providers in Victoria;

    15.2 promote continuous improvement in the quality and safety of mental health services provided by mental health service providers;

15.3 promote the rights of persons receiving mental health services from mental health service providers; and

15.4 provide advice to the Minister and the Secretary to the Department about the provision of mental health services by mental health service providers.

16. Pursuant to s 121 of the Act, my functions include, but are not limited to, the provision of standards, guidelines and practice directions for the provision of mental health services in Victoria.

17. As part of its leadership functions and clinical safety responsibilities, the Office of the Chief Psychiatrist (**OCP**) has some influence over public mental health services practice but not a direct influence. Governance for health services lies with the boards of the designated mental health services.

18. In addition to this statutory role, the Office of the Chief Psychiatrist provides expert advice across the Department and the health system to influence policy directions, operational activities and to promote the delivery of safe and effective mental health services.

MENTAL HEALTH AND FAMILY VIOLENCE

Mental health concepts and overview

19. Mental health is a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve her or his potential. Mental health and mental illness are often used interchangeably, but mental health is not simply the absence of mental illness.

20. Mental illness is a clinically diagnosable illness or disorder that significantly interferes with an individual's cognitive, emotional and social abilities. The effects of mental illness are usually more pronounced than that of a mental health problem. Symptoms are characterised by alterations in thinking, mood and/or behaviour (or a combination of these) and associated distress and/or impairment in every day functioning.

21. A diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision (DSM-V) or the International Classification of Diseases, Tenth Edition (ICD-10). These classification systems apply to a wide range of mental disorders (for the DSM-V) and mental and physical disorders (for the ICD-10).

People with mental illness: victim, perpetrator or both?

22. People with mental illness are more likely to be a victim of violence and crime than the perpetrator of such violence. The belief that all people with mental illness are "dangerous" or are more likely to perpetrate a violent crime is steeped in beliefs representing stigma and discrimination, rather than facts.

23. While a small percentage of people with mental illness perpetrate violence, the majority of those diagnosed with mental illness are more likely to be the target of a range of violent acts, including family violence, than others.

24. A range of contextual aspects in the lives of people with mental illness contribute to the increased likelihood of experiencing violence. This includes, but is not limited to, social factors such as poverty, unemployment status, low socio-economic status, homelessness or insecure housing, social isolation or being a sole parent.

25. Women with a mental illness can experience a number of issues, making their situation more complex and more difficult. For example, they might experience the impact of mental illness combined with social aspects (poverty), adverse life events (childhood abuse/re-victimisation), limited choices (such as housing) or dependency on a partner who in turn perpetrates violence.

26. According to a recent study:

    26.1 the majority of schizophrenia patients do not engage in criminal violence, but a diagnosis of schizophrenia is significantly associated with the risk of criminal and family violence in comparison to the general community;

    26.2 within this particular subgroup, family members, including partners, are most likely to be subjected to such violence (Short, Thomas, Mullen and Ogloff, 2013);

    26.3 robust case linkage and birth cohort studies, indicate that schizophrenia patients are somewhere between two to five times more likely than other community members to engage in criminal violence (Short et al, 2013); and

    26.4 the population-attributable risk for violent offending in schizophrenia was 6.99%, which indicates that 7% of all violent crimes committed could be theoretically attributed to the effects of schizophrenia. In other words, if all schizophrenia patients were removed from the community (and if

schizophrenia was indeed causally related to violence), the amount of violent crime would drop by only 7% (Short et al, 2013).

27. This further emphasises that schizophrenia disorders are only one of many potentially associated factors for violence and that the majority of violent incidents are not necessarily related to psychotic disorders.

28. Violence is, however, strongly linked with the diagnosis of psychopathy. Psychopathy (also known as antisocial personality) is a broad term but is generally understood to be any behavioural dysfunction that is primary and manifests itself in abnormally aggressive or seriously irresponsible conduct. Antisocial personality disorder manifests in a disregard for the law or for the rights of others, with a lack of remorse, lying and stealing, aggression, violence or illegal behaviour. People with antisocial personality disorder frequently lack empathy and can be indifferent to the feelings, rights, and sufferings of others.

29. Violence in patients with a diagnosis of psychopathy is often associated with predatory aggression, which is planned, purposeful and goal-directed. There is usually an absence of observable antecedent behaviour and the violence is targeted usually at one individual.

30. Mental illness is not ranked as a strong predictor of violent behaviour, and a longitudinal study suggests that people with severe mental illness were not at increased risk of committing serious violent acts. Without substance abuse, a person with severe mental illness has the same chance of being violent as any other person in the general population (Elbogen and Johnson, 2009). In the long term prediction of risk of violence, mental health variables have less significance than other variables such as gender, age, past history of offending and social class. (Mullen, 2001).

Family violence impacts on victims

31. Family violence is a major public health issue across the globe. In Australia one in three women have experienced physical violence and one in five women report having been sexually abused since the age of 15 (VicHealth, 2004). At the same time, one in four young people have witnessed family violence against their mother (Australian Bureau of Statistics, 1996, 2006).

32. Most family violence is perpetrated towards women and children by male partners, ex-partners, fathers or family members, with almost 80 per cent of reported family

violence victims being women or girls. When other types of violence such as emotional and financial abuse are included prevalence rates are even higher. Abuse of parents by teenage children is an emerging problem, as is elder abuse.

33. Family violence can have a detrimental effect on women's and children's mental health and can exacerbate existing mental health problems and mental illness. A meta-analysis found in research studies that just under half (47.6%) of all abused women suffered from clinical depression compared with 10.2 to 21.3% in women in the general community (Golding, 1999). The same study found that women who access women's refuges show higher rates of depression and problematic alcohol/substance abuse or dependency.

34. Partner violence is the greatest risk factor for preventable depression, anxiety and other mental health issues for Victorian women aged 15-44 years (VicHealth, 2004).

35. There is a correlation between the severity, frequency, chronicity and recency of interpersonal violence and greater levels of psychopathological distress. Prolonged (or severe) violence is likely to produce longer-term effects on the person.

36. A study undertaken in a hospital emergency department in Brisbane found that women who had experienced family violence by an intimate partner were nine times more likely to have harmed themselves or have thoughts of harming themselves compared to women who had not experienced intimate partner violence (Roberts et al, 1998).

37. A high number of people diagnosed with mental illness also experience substance dependency problems at some stage in their life. Of those diagnosed with schizophrenia up to 50 per cent will have a substance problem (Meadows et al, 2007). Those diagnosed with problematic substance use frequently also suffer from mental illness such as mood and anxiety disorders, Post-Traumatic Stress Disorder or personality disorders (Bernstein, 2000). Dual diagnosis can render a person more vulnerable to being exposed to interpersonal violence, in particular women.

38. Family violence has also been connected to increased and/or problematic drug and alcohol use and dependency, with women who have experienced family violence being up to six times more likely to use substances (Briere and Jordan, 2004 and Golding, 1999). The use of substances can be understood as managing symptoms of Post Traumatic Stress Disorder (**PTSD**) and as a coping strategy to avoid feelings associated with abuse.

39. Community surveys in many countries have shown that witnessing parental violence, physical abuse by a partner or spouse, other physical assault and sexual assault, are associated with PTSD (Karam et al, 2013).

40. While research about the impact of family violence has predominately focussed on women and their accompanying children, evidence shows that many men with a diagnosed mental illness have experienced child abuse and in particular childhood sexual abuse (Morrison et al, 2005). Childhood abuse, including sexual abuse is frequently perpetrated by a trusted caregiver, male relative or father and often separated as 'child abuse' rather than 'family violence'. The impact of abuse during childhood features large for people with mental illness.

41. While family violence occurs across all cultures, Aboriginal women experience such violence at far greater rates than non-Aboriginal women, with some studies showing that Aboriginal women are at up to 40 times more likely to experience family violence (Department of Planning and Community Development, 2008). Family violence affects the social and emotional wellbeing of women, children and families and communities.

42. Traditional Aboriginal understandings of the person are inherently inter-relational and inter-dependent with other family and community members. Family violence impacts the whole of community because of this inter-connectedness (Koori Alcohol Action Plan Department of Health, 2010).

Family violence impacts on children

43. More than one million Australian children are affected by family violence and almost one quarter of young people have witnessed physical violence towards their mother (Australian Bureau of Statistics, 2006). The indirect experience of domestic violence as well as being the "target" of violence can have long term effects long after the violence has occurred.

44. One of the most likely impacts of experiencing family violence for children is a disruption to attachment (formation). Family violence disrupts attachment for children in many ways; one can be an attack on the mother-child relationship. Equally it is likely that the child experiences a disruption of attachment to their father who perpetrates the violence.

45. Other impacts of violence on children are far ranging and can include depression, anxiety, post traumatic symptoms, lower social competence, increased aggression,

low self-esteem, loneliness, as well as eating disorders, suicide attempts (including during adulthood) and a range of other psychological, developmental and behavioural problems. The impact of violence on children can manifest during childhood, adolescence and adulthood. It has been found that having experienced childhood sexual abuse is a greater predictor for adult suicidality than current depression (Read, 1998).

46. The impacts on children include psychological, emotional, social and behavioural functioning; it can lead to socioeconomic disadvantage and their cognitive (and academic) functioning can be negatively affected.

Experiences of repeated violence

47. If someone has experienced abuse during childhood, they are more likely to experience abuse as an adult. Women who have experienced violence are at greater risk of being re-abused, with an Australian study showing that those with childhood abuse experiences are one and a half times more likely to experience violence during adulthood (Mouzos and Makkai, 2004).

48. People with mental illness are often more vulnerable to interpersonal abuse, due to a range of reasons. Factors that increase such vulnerability include unsafe environments, such as unstable housing, homelessness or inadequate housing such as rooming houses or mixed gender facilities and drug or alcohol use.

49. Similarly, studies show that women with a diagnosis of mental illness can be at increased risk of interpersonal/family violence. One study found that "women with chronic psychotic illnesses (schizophrenia) are easier prey for sexually or physically abusive men" (Briere and Jordan, 2004).

THE VICTORIAN MENTAL HEALTH SERVICE SYSTEM

The devolved system of governance

50. People receiving treatment in the public mental health system are not patients or clients of the Department. Victoria's health policy has involved a devolved system of governance since the mid-1990s. Health services are governed by boards, non-executive members of Boards are appointed by the Governor in Council on the recommendation of the Minister for Health and the Chief Executive Officer is appointed by the Board. Health service boards are responsible for:

50.1 the performance and quality and safety of the service; and

50.2 the establishment of policies and procedures to ensure that the service meets performance, quality and safety requirements.

51. The boards oversee the health services on behalf of the Minister and in accordance with government policy and legal obligations. The boards are responsible for setting strategic direction, managing risk, improving performance and ensuring compliance with statutory requirements.

52. This devolved governance model enables these service providers to determine the most effective and efficient service structures and service delivery mechanisms for the population in the catchments for which they are responsible. It also means that there can be some variation in approaches and practices across the services.

53. Health services also have processes in place to ensure all staff have appropriate skills, knowledge and training and maintain professional standards and registration.

54. Ultimately, the health service boards are accountable for the quality and safety of clinical services to the Minister for Health, and through the Minister who is acting on their behalf to the local community. At the level of clinical service delivery, accountability for the quality of care is shared among members of the multidisciplinary health care team consistent with their defined roles and responsibilities.

55. Statements of Priorities are key accountability agreements between Victorian public health services and the Minister for Health. These annual agreements facilitate delivery of or substantial progress towards the key shared objectives of financial viability, improved access and quality of service provision.

56. The 2014-15 Statements of Priorities highlight government's commitment to provide responsive, integrated and innovative health care options. One specific commitment relates to supporting emergency departments to better identify, respond and intervene early in instances of family violence and sexual assault. This is also reflected in the *Victorian Health Policy and Funding Guidelines 2014-15* (see pages 1 and 14) (attached to this statement at **Attachment MOB-3**). These guidelines contain, among other things, the conditions of funding for publicly-funded mental health services.

The role of the Commonwealth

57. Both the Commonwealth and Victorian Governments have responsibility for the provision of mental health services. The Commonwealth provides leadership in the development of national policy and standards, the delivery of national mental health promotion and preventative health programs, and is the funding source for mental health services through the primary health care and private psychiatry sectors.

58. Just under 90% of Commonwealth expenditure in mental health is through five major programs, four of which are demand-driven programs providing benefits to individuals - Disability Support Pensions, Carer Payment and Allowances, Medicare Benefits Schedule and Pharmaceutical Benefits Scheme. These schemes equated to $7.4 billion of funding in 2012-13.

59. The fifth major area of Commonwealth expenditure is an estimated $1 billion provided to States and Territories under the 2011 National Reform Agreement for the treatment of patients with a mental health issue in the public hospital system.

60. The remaining Commonwealth expenditure sits across programs directly funded by the Commonwealth, such as Headspace, Partners in Recovery, Access to Allied Psychological Services (ATAPS), Personal Helpers and Mentors Service (PHaMS) and programs managed through national partnership agreements, such as the National Partnership Agreement Supporting National Mental Health Reform.

The Victorian public mental health system

The components to the system

61. The public sector mental health service system in Victoria comprises:

    61.1 clinical services provided by designated mental health services within the meaning of the Act. These include:

        (a) acute, sub-acute and continuing care programs;

        (b) hospital and community based services; and

        (c) ambulatory and residential community based services;

    61.2 non-clinical services provided by Mental Health Community Support Services (**MHCSS**) which are publicly funded and delivered through the non-government sector. These include:

(a) individualised client support packages;

(b) residential rehabilitation services (youth and adult);

(c) supported accommodation services;

(d) mutual support and self-help;

(e) planned respite;

(f) Aboriginal Community Controlled Organisations and Koori Psychiatric Disability Rehabilitation and Support Services;

(g) Psychiatric Disability Rehabilitation and Support Services Carer Support; and

(h) statewide support.

62. In terms of clinical mental health services, Victoria has a statewide public network of 18 designated mental health services. A number of these designated mental health services operate multiple 'area mental health services'. They are arranged as:

62.1 21 area mental health services for adults;

62.2 17 aged persons' mental health services; and

62.3 13 child and adolescent mental health services.

63. The Victorian Institute of Forensic Mental Health (**Forensicare**) is also a designated mental health service. Forensicare provides inpatient and community services to mentally ill offenders and forensic mental health patients. I discuss specific programs offered by Forensicare at paragraphs 73 to 79 below.

64. Each area mental health service referred to in paragraph 62 above operates within a defined geographical catchment area. Access to an area mental health service is determined by the catchment in which a person resides.

65. Non-clinical mental health services are provided by MHCSS. MHCSS provide publicly-funded 'non-clinical' services for people with serious mental illness and associated significant psychiatric disability. MHCSS are a core component of the specialist mental health service system within Victoria, complementing clinical mental health services. MHCSS focus on addressing the impact of mental illness on

a person's daily activities and the social disadvantage resulting from illness. They work within a recovery and empowerment model to maximise people's opportunities to live successfully in the community.

66. Consumers are screened for eligibility for MHCSS Individualised Client Support Packages, Adult and Youth Residential Rehabilitation Services and Supported Accommodation Services via catchment-based Intake and Assessment function. The MHCSS Common Intake Assessment tool used for this process includes consideration of whether a consumer is potentially experiencing family violence and, if so, whether family violence support services are in place for the individual.

67. Clients who meet the eligibility criteria for MHCSS are prioritised for allocation according to functional impairment, homelessness and a range of complexity and vulnerability factors. Whether someone has experienced family violence within the last three months or is a victim of abuse/trauma (including family violence) are factors, which may (in combination with other complex factors) upgrade prioritisation of the client's access to MHCSS. The MHCSS Common Intake Assessment Tool and Upgrade Prioritisation Tools are attached to this statement as **Attachment MOB-4**.

68. Similar to the state funded drug treatment sector, MHCSS has undergone major reforms that have been in place for less than a year. The Minister for Mental Health recently announced a review of the current status of the reformed system, which will assist in identifying outstanding areas for further focus.

Access and entry points to the Victorian mental health system

69. The division of responsibilities between the Commonwealth and the state governments in respect of mental health means that Commonwealth treatment responses and resources tend to be directed towards services delivered by primary care providers and the treatment of high prevalence mental illnesses such as depression, anxiety and substance use disorders.

70. The state-funded service system generally provides treatment for persons with low prevalence illnesses such as schizophrenia, bipolar affective disorder, severe depression and severe personality disorders. The threshold for entry into the state-funded system is based on a clinical assessment of severity of illness, complexity and acuity of need and level of risk to self and/or others.

71. Compulsory treatment for mental illness can only be provided in public sector mental health services.

72. In 2013-14, there were over 63,000 people registered within the Victorian mental health system.

Forensicare – its role with offenders and serious problem behaviours

73. Forensicare provides outpatient and community based programs through the Community Forensic Mental Health Service. The programs are primarily for people who have a serious mental illness and have offended or are at high risk of offending. Specialist assessment and treatment is also provided for people who present with a range of serious problem behaviours.

74. Services are provided on the basis of a referral and subsequent assessment. Most people are referred from area mental health services, Corrections Victoria, courts, the Adult Parole Board, Thomas Embling Hospital, the Acute Assessment Unit of the Melbourne Assessment Prison, other government agencies and private practitioners.

75. Services provided include primary and secondary consultations, the Problem Behaviour Program, the Community Integration Program, and the Non-custodial Supervision Order consultation and liaison program. Services to the courts include pre-sentence court reports and the Mental Health Court Liaison Service.

76. The Problem Behaviour Program provides psychiatric and psychological consultation and treatment for people with a range of problem behaviours associated with offending and for whom services are not available elsewhere. The program is directed at people known to have recently engaged in, or be at risk of engaging in, one or more problem behaviours. Around 50% of referrals to the program come from Corrections Victoria.

77. Problem behaviours include serious physical violence, threats to kill or harm others, stalking (repeated unwanted contact), sexual offending, including adult sexual assault and rape, paedophilia, collection and possession of child pornography, including internet child pornography, fire-setting, querulous (vexatious) complainants and problem gambling associated with serious offending.

78. The Community Integration Program consists of two service delivery areas:

78.1 community-based mental health care for those on a custodial supervision order under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic.). This service is for those clients at the Thomas Embling Hospital in the lead up to an extended leave application to a court and following the grant of extended leave. For this client group, participation in the program is not voluntary and is a condition of successfully applying for and participating in extended leave; and

78.2 short-term linkage assistance to people with serious mental illness leaving the Melbourne Assessment Prison or the Dame Phyllis Frost Centre. It aims to improve the outcomes of clients by ensuring that their mental health needs are addressed through the release/discharge planning process, and community-based supports are established. The focus is on connecting the client with their local area mental health service. Support is usually provided for six weeks prior to release from prison and six weeks following release from prison or until linkages are established with the relevant support services.

79. The Forensic Clinical Specialist Initiative was established in 2010 to build capacity in area mental health services to manage the risks associated with consumers with offending histories or behaviours, and improve referral pathways and information transfer between the mental health, justice and correctional systems. The initiative funded 10 positions based in area mental health services and a program coordinator based at Forensicare's community forensic mental health service.

RESPONDING TO FAMILY VIOLENCE

80. The service system response to mental illness can be conceptualised in three tiers:

80.1 'Severe and persistent': associated with enduring psychosocial disability; while this constitutes the smallest group of people with mental illness, the impact of their illness, associated disability and their needs are the highest and most complex – they are in need of the greatest resources;

80.2 'Severe episodic/severe and persistent': complex and chronic illness; this is often associated with 'low prevalence disorders' but not always; and

80.3 'Mild-moderate': the impact of the mental illness is of a nature that requires a less intense response.

81. It is the level of impact of the mental illness that will determine the level of need for a person, rather than the type of illness. For example, a person with schizophrenia may be functioning well and may be employed. They may require a less intensive response. In comparison, a person with severe depression may be unable to perform simple daily tasks and require a higher level and more intense response.

82. Different parts of the system ought to be involved in responding to victim/survivors and perpetrators of violence in association with mental health problems and mental illness. It is likely that in many situations a combination of services from different systems working collaboratively to address the violence and support the victim/survivor would be beneficial. Those accessing family violence services (both women's and men's services) may or may not receive care by a mental health service and they may or may not need such care as a result of experiencing or perpetrating family violence.

83. Usually the most appropriate treatment for those experiencing family violence are psychosocial responses and interventions. These treatments are best informed by 'trauma-informed care', which recognises people's history and experiences of trauma, and the impact on people's health, wellbeing and behaviour.

84. As discussed previously only a small proportion of people with mental illness engage in violence. For a small minority the violence is directly related to their mental illness for example, acting on their delusions. For some, mental health is a contributing factor, among other factors, and addressing the mental health problems may help reduce the risk of violence. For others, the mental health problems are not incidental (related) to the violence and addressing the mental health problem will not reduce the risk of violence.

85. The level and type of service involved for both victim/survivors and perpetrators depends on the person's level of need. The type of service and also the type of treatment provided will depend on a number of variables; such as personal characteristics, age presenting symptoms, their level of risk to themselves and others for example. Some people may receive both treatment and care with a clinical mental health service and a MHCSS, while others may receive support by a MHCSS and a general practitioner or private psychiatrist. Again, others may receive care by their general practitioner and no other mental health service.

POLICIES AND INITIATIVES AND FAMILY VIOLENCE

Commonwealth

86. At the Commonwealth level, there are several overarching key policies that guide the provision of mental health services in Australia. They are:

86.1 the *National Standards for Mental Health Services* (2010) (attached to this statement at **Attachment MOB-5**);

86.2 the *National Practice Standards for the Mental Health Workforce* (2013) (attached to this statement at **Attachment MOB-6**);

86.3 the *National Framework for Recovery-oriented Mental Health Services: guide for practitioners and providers* (2013) (**National Recovery Framework**) (attached to this statement at **Attachment MOB-7**); and

86.4 the *Fourth National Mental Health Plan: An Agenda For Collaborative Government Action In Mental Health* (2009-2014) (**Fourth National Mental Health Plan**) (attached to this statement at **Attachment MOB-8**).

87. As Tasmania's, and then Victoria's representative on the Safety and Quality Partnerships Standing Committee, I was involved in the development of the National Standards for Mental Health Services. The majority of Safety and Quality Partnerships Standing Committee members are State and Territory Chief Psychiatrists or the equivalent thereof. We report and provide advice to the Mental Health, Drug and Alcohol Principal Committee and we progress its work plan. Our vision is to ensure improvements in safety and quality of mental health services consistent with the National Mental Health Strategy, by developing functional and collaborative linkages with other activity and groups pertinent to safety and quality, improving the quality and integration of data that informs quality standards and promoting best practice standards across mental health services.

88. The Mental Health, Drug and Alcohol Principal Committee is one of six principal committees of the Australian Health Ministers Advisory Council (**AHMAC**). AHMAC is ultimately responsible for the provision of advice to the COAG Health Council. I attach the Terms of Reference for Mental Health, Drug and Alcohol Principal Committee at **Attachment MOB-9** which further describe the committee's role.

89. The National Standards for Mental Health Services:

89.1 describe care that is consistent with the Key Performance Indicators for Australian Public Mental Health Services and are used during accreditation; and

89.2 set out the principle that mental health services support and promote opportunities to enhance consumers positive social connections with family, children, friends and the community.

90. The National Practice Standards for the Mental Health Workforce:

90.1 set out the values, attitudes, knowledge and skills required for working in the mental health sector;

90.2 set out the principle that, in delivering mental health treatment and support, the least personal restriction on the rights and choices of people should be imposed, taking into account their living situation, level of support within the community and the needs of the person's family or carer; and

90.3 contain standards on working with people, families and carers in a recovery focused way (Standard 2) and taking into account safety issues including the family situation (Standard 5).

91. My predecessor, Dr Ruth Vine, was involved in the development of the National Recovery Framework when she was chair of the Safety and Quality Partnerships Standing Committee. The National Recovery Framework:

91.1 gives guidance to mental health practitioners and services on recovery-oriented practice and service delivery;

91.2 acknowledges principles of trauma-informed care in recovery-oriented practice and service delivery; and

91.3 acknowledges the role that violence and abuse play in the lives of people seeking mental health and drug and alcohol services.

92. The Fourth National Mental Health Plan:

92.1 provides an overarching vision and intent for the Australian mental health system;

92.2 articulates the need to support highly vulnerable children and young people who have experienced trauma or abuse;

92.3 articulates the need to improve communication and information flow between clinical and community services; and

92.4 recognises that some people, because of past experiences of trauma or abuse, may be particularly vulnerable to mental health issues.

93. Each of these Commonwealth policy documents guides the provision of mental health services and policy formulation in Victoria.

Victorian initiatives, strategies and policies

94. The Department, through the Mental Health Branch, the Office of the Chief Psychiatrist and other program areas, coordinates the management of the Victorian mental health system, including program and funding policy, service performance, strategic policy development and consumer, carer and national relations.

95. In 2005, the Department supported the development of a guide entitled *Identifying and responding to family violence: a guide for mental health clinicians in Victoria* (attached to this statement at **Attachment MOB-10**). The guide was developed by the Victorian Community Council Against Violence and is aimed at providing assistance to mental health workers to assess whether a patient may be a victim of family violence and the steps to take to respond. The guide contains the contact details of a variety of referral services. The guide was distributed to mental health services and is available for use at the discretion of the clinician or service.

96. In 2003 and 2004, the Mental Health Branch led the Building Partnerships between Mental Health Services, Family Violence and Sexual Assault Services project (**Partnerships Project**). Specifically, the Partnerships Project aimed to:

96.1 facilitate improved relationships and service collaboration between family violence, sexual assault and specialist mental health services;

96.2 improve service access and referral pathways between family violence, sexual assault and specialist mental health services; and

96.3 improve service delivery outcomes for female consumers of mental health services, including women with a mental illness who have experienced sexual assault and/or family violence.

97. The Partnerships Project delivered its report in 2006 (attached to this statement at **Attachment MOB-11**). At pages 20-21 of the report, recommendations directed at mental health, sexual assault and family violence services were made, including:

97.1 exploring and creating opportunities for collaboration with one another, including the provision of consultation and advice to one another and the development of local protocols;

97.2 the provision of training and access to information for staff to enable them to respond to women with mental health problems who have experienced family violence and/or sexual assault; and

97.3 mental health services referring women requiring legal advice about violence and assault to an appropriate organisation.

Families where a parent has a mental illness

98. In 2007, the *Families where a parent has a mental illness strategy* began. It followed increased recognition of the impact of mental illness on parents and the consequences for their families, particularly dependent children. Its inception was part of the (then) Victorian Government's *A Fairer Victoria* commitment to support vulnerable families and improve the safety, health, development, learning and wellbeing of infants, children, young people and families.

99. The overall aim of the strategy was to reduce the impact of parental mental illness on family members through timely, coordinated, preventative and supportive action. The strategy encourages family focused practice through workforce training and networking to ensure timely identification and appropriate referrals to supportive services.

100. Coordinator positions are embedded in mental health services across the five rural regions and in three metropolitan area mental health services. These positions work towards increasing support to mental health services to ensure timely identification and appropriate referrals to supportive services to reduce the impact of parental mental illness on the family. This is done via an array of service development activities involving mental health services and network partners such as universal and targeted early years services, child and family support services, housing and drug and alcohol services, and primary care and community health services.

Gender sensitivity and safety

101. Since 2008, the Department has engaged in a wide-ranging program of work to promote gender sensitivity and safety in Victoria's mental health services. The program of work has included guideline development, capital investment, resource development training and workforce investment. It includes:

101.1 allocation of more than $2.69 million (of a $4 million commitment over four years) and provision of an additional $2.1 million to 63 projects across 16 health services, for capital projects under the *Safety of Women in Care* initiative to improve women's safety in mental health inpatient services;

101.2 a pilot of a female only Prevention and Recovery Centre based in Springvale (operated by Monash Health) and the production of a gender-specific Prevention and Recovery Centre service manual;

101.3 a trauma-informed care train-the-trainer program delivered by the state-wide Reducing Restrictive Interventions team on trauma-informed care (I describe trauma-informed care and the Reducing Restrictive Interventions project at paragraphs 104 to 109 below);

101.4 developing a service guideline entitled *Service guideline on gender sensitivity and safety: Promoting a holistic approach to wellbeing* (2011) (attached to this statement at **Attachment MOB-12**) which sets out requirements for mental health and alcohol and other drugs services and practitioners to provide gender-sensitive care for women, men and people who identify as transgender or intersex;

101.5 funding of the Women's Mental Health Network Victoria (**WMHNV**) to develop a training resource to support implementation of the *Service guideline on gender sensitivity and safety: Promoting a holistic approach to wellbeing* (2011);

101.6 delivery of the WMHNV training resource as a "train-the-trainer" program to 74 practice leaders from all Victorian adult inpatient area mental health services; and

101.7 oversight of health service development of an implementation plan outlining how they will deliver the training program to the workforce in adult inpatient settings, and undertake practice, system, policy and environmental

changes to comply with the Department guidelines and make improvements for gender sensitive care.

102. The *Service guideline on gender sensitivity and safety: Promoting a holistic approach to wellbeing* (2011) includes dedicated sections on trauma-informed care and on family violence. The family violence section outlines key facts and statistics on family and interpersonal violence and then provides guidance for practitioners on:

102.1 responding to a victim/survivor, including specific guidance in respect of children who are exposed to, or are victims of, family violence;

102.2 working with people who use violence against family members; and

102.3 working with partners involved in intimate partner violence.

103. The guideline also provides guidance for organisations to assist them in their responsiveness to victims/survivors of family violence based around collaboration, leadership, policy and visibility.

104. Trauma-informed care recognises the impact of trauma on health, wellbeing and behaviour. Trauma-informed care also emphasises physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment. Trauma-informed care practice is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and interpersonal violence and the prevalence of these experiences in persons who receive mental health services.

105. In recent years, there has been a growing acknowledgement of the role of trauma in the lives of those who experience mental health problems. This has encompassed research into neurobiology and psychological consequences of trauma alongside a greater willingness on the part of clinicians to listen.

106. Whilst recognising the role of childhood trauma, trauma-informed care also requires an examination of the role of mental health services in inadvertently perpetuating trauma, and to look for ways of minimising the distress of consumers who require these services. This strength's-based model also recognises the consumer as survivor, and acknowledges that behaviour is adaptive to traumatic circumstances.

107. If people coming into mental health services have experienced past trauma (including violence and abuse), the use of restrictive practices, such as the use of seclusion (isolating someone and locking them in a room on their own), and the use

of physical and mechanical restraint, may re-expose them to violence when they are at their most vulnerable mental state, and re-traumatise them. The Reducing Restrictive Interventions project was undertaken by the Chief Mental Health Nurse, within the Office of the Chief Psychiatrist as a component project to support the administration of the Act and to assist services to comply with the *Charter of Human Rights and Responsibilities Act 2006* (Vic.). The project aims to support mental health services and emergency departments to reduce, and where possible eliminate, restrictive interventions.

108. A collaborative Reducing Restrictive Interventions training program was also developed to strengthen mental health services' capacity to deliver and support sensory modulation and trauma-informed care as clinical approaches to reduce restrictive interventions. Both trainer programs were co-produced with consumers, carers, occupational therapy and nursing.

109. During the Reducing Restrictive Interventions project, a number of services identified trauma-informed care education as a priority. An education package was developed targeting mental health cares, consumers and clinical staff with a background in education. All mental health services committed to providing time, resources and support to the introduction and roll out of the trauma-informed care training via a memorandum of understanding. Training was provided across the state in 2014.

Other initiatives

110. In 2011, Victoria released its *Framework for recovery-oriented practice* (attached to this statement at **Attachment MOB-13**) which:

110.1 identifies the principles, capabilities, practices and leadership that should underpin mental health service delivery;

110.2 provides broad guidance to individual practitioners and service leaders on recovery-oriented care;

110.3 articulates the requirement for mental health services to recognise environmental, family and social factors that impact a person's wellbeing; and

110.4 sets out principles for good practice including recognising the impact of mental illness on family and caring relationships and communicating and involving families and others in recovery.

111. In 2015, Victoria trialled Safewards, a UK model that identifies and addresses the causes of behaviours in staff and consumers that may result in violence, self-harm or absconding. The aim was to reduce or eliminate the use of restrictive interventions. The model recognises family and relationship factors, experiences and histories, including trauma and abuse and prompts staff to support people in the context of their personal circumstances. This can assist in mitigating the likelihood or severity of negative outcomes that might have led to conflict and the use of restrictive interventions, and the subsequent potential for re-traumatisation.

112. The Department and Victoria Police have recently collaborated to deliver the Mental Health and Police (**MHaP**) response initiative. MHaP response builds on the early trial of the Police, Ambulance and Clinical Early Response (**PACER**) pilot in Southern Metropolitan Region. PACER was designed to improve emergency services responses to psychiatric crises in the community by including a mental health clinician with police, which enabled, among other things, mental health assessments being conducted onsite, thereby avoiding the need to attend health service emergency departments.

113. Each of Victoria's area mental health services will receive recurrent funding to roll-out out the MHaP response program. The program:

113.1 strengthens the way mental health, police and emergency services work together to provide consumers with timely access to appropriate urgent mental health assessment and treatment; and

113.2 is supported by local Emergency Services Liaison Committees which operate in each mental health catchment area across the State. These Committees bring together representatives from police, mental health and emergency services, to plan and deliver services that provide a joint crisis response.

Chief Psychiatrist's guidelines

114. As Chief Psychiatrist, I have responsibilities for the development of standards, guidelines and practice directions for the provision of mental health services. These guidelines inform the development of the local policies developed by the mental

health services. The guidelines, in addition to national documents and frameworks, relevant state-based guidelines, documents and frameworks, and relevant legislation (including but not limited to the Act), assist in the development of mental health service policies and protocols.

115. Chief Psychiatrist guidelines are multi-purpose and are generally not prescriptive. Their role is to:

115.1 provide advice and clarification on relevant legislation;

115.2 establish minimum standards in relation to clinical practice; and

115.3 assist health services to develop local policies and procedures.

116. Chief Psychiatrist guidelines are also used by other government agencies such as the Mental Health Complaints Commissioner, the Mental Health Tribunal and the Health Services Commissioner to determine whether health services have appropriate local policies and procedures.

117. Although the Chief Psychiatrist has not developed a 'family violence' guideline, the following Chief Psychiatrist guidelines do relate to family violence:

117.1 *Working together with families and carers* issued on 8 April 2005 (attached to this statement at **Attachment MOB-14**);

117.2 *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units* updated on January 2012 (attached to this statement at **Attachment MOB-15**);

117.3 *Discharge planning for Adult Community Mental Health Services* issued in August 2002 (attached to this statement at **Attachment MOB-16**);

117.4 *Treatment plans under the plans under the Mental Health Act* updated in August 2009 (attached to this statement at **Attachment MOB-17**).

118. The *Working together with families and carers* guideline provides that:

118.1 families and carers should be recognised, respected and supported as partners in providing care to the consumers;

118.2 families and carers should be engaged as early as possible in the episode of treatment and care. Clear and open communication and the sharing of

information between clinicians, consumers, families and carers needs to occur regularly;

118.3 clinicians require a sound understanding of relevant statutory confidentiality provisions which define what information can be conveyed to families and other carers and under what circumstances; and

118.4 services should ensure the cultural and language needs of families and carers are considered.

119. The *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units* deals with sexual safety. It provides for:

119.1 early identification of those who are vulnerable to risk of sexual activity, harassment, abuse or assault should be undertaken;

119.2 an assessment being undertaken which includes, among other things:

(a) any concerns relating to visitors that may contribute to the person's vulnerability;

(b) history of violence; and

(c) history of sexual assault or harassment;

119.3 further enquiry where an initial assessment indicates past trauma, which assessment should seek to identify:

(a) the trauma history such as childhood physical, emotional or sexual abuse;

(b) any adult experiences of domestic violence;

(c) any other physical or sexual assault or harassment; and

(d) any experience of witnessing a violence act; and

119.4 appropriate management strategies being established, including:

(a) offering the patient a referral to the Victorian Centre Against Sexual Assault or other relevant service;

(b) outlining the process for making a police report and ensure the patient is assisted in making the report; and

(c) ensuring discharging planning addresses any ongoing support and treatment needs.

120. The *Discharge planning for Adult Community Mental Health Services* guideline provides, among other things, that:

120.1 discharge should occur in close consultation with the consumer and carers where ever possible, which can involve engaging with the family in interviews;

120.2 discharge planning should occur, which ensures the patient is appropriately supported in the community with relevant service providers; and

120.3 the intensity and type of services provided should be based on the clinical needs of the consumer and the range of services available within a broader integrated health care system.

121. The *Treatment plans under the Mental Health Act* guideline provides for:

121.1 the involvement of families and carers in the development of treatment plans for patients, and their regular consultation during the treatment process;

121.2 an assessment of the needs of families and carers, both to support the recovery of the patient and to maintain their own health and welfare, should be taken into account; and

121.3 the circumstances in which families and carers and other service providers can be given information about treatment and care of a patient in accordance with relevant legislative provision.

Local policies and screening tools

122. As observed earlier in this statement, mental health services are responsible for developing their own local guidelines, policies and procedures. These are based on national documents and frameworks, relevant state-based guidelines, documents and frameworks, and relevant legislation (including but not limited to the Act).

123. All health services undergo a regular cycle of accreditation; this is a rigorous process in which services are accredited against national standards. Review of their assessment tools is part of the accreditation process.

124. In the course of preparing this statement, I caused for enquiries to be made to each of the designated mental health services for the purposes of determining the extent to which they have established policies, protocols and assessment tools that bear on matters pertaining to family violence. I attach to this statement as **Attachment MOB-18** a table which sets out a summary of the outcome of those enquiries.

TRAINING THE MENTAL HEALTH SECTOR

MHPOD

125. Mental Health Professional Online Development (**MHPOD**) is a nationally available, online professional development resource for the mental health sector. It was developed as a national collaboration between each of the States and Territories and the Commonwealth. It was intended to be the primary resource to support the implementation of the *National Practice Standards for the Mental Health Workforce* (2002). The total number of MHPOD users, registered nationally since 2011, now exceeds 18,000, with 4,500 of these in Victoria.

126. There are 68 topics, and approximately 110 hours of content, in the MHPOD library, including information about the following topics:

126.1 working with people with forensic histories or at risk of offending, which information:

(a) addresses evaluating, determining or identifying risk of violence or assault, risks to the community and risk of reoffending;

(b) provides insight into problematic thinking and behaviour;

(c) addresses actuarial risk assessment instruments; and

(d) addresses topics such as families of offenders, psychological trauma, and families as victims;

126.2 risk assessment and management, which information:

(a) supports clinicians to understand risk at critical points, and at times of heightened risk (such as life events);

(b) highlights factors such as history of violence and the need to discuss the risk management plan with family or carers; and

126.3 social relationships: working with families, which information:

(a) supports clinicians to understand the significance of relationships;

(b) describes a range of approaches to working with families; and

(c) addresses different types of clinical risk to self and others, including violence and vulnerability.

Department-funded training

127. The Department funds a number of statewide education providers to provide targeted training across a number of priority and discipline-specific areas, but does not mandate training activity.

128. Under the devolved system, health services are largely responsible for determining local education and training needs.

129. There are a number of factors that influence training requirements and policies of health services, including:

129.1 professional registration standards;

129.2 health service training and development needs and policies; and

129.3 individual experience, interests and training needs guided by clinical supervisors.

130. The Department funds a number of state-wide and regional mental health and alcohol and drug education and training providers. These training providers deliver targeted training across a range of priority and discipline-specific areas to workers in these sectors.

131. The Department also funds Mental Health Learning and Development Clusters (**Clusters**) which serve the specialist mental health workforce (clinical and Mental Health Community Support Services) through regional catchments covering the State. The clusters are:

131.1 Latrobe Regional Hospital Mental Health Services, Alfred Psychiatry, Monash Health, Peninsula Health Psychiatric Services, Southern Synergy (LAMPS) Mental Health Learning and Development Cluster (Monash Health);

131.2 North East Victoria Innovative Learning (NEVIL) Mental Health Learning and Development Cluster (St Vincent's Hospital); and

131.3 Western Mental Health Learning and Development Cluster (Melbourne Health).

132. Clusters were established in 2004 after consultation with the mental health sector to improve access to training, education and professional development for the specialist mental health workforce including consumer and carer consultants, especially for those working in rural areas.

133. The choice of content areas for training activities arise from local training needs analysis or opportunities arising from offers from specialist providers, rather than being commissioned by the Department.

134. Examples of Department-funded training courses with regard to family violence over the past year are set out in a document attached to this statement at **Attachment MOB-19**.

135. In addition, Department-funded education and training providers also deliver training on a broader range of topics, such as trauma-informed care, that encompass family violence. **Attachment MOB-19** also includes a table summarising this training.

MANAGING THE RISK OF VIOLENCE, DETECTING VICTIMS AND INFORMATION SHARING

Risk of violence

136. Clinicians need to look at environmental and contextual factors that have an impact upon a person's historical and current life situation, beyond diagnosis, when assessing risk of violence. Additionally, people with severe mental illness are more prone to experience environmental stressors that elevate violence risk, and more vulnerable to past histories of physical abuse or parental criminal acts.

137. Although there is an established association between certain mental disorders (such schizophrenia) and increased rates of violent and criminal behaviours, most persons with mental disorder are not violent.

138. In the long term, mental illness is not ranked as a strong predictor of violent behaviour. When considering the long term prediction of risk of violence, mental health variables have less significance than other variables such as gender, age, past history of offending and social class (Mullen, 2001).

139. In order to manage risk of violence, the Act provides for the involuntary treatment of a person in the event that the treatment criteria in s 5 apply. The treatment criteria are:

139.1 that the person has a mental illness;

139.2 because the person has mental illness, the person needs immediate treatment to prevent:

(a) a serious deterioration in the person's mental or physical health; or

(b) a serious harm to the person or another person;

139.3 the immediate treatment will be provided to the person if the person is subject to a temporary treatment order or a treatment order; and

139.4 there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

140. In many instances, a person experiencing mental illness will not fit the criteria for compulsory treatment. Clinicians are required by the Act to balance the principle of providing treatment in the least restrictive and least intrusive manner, and a preference for voluntary treatment, with the potential risk that the person may pose to themselves or others.

141. The risk of serious harm to another person can include the risk of serious harm to a family member, carer or other members of the household. Clinicians should routinely consider the extent of any risk of serious harm to a family member, carer or household members that their patient may pose when conducting risk assessments.

142. After assessing the person, an authorised psychiatrist of a designated mental health service may subject a person to a temporary treatment order under the Act if the

authorised psychiatrist is satisfied that the treatment criteria apply. A temporary treatment order enables the person to be compulsorily:

142.1 treated In the community (community temporary treatment order); or

142.2 taken to, and detained and treated in, a designated mental health service (inpatient temporary treatment order).

143. A temporary treatment order may last for up to 28 days.

144. In order for compulsory treatment to continue, the Mental Health Tribunal is empowered to make a community treatment order or an inpatient treatment order if it is satisfied that the treatment criteria apply to the person.

145. The maximum duration for a community treatment order is 12 months (for an adult) or 3 months (for a child). The maximum duration for an inpatient treatment order is 6 months (for an adult) or 3 months (for a child).

146. As mentioned earlier in this statement, each area mental health service is responsible for developing their own policies and assessment tools. This includes policies and tools relating to risk assessment and detecting family violence.

Disclosure and use of screening and assessment tools to detect victims

147. Disclosure of violence is more likely if a victim is asked about his or her circumstances in a compassionate and non-judgmental manner, in private and in an environment where the person feels safe and confidentiality can be protected.

148. While identification in health care settings could be increased if all women were asked about intimate partner violence, this is only effective if followed by appropriate responses by the service.

149. It is important to distinguish between:

149.1 universal screening, which is the application of a standardised question to all symptom-free women according to a procedure that does not vary from place to place;

149.2 selective screening, where high risk groups such as pregnant women, are screened;

149.3 routine enquiry, where all women are asked but the method or questions may vary according to the provider or woman's situation; and

149.4 case finding, where questions are asked if indicators are present (Taft et al, 2013).

150. A review of the evidence base for universal screening for intimate partner violence in health care settings concluded there is an absence of evidence of long-term benefit for women, and as a result at this time there is insufficient evidence to justify universal screening (Taft et al, 2013).

151. While the current evidence is not necessarily supportive of universal screening, there is consensus that women identified as high risk should be asked about their experiences of family violence (case finding). All mental health service clinicians should ask questions regarding women's safety as part of routine inquiry about risks to self and others (Taft et al, 2013).

152. The questions asked in the risk assessment, and the responses, inform the patient's treatment and care plan.

153. In Victoria, while there is no single mandated family violence assessment tool, there is the Family Violence Risk Assessment and Risk Management Framework (otherwise known as the Common Risk Assessment Framework or CRAF) that is available for use by a range of professionals including 'front line' workers such as those working in health care settings. Training has been offered and provided to a range of 'front line' workers and some mental health clinicians have been trained in the use of this tool.

154. The CRAF is a sound starting point and a useful framework for mental health professionals; it contains clear information about appropriately responding to and dealing with perpetrators of family violence, and supporting victims of family violence. It highlights referral pathways and risk management strategies that should be considered by clinicians. It should be noted however, that the assessment tools have not been validated for use as a universal screening tool.

Information sharing

155. The Act enables 'health information' (as defined in s 3 of the Act) to be disclosed in specified circumstances, to ensure that people with mental illness receive effective treatment and care.

156. Health information may be disclosed if the person to whom the information relates consents to its disclosure.

157. Where a person is unable to consent or refuses consent to disclose health information, the Act permits information to be disclosed in specified circumstances.

158. Section 346 relates to the disclosure of health information about a consumer. It sets out a general prohibition of disclosure of health information about a consumer. However, it also provides for specific exceptions.

159. Subsection 346 (1) provides that the following must not disclose health information about a consumer:

159.1 the mental health service provider;

159.2 any member of staff or former member of staff of the mental health service provider;

159.3 any person who is or was a contractor of the mental health service provider;

159.4 any volunteer or former volunteer at the mental health service provider;

159.5 any member of the board or former member of the board of the mental health service provider.

160. Relevant exceptions are listed in s 346(2). They include, but are not limited to:

160.1 where the consumer consents;

160.2 if the disclosure is permitted by another Act other than the *Health Records Act 2001* (Vic.) (such as, for example, the *Children, Youth and Families Act 2005* (Vic.));

160.3 if the disclosure is permitted by certain Health Privacy Principles (**HPPs**), including but not limited to:

(a) HPP 2.1. – The information may be disclosed for the primary purpose it was collected;

(b) HPP 2.2(a) – The information may be disclosed for a secondary purpose directly related to the primary purpose and the individual

would reasonably expect the disclosure for the secondary purpose;

(c) HPP 2.2(h) – The information may be disclosed where the organisation reasonably believes disclosure is necessary to lessen or prevent:

(i) a serious and imminent threat to an individual's life, health, safety or welfare; or

(ii) a serious threat to public health, public safety or public welfare;

and the information is use or disclosed in accordance with guidelines, if any, issued or approved by the Health Services Commissioner under s 22 of the *Health Records Act 2001*;

160.4 where disclosure is made in general terms to a friend, family member or carer of the person to whom the health information relates and the disclosure is not contrary to the views and preferences expressed by the person that the health information must not be disclosed to that friend, family member or carer;

160.5 the information may be disclosed if the person to whom the health information relates is a patient and—

(i) the disclosure is reasonably required by a carer of the patient to determine the nature and scope of the care to be provided to the patient and to make the necessary arrangements in preparation for that role or to provide care to the patient; and

(ii) regard has been had to the patient's views and preferences, including those expressed in any advance statement that the patient may have prepared;

160.6 where the disclosure is made to a parent of the person to whom the health information relates and the person is under the age of 16 years; and

160.7 where the disclosure is reasonably required in connection with the performance of a duty or the exercise of a power by the Minister, the

Secretary, the Commissioner, the Chief Psychiatrist or an authorised officer under the Act or the regulations.

IMPROVING THE RESPONSE TO FAMILY VIOLENCE

Trauma-informed care

161. There is increasing recognition in mental health services that clinical practice and patient treatment and care should be informed by trauma-informed care and have a focus on recovery. As observed earlier in this statement, trauma-informed care recognises the high prevalence of experiences of assault and abuse among people accessing mental health services and acknowledges the ongoing impact of trauma on people's health, wellbeing and behaviour. Trauma-informed services take care to avoid practices that may exacerbate or retrigger previous experiences of trauma and undertake routine enquiry about people's experiences of abuse.

162. There is a need to introduce and support trauma-informed care within mental health services, which will assist in providing a better response to victims of family violence.

163. Reorientating mental health services to implement trauma-informed care constitutes a major shift in current practice, takes time, and needs a staged approach and state and local agency support. To assist mental health services implement a trauma-informed care response the following is required:

163.1 development of a Statewide Trauma-Informed Care Strategy;

163.2 development of a Trauma-Informed Care Guideline;

163.3 development of a Trauma-Informed Care Implementation Plan.

Improving processes

164. There is also an opportunity for mental health services to improve their intake and assessment processes to inform better treatment and also improve their discharge planning to ensure those leaving 'in-patient care' settings have a safe home to go to, and an integrated and supported recovery plan in place.

165. Mental health services should also be supported in the use of assessment frameworks such as CRAF.

Increased education, training and professional development

166. Further training of health professionals to enable them to respond effectively to family violence is required.

167. There is also a need to build on the existing professional development and training programs, to support core competencies and capacity of specialist child and youth, adult and aged mental health services to recognise the association between mental illness and trauma.

168. The topic of family violence should be included in the training curricula of student doctors, nurses, midwives, and other health workers, to help improve professional attitudes and service responses. Any training needs to be sustained and supported by ongoing supervision and mentorship.

The role of advocacy

169. There is also a need to support the use of advocacy by health-care providers with additional training or the use of specialist advocates against family violence. Advocacy interventions aim to help abused women directly by providing them with information and support to help them access community resources.

Inter-sectorial development

170. There is a need for the mental health workforce to develop skills in family violence and for the family violence workforce to develop skills in mental illness. A range of targeted strategies can strengthen inter-organisational relationships, increasing confidence and referral pathways. This could include provision of 'in-house' secondary consultation. For example, mental health workers in family violence services and vice versa.

171. In addition to supporting mental health services, it is important to strengthen capability and competency of family violence services to:

171.1 routinely assess clients for emerging or existing mental illness;

171.2 determine the relationship between mental illness and violence in any given instance; and

171.3 appropriately support and refer clients with mental illness to specialist services.

172. The UK Institute for Health and Care Excellence (**NICE**) provides detailed guidance for the development of a multi-service system response to family violence. I attach the *Nice Pathways: Domestic Violence and Abuse Overview* at **Attachment MOB-20**, which describes this approach.

173. The NICE Guidance provides both strategic and operational recommendations to support this multi-agency response. A strategic level response includes recommendations for: organisational leadership and governance, service mapping, policy development, supporting multi-agency partnerships, coordination of responses across health services and the identification of service gaps.

174. An operational level response includes: integrated care pathways, staff training, creating an environment for disclosure, use of appropriate tools, and adopting clear protocols and methods for information sharing. Services should tailor support to meet people's needs, including prioritising safety, and helping access generalist and specialist services as required through assessment and referrals.

175. Ultimately, working in multi-agency partnerships is the most effective way to approach the issue of family violence at both an operational and strategic level.

Signed by **Mark Oakley Browne**)

at Melbourne)

this 17th day of July 2015)

Before me [redacted]

[redacted]