Victorian Royal Commission on Family Violence

RANZCP Victorian Branch Submission

Background

This submission is made by the Victorian Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to the Victorian Royal Commission on family violence. The Victorian Branch welcomes the opportunity to make a submission on reforming family violence service delivery and informing best practice in Victoria. The Victorian Branch represents approximately 1000 Fellows of the College. The RANZCP is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand and has responsibility for setting the training program, examining and providing access to Fellowship of the College to medical practitioners.

Executive Summary

This submission addresses the need for Psychiatrists to engage with the mental health impacts of family violence (FV) and to minimise the risk of violence through timely and appropriate responses by the health system to enhance early detection and identification of FV in both victims and perpetrators. Optimally to support and treat the victims; and manage the risk of violence by providing mental health treatment to and rehabilitation of perpetrators where necessary. FV is a complex societal issue (Heise, 1998) and the health problems of victims and perpetrators add further to the complexity, heightening the risk of violence against women and children.

This document is divided in 6 segments

- A need for change in health and justice systems
- Perpetrators and the impact of mental health issues
- Family Violence systems
- Mental health impacts of domestic violence on victims and children '
- Education and training of psychiatrists, mental health practitioners and other medical professionals
- Setting up a Victorian Centre for Excellence around family violence and mental health.

The RANZCP recommends the following steps be implemented:

1. A close consultative relationship between Peak Mental Health Bodies and Men's Behaviour Change programs at points of policy, research, training and service delivery.
2. The Justice System and the Health System at a policy level and service delivery level, provide inter-disciplinary training and education to staff; and provide on-going health support for victims, children, and perpetrators accurately and appropriately.

3. The following amendment from New Zealand legislation be added to the Australian Family Law Act:

   "A court must not order that a child spend unsupervised time with the person who has used violence (that is found to be proven) unless the Court is satisfied that such an arrangement could be safe and in the child's best interests"

4. Organisations specialising in the therapeutic needs of children be included in any response by the sector on FV service delivery reform.
5. That unfettered legal access to psychiatric records should be stopped.
6. Guidelines to establish links between FV and Mental health Systems at policy, academic, education and training levels are required.
7. Adoption of the RANZCP Round table multidisciplinary meeting recommendations [see page 13] to set up a multi-disciplinary working group that would facilitate liaison between health, justice and FV services, and community based organisations.

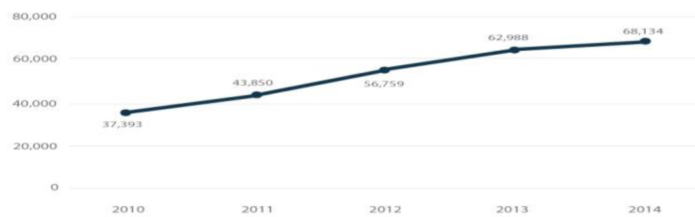
Introduction

Family violence (FV) is defined in the Victorian Family Violence Protection Act (2008) as:

> *(a) behaviour by a person towards a family member of that person if that behaviour—(i) is physically or sexually abusive; or (ii) is emotionally or psychologically abusive; or (iii) is economically abusive; or (iv) is threatening; or v) is coercive; or vi) in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person; or (b) behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the above effects.*

A recent Australian survey found 19 per cent of women had been subjected to sexual violence and 34 per cent had experienced physical violence after the age of 15 (Australian Bureau of Statistics, 2012). Although Australian population studies reported a downward trend in FV in the decade from the mid-1990s to 2005, subsequent surveys reveal a disappointing lack of reduction in FV from 2005 to 2011 (Australian Bureau of Statistics, 2005, 2012). Indeed, in the State of Victoria, FV reports increased from 43,850 in 2011 to 62,988 in 2013 to 68,134 in 2014 (Victorian Government, 2014). In 2013 alone 44 FV related deaths occurred in Victoria (Premier of Victoria website, 2015). It is not clear as to the reason for this increase - is it increased reporting, or increased incidence due to the recent surge in immigration, or both? *There is an urgent need for finding new approaches to minimise and to manage the risk and address the complexity of FV*. Thus RANZCP welcomes this Royal Commission. As the peak body responsible for mental health professionals the RANZCP makes this submission to suggest ways to minimise the risks of FV, and enhance the chances of recovery and rehabilitation of victims, children and perpetrators.

Figure 1 Rising rate of police reports of FV.



FV is a complex issue. The ecological model of Heiss and colleagues (Heise, 1998) adopted by WHO (2002) illustrates the interactions between societal, cultural, family and individual factors, each overlaid by patriarchy which gives men the privilege of position, power, dominance and control over women and children (Pease, 2010). Factors such as mental illness, alcoholism, gambling and social issues like unemployment and racism intersect leading to an exaggerated of risk of violence.

Figure 2. The complex nature of domestic violence (Heise, cited in WHO, 2002)

CURRENT STATE OF FAMILY VIOLENCE SERVICES

The current pathways and systems that serve as points of entry into the FV system and on-going care of victims and perpetrators as shown in Figure 3 are the Justice system, FV Services and main stream services (Victorian Department of Human Services, 2012). There is administrative linkage at the policy and practical level between the Justice System and FV services but there is no existing policy to link health services with FV or the justice system. The serious consequence of this fragmentation was brought home to the nation by tragic murder of the 11 year old Luke Batty in full public view by his mentally ill father Greg Anderson on the 12th February 2014 (Hurley, Dowsley, Dowling, & Hadfield, 2014). This abnormal behaviour was followed by Anderson attacking the police who in turn shot him to his death.

Further analysis reveals Anderson had shown previous behaviours depicting his sense of male entitlements, dominance and control over his ex-partner Rosie Batty (Spencer, 2014). Anderson had breached multiple Interpersonal Violence Orders (IVO) and, as Batty explained at a RANZCP hosted multi-disciplinary Round Table, his behaviour had deteriorated after becoming unemployed and unemployable, homeless, violent outside the home, and living an increasingly itinerant life style over the preceding 5-7 years. Various community and faith

groups who had tried to assist Anderson gave the same story of his abnormal thought patterns and beliefs of a religious nature and his hearing voices (Spencer, 2014).

Anderson's psychological autopsy, conducted by Professor Paul Mullen for the Coroner's Report, said there was sufficient evidence to suggest he had Delusional Disorder that was not diagnosed nor treated (pers. comm., R. Batty 28th December, 2014). Furthermore a lack of training and sensitisation to FV among the hospital staff led to a blind spot (Hegarty 2011) which overlooked the linkage between mental illness and Anderson's violence against his partner Rosie Batty and son.

This story has captured the nation's attention because of the inhuman cruelty displayed by Greg Anderson but also because like so many others it was a preventable tragedy. The missed opportunities for early identification of Anderson's Delusional Disorder by the health system, a lack of communication and sharing of key information between the Justice and the Health Systems could have minimised the risk of violence and possibly prevented Luke Batty's unnatural death.

It is highly likely that Anderson's abuse of power and control over Batty pre-dated his "psychotic" behavioural deterioration and was an aspect of his sense of male privilege over women (pers. comm., R. Batty 28th December, 2014). This case exposes the complex nature of FV, where many factors intersect and each requires a careful understanding, with application of correct, effective and efficient treatment (pers. comm., R. Batty 28th December, 2014). Only then we will minimise the harm caused by this complex social issue.

Figure 3: The victim's journey through an integrated service system (Victorian Department of Human Services, 2012).

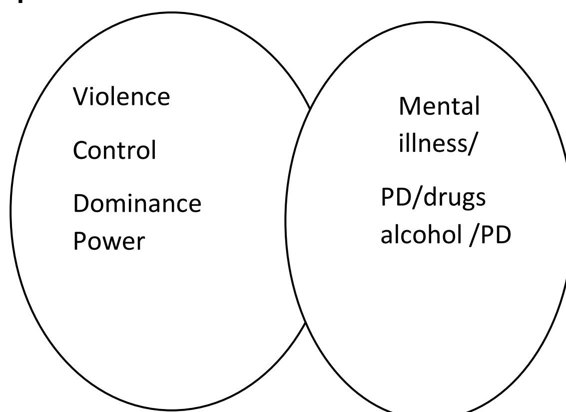
Every case is different making matters difficult and unpredictable thus presenting a unique challenge; testing the "System" and professional capabilities. A lack of training of mental health professionals in FV, of hospital systems to detect and support the victims and perpetrators, of appropriate polices at departmental levels all contribute to lost opportunities for early intervention, harm minimisation and rehabilitation back to a productive life. Each case is a potential Rosie Batty case.

MENTAL HEALTH ISSUES AND PERPETRATORS

Although violent behaviour and psychopathology often co-occur, there has been little research on psychiatric disorders among men in treatment for FV and therefore treatment approaches that will yield good outcomes (O'Connor, Castle & Cox, 2015; Askeland, & Heir, 2014). There are no risk factors among perpetrators that can predict FV accurately. Some factors, however, can accelerate or exaggerate violent behaviours. The interplay between mental health issues and domestic violence needs to be explored (Stark & Douglas, 2010). For example psychotic illness, obsessive sexual jealousy, alcoholism, gambling, substance abuse and Psychopathic, Narcissistic, and Borderline Personality Disorder can influence behaviours and outcomes in relation the above (Lang 2013).

A recent survey of perpetrators in Norway, participating in a men's behaviour change program on a voluntary basis (Askeland & Heir 2014; Askeland, 2012) found mental illness in 70 per cent of men (Fig 4). The authors point to problematic rehabilitation, relapse and risk of serious offending (Spencer, 2014). The RANZCP recommends that this study be replicated in Australia.

Figure 4: Perpetrators



Recommendation 1:

RANZCP recommends a close consultative relationship between Peak Mental Health Bodies and Men's Behaviour Change programs at points of policy, research, training and service delivery.

THE JUSTICE SYSTEM

That family violence is a crime is re-enforced under the Victorian FV Protection Act (2008). The criminal nature of FV has "*a symbolic and a substantive effect*". The FV laws provide protection for victims and act as a deterrent for would be perpetrators (Douglas and Stark, 2010). Under the FV laws family violence is treated as a criminal assault. Yet there are important differences between ordinary assault and domestic assault. Both are criminal in nature but domestic assault is complex and different. *A single charge of assault may not reflect the gravity of the harm experienced by the victim, may not reflect his criminal history, or signify the seriousness of future risk.* FV is a problem that includes webs, networks and family connections. Furthermore FV is not a one off episode; it is often recurrent and underhanded with insufficient proof of evidence (Douglas and Stark 2010). *There is a need for revisionary thinking and "broadening of our gaze" while identifying early opportunities to interrupt the cycle of violence* (Centre for Innovative Justice, 2015).

Recommendation 2:

RANZCP recommends that the justice system and the health system at a policy level and service delivery level, provide interdisciplinary training and education to staff; and provide on-going health support for victims, children, and perpetrators accurately and appropriately.

Impact on children of witnessing family violence

For young children psychological trauma can occur when they experience frequent, overwhelming and protracted states of fear or terror that are unrelieved and not adequately buffered by parents or care givers. To survive the traumatic fear the child attempts to make costly adaptions to survive and can lose the opportunity for normal childhood experience.

A range of evidence based child-parent psychotherapeutic interventions are available to treat traumatised young children and their families (Osofsky, 2007; Jordon & Sketchley, 2009). Several are specifically designed with developed manuals aimed at children subjected to family violence (Bunston & Heynatz 2006; Lieberman et al 2005). Some work has been done adapting interventions to families caught in conflicted family court disputes. Interventions have also been developed for children in context of Child Protection services.

While much of the above specifically relate to young children the same or similar interventions with child-parent and family relationships can be used of older children and adolescents (National Child Trauma Stress Network accessed 27 May 2015).

Recommendation 3:

RANZCP recommends organisations specialising in the therapeutic needs of children be included in any response by the sector on reform.

Children and the Justice System

The Family Law Act (1975) and the immediate and long-term effects of parental and care-giver abuse perpetrated on children.

The immediate effect of physical, sexual and emotional abuse perpetrated by a parent or care-giver on children includes intense fear of the perpetrator. Because of threats by the perpetrator to kill one or more of the child, siblings, pets or non-abusing parent if the child discloses the abuse, the child may go to great lengths to disguise the consequences of abuse. For example, the child may refuse to participate in school sport because removal of clothing will reveal bruising. It may take many consultations with a treating psychiatrist to establish a therapeutic alliance and gain the child's trust before the child will disclose the abuse.

Abused children frequently present with symptoms of PTSD, including anxiety, nightmares and depressed mood. Children may present to the psychiatrist with symptoms of depressive illness, self-harm and suicide attempts. Marked improvement in symptoms may be observed after parental separation. It is often only after separation that a child is able to disclose the extent of the abuse he or she has suffered, including threats to kill the child.

The added emotional stress of abuse can harm the development of children's brains and impair cognitive and sensory growth (Perry, 2001). Children are at risk of poor developmental outcomes. Fear may trap children into a position where they cannot discuss their parents' problems or to ask for help from their peers, other family members, family support networks or professionals (Odyssey House, Victoria, 2004, Dawe, et al., 2007). In discussion of risk to children of witnessing domestic violence, Perry states: "A toxic stress and complex trauma caused by living in a perpetual state of alert can damage the developing brain and have profound long-term psychological effects" (Perry, 2001). Here Perry provides a detailed discussion of the biological damage to the brain of living with constant fear of violence (Perry, 2001).

In these cases any contact with the abusing parent can have detrimental effects on the child's mental health including increased risk of suicide and in some cases increased risk of homicide. The impact of childhood experiences of violence is associated with future risk of FV especially physical abuse as a child can be associated with adult violence and psychologically controlling behaviours and sexual abuse with sexual violence (Askeland, Evang, & Heir, 2011)

Because of the current Family Law Act legislation, a child can be legally prevented from continuing psychiatric treatment with their psychiatrist. One of the risks of premature cessation of treatment is that the child may die from a preventable suicide. In the case of child abuse, the parent who is the perpetrator of the abuse may want to terminate the child's psychiatric treatment to prevent disclosure of the abuse.

The medical practitioners involved in these complex cases are in a conflict between their ethical professional obligations and a law that forbids them to continue ethical treatment. An example is where the child who was not permitted to receive psychiatric treatment made a serious suicide attempt. When psychiatric treatment was resumed with legal permission there were no further suicide attempts. However, the process of getting legal permission required extraordinary efforts by the psychiatrist.

New Zealand Family Law legislation provides that:

> "A court must not order that a child spend unsupervised time with the person who has used violence (that is found to be proven) unless the Court is satisfied that such an arrangement could be safe and in the child's best interests" (Strickland, 2012).

Recommendation 4:

RANZCP recommends the above amendment be added to the Australian Family Law Act.

Detrimental Effects of Subpoena of the Medical Record in Family Law Litigation

RANZCP is concerned about the frequent practice of solicitors subpoenaing patients' psychiatric records during family court litigation. The patients are often already victims of domestic violence and experience the violation of medical confidentiality of their psychiatric treatment as a further emotional abuse. Many psychiatrists have expressed their concern about their ability to continue practising in these circumstances, in which their medical ethics are compromised. [See Attachment] (Australian Medical Association, 2014).

Unfettered legal access to psychiatric records is inconsistent with professional ethical guidelines and risks undermining the provision of quality psychiatric care to the community. The existing legal provisions are failing to protect psychiatrist-patient confidentiality. (Levy, Galambos, & Skarbek, 2014)

Recommendation 5:

RANZCP recommends Unfettered legal access to psychiatric records should be stopped.

Family Violence Service Systems

FV services serve as a source of significant support for victims. There is an administrative linkage between FV services and the Justice System. The clients can be referred by the Justice System but there is also a capacity for self-referral. FV services provide refuge, shelters, case management, housing and counselling. FV services also oversee 'Men s Behaviour Change Programs'. The RANZCP recommends a closer working relationship between FV and Mental Health services.

Some 75 per cent of women suffering multiple forms of abuse (the most common scenario) are likely to develop a mental illness, for example PTSD, Depressive Illness, Anxiety Disorder, Alcohol and Substance use disorder. Inadequate recognition and treatment of the above conditions is putting the recovery of women and children in jeopardy and yet less than half of countries provide adequate mental health support to women (WHO, 2013b).

Recommendation 6:

RANZCP recommends that guidelines to establish links between FV and mental health systems at policy, academic, education and training levels must be developed.

Health Systems - Potential Allies In Early Detection, Intervention And Prevention

Women who are abused seek health care more often than their non-abused counterparts. Health professionals are therefore in a unique position to address the health and psychosocial needs of women who have experienced violence. Health professionals can provide assistance by facilitating disclosure, offering support and referral, providing the appropriate medical services and follow-up care, or gathering forensic evidence, particularly in cases of sexual violence (Hegarty et al., 2013).

WHO (2013b) states "*a health-care provider is likely to be the first professional contact for survivors of intimate partner violence or sexual assault*". For example 76 per cent of abused women who suffered head, neck and facial injuries (Lowe 2001) and would cancel other medical appointments but tend to keep their dental appointments.

HEALTH CONSEQUNCES IN VICTIMS

Figure 5 - Serious Health consequences of FV in victims (WHO, 2013a).

PHYSICAL INJURY	MENTAL/ STRESS	FEAR AND CONTROL
Musculoskeletal/ Fractures/ Head Neck Injuries	PTSD, Anxiety, Depression, Eating Disorders, Suicdality 87% will develop MH condition if 3-4 types of abuse	Health Care Seeking Lack Of Autonomy
Soft Tissue	Alcohol, Substance Use Tobacco	Lack of contraception Unsafe sex, unwanted sexual practices
Sexual	Physical Illness- CV Dis, H/T, IBS, Chr Pain, Pelvic Pain	Forced TOPs, STI, Gynae problems
Other Internal	Pregnancy -Perinatal Problems, premature babies, pregnancy loss	Pregnancy -Perinatal Problems, premature babies, pregnancy loss
Disability Death Suicide Homicide	Disability – Death Homicide	Disability – Death Homicide

The most profound and long lasting effects of FV are those related to mental health ill health. Chronic stress such as that seen in FV leads to neuro-biological impacts which in turn produces mental illness and physical illness.

Figure 6. Chronic stress produces neuro-biological impacts that lead to long term mental and physical illness.

(Miller, 1998)

FV has profound consequences in many aspects of health and wellbeing. Around 75 per cent of FV cases result in physical injury or adverse mental health consequences for the victim (WHO 2008, 2013b). This often extends beyond the primary victim to other family members, especially children (WHO, 2013 a). Victims of FV suffer from a range of medical, gynecological, psychiatric, and orthopedic complications (Campbell 2001). Recurrent physical illnesses,

including urinary problems and sexually transmitted infections, often lead to unnecessary investigations and treatments.

The relationship between mental health issues and violence against women is complex. FV is a major risk factor for depression, deliberate self-harm and PTSD (WHO, 2013a); women with diagnosed mental illnesses also have increased vulnerability to physical and sexual violence (Khalifeh et al, 2015). Yet health is an under-utilised pathway to healing and prevention in FV (WHO, 2013b).

Mental illness leads to disability and impaired ability to make healthy choices and prevents a return to a more productive life. New emerging evidence shows a shorter life span for victims of FV as compared with non-victims and high suicide rates (WHO 2008; Shidhaye & Patel, 2010, Trevillion et al 2014). There is evidence of good outcomes with expert treatments and social supports, with recovery from mental illness and long term rehabilitation. Treatments include psychological therapies, psychotropic medications, and supportive networks (WHO, 2013b).

Training of Health professionals

The relative lack of engagement of health professionals with this issue results in missed opportunities for early detection and intervention. There has been emerging recognition in recent years that doctors require training to identify cases of FV, and to respond appropriately when it is disclosed (Hegarty et al, 2013). Lack of FV in Psychiatric classificatory systems is a major barrier to teaching medical students and for clinicians interacting with patients with the complex issue of FV. When questioned professionals did not believe that enquiry about FV was part of their role and within their competence (Rose et al., 2010). The Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 has corrected this omission by including FV under 'Other Conditions that may be a focus of clinical attention'. Furthermore 'Adult abuse by non-spouse or non-parent' now earns a label of its own (American Psychiatric Association, 2013). This is particularly relevant for Aboriginal and certain culturally and linguistically diverse (CALD) communities where extended family systems are the norm; FV can be perpetrated by multiple perpetrators including mothers and fathers-in-law, brothers–in-law among others (O'Connor & Colucci, in press). A collaborative approach between the treating doctor, protective agencies and FV services is required.

Inadequate training of health professionals

There is NO provision currently for mental health professionals to obtain specialised FV focused training in any of the following fora:

- Continuous Professional Development
- Tool kits to train individual practitioners

- Clinical approach to possible victims and perpetrators in psychiatric services and hospital
- Curriculum of medical undergraduates
- Psychiatry Trainees at post graduate training

There is a lack of FV education at all levels of medical and psychiatry training that is hindering optimal engagement with the complex issue of FV, which requires input from all mental health professionals and FV services.

RANZCP hosted Multidisciplinary round table (27th February, 2015)

A RANZCP hosted round table was held to address the current lack of emphasis on mental health in FV service delivery. The meeting had following goals and objectives:

1) To enhance the mental health response to FV and to make mental health service delivery aligned with main FV services.
2) To prepare a document that will incorporate mental health responses to FV comprising assessment and treatment of victims and perpetrators and preparation of the Mental Health system through training and education of psychiatrists. This document will be submitted to the Royal Commission.
3) To establish pathways for interaction between psychiatry and existing key organisations, with discussion to gauge the response of the current stakeholders to the idea of placing mental health issues in the middle of the FV discussion.

Outcomes from the Multidisciplinary round table

The meeting agreed that:

- Violence against women is not a small problem that only occurs in some pockets of society, but rather is a global public health problem of epidemic proportions, requiring urgent action.
- FV has significant effects on women's physical, sexual and reproductive, and mental health and there is a bidirectional relationship between mental illness and victimisation.
- Society needs to talk about partner violence and not disguise it or refer to it in vague terms like 'family conflict'.
- Recognise the gap in research on immigrant domestic violence where cultural taboos and secrecy keep FV hidden.
- Better training is necessary for medical practitioners to recognise and understand the causes and manifestations of FV.
- Hospitals and health care services need to put recognition of FV into their safety and quality infrastructure to help recognise injury presentations and distress caused by FV.
- Establish women centered care and a national centre on domestic violence with appropriate resources for practitioners and patients.

- Develop a practice guideline for treating complex trauma across disciplines, not exclusively for medical practitioners.
- Recognise the physical and emotional impact on children of witnessing FV and the cumulative and compounding trauma that can result.
- It is crucial to understand the importance of how service delivery is done, simple interactions and relationship building between the health practitioner and the patient can help begin to repair the individual.
- Practitioner self-care is important when dealing with cases of FV trauma and abuse.
- Housing services are imperative to allow women a safe place to stay once they leave a violent relationship.
- Develop a multidisciplinary approach to service delivery to reduce the service silos that exist across housing, legal, mental health, and child protection.
- Provide a safe reporting environment and support women to disclose then assist them to leave the relationship when they are ready.
- Health offers a significant pathway to early intervention, recovery and rehabilitation of the victims as well as perpetrators and for those witnessing FV such as children.

The Health system has not received due emphasis in this epidemic of FV – either at the response or prevention level. There is a clear need to scale up efforts across a range of sectors, both to prevent violence from happening in the first place and to provide necessary health and safety services for women experiencing violence.

Recommendation 7:
RANZCP recommends adoption of the roundtable multidisciplinary meeting agreed to set up a multi-disciplinary working group that would facilitate liaison between health, justice and FV services, the RANZCP along with Community based organisations such as WIRE, DVRC, CALD organisations, including Australasian Centre for Human Rights and Health (ACHRH), and faith leaders. The office of the Chief Psychiatrist and Office for Women need to be involved to influence policy settings.

Recommendations

RANZCP calls on the Royal Commission to adopt the following recommendations:

1. Mental health settings are likely to see complex cases illustrating the relationship between mental illness and FV. It should be mandatory for all mental health professionals to be trained in FV. The RANZCP recommends the Office of the Chief Psychiatrist be involved to formulate policy, initiate training and setting up of trauma informed services for victims of FV; and institute on-going evaluation in mental health settings. RANZCP recommends one main respected champion of the cause at each institution.

2. In Australia health care is provided largely by private medical and allied health practitioners. Public mental health facilities, general hospitals and private hospitals also play an important role. Optimal care and standardised procedures for all women entering any health system needs to include case identification and appropriate referral where there are suspicious injuries, dental injuries ,suicidal attempts, depression, PTSD, Alcohol abuse. Thus all health settings to have at least one dedicated person for example a Nurse or a Mental Health Nurse to have training in FV and work with suspected FV victims, children and perpetrators.

3. Communications at policy, administrative, training and research levels is required between the mental health sector, the health sector, Justice System and FV services.

4. Awareness and understanding of FV is of vital importance for medical practitioners to recognise in both victims and perpetrators. Training in FV and its health impacts should be incorporated at under-graduate medical training and post graduate education and on the job training in all relevant specialties such as Paediatrics, Psychiatry, Obstetrics and Gynaecology, Emergency Rooms, Dentistry, Physicians and Orthopaedics.

5. Funding for a Centre of Excellence in Mental Health and Family Violence. The centre needs to be established with the following goals:

   Goal 1 - Enhance networks between FV services, the Mental Health Services and Justice Services; research in mental health associated with FV and child maltreatment in intimate partner violence; and to develop strategies for enhancing existing interventions and developing new ones.
   Goal 2 – To research and liaise with international centres, for example the Canadian Research Centre's PReVAIL Network that seeks to "*Understand and Foster Resilient Mental Health Outcomes in the Context of Violence across the Lifespan"* (Ref: PReVAIL network Canada (WHO 2015).

   Goal 3 – To break the silence on the FV issue in mental health settings; to provide safe evidence based services for men and women - both victims and perpetrators.

6. Where a child is undergoing psychiatric treatment, the possibility of serious detriment to the child as a consequence of mandated termination of treatment should be taken into consideration by the judicial decision-maker. In such cases a report should be sought from the treating psychiatrist.

7. Proposed amendment to the Family Law Act (1975) - Family Law legislation recognises that for some child victims of parental abuse it is detrimental to the children's mental health and development to have any contact with the perpetrators of the abuse.

8. That the amendment below be added to the Family Law legislation:

   "A court must not order that a child spend any time with the person who has used violence (that is found to be proven) unless the Court is satisfied that such an arrangement could be safe and in the child's best interests."

9. Only when it is considered legally necessary to obtain information from the treating psychiatrist, rather than subpoenaing the medical record, should a treating psychiatrist's report be requested.

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Subpoenaing medical records – a violation of the doctor-patient relationship?

There is growing concern among psychiatrists about the prolific use of subpoenas to gain access to their patient's psychiatric records. Particularly common in family court matters, it appears that some solicitors are trawling through the psychiatric records of an estranged partner of their client on a 'fishing expedition' for material that might reflect unfavourably, thereby improving their own client's position in custody battles.

Using subpoenas to obtain third party access to medical records is not unique to psychiatry. The practice is becoming increasingly common in Worksafe and TAC matters also, with subpoenas issued to general practitioners and treating specialists. This has the consequence that many unrelated medical conditions which form part of a patient's general practice record, for example, being known to the court.

This is extremely concerning on a number of levels.

Firstly, confidential medical records are generally not prepared with the anticipation that they will be viewed by third parties. It is easy for a medical record to be misinterpreted when it is read by someone other than the practitioner who prepared it, particularly when that third party may not have medical training or sufficient technical understanding to accurately interpret it, such as a solicitor or the patient.

Some psychiatrists and practitioners are acutely aware of this problem. In matters where it is highly likely that court proceedings will ensure (if they are not underway already), some practitioners are recording a more limited set of patient notes in anticipation that these records will be required to be presented to the court.

This emerging practice has the benefit of limiting the violation of their patient's privacy. However, it raises greater concerns in that it limits the efficacy of the consultation between the doctor and patient. It also has the potential to expose the doctor to allegations of professional misconduct for failing to keep full and accurate patient notes in line with Medical Board requirements.

In psychiatry, particularly, establishing a relationship of trust and confidence between doctor and patient is crucial

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to optimum care of the patient. If a patient cannot rely on absolute confidentiality of the information they share in a consultation, they will be very unlikely to open up to their psychiatrist. Not surprisingly, this limits the psychiatrist's ability to treat the patient effectively. Arguably, it would be devastating to the therapeutic relationship if a practitioner had to preface consultations with a declaration that information shared between doctor and patient was not confidential, and that the patient should not tell the doctor any information that the patient is not happy to be revealed in court at a later date. This situation, however, is reflective of reality in many circumstances.

A treating psychiatrist is put in a very difficult position where a patient reveals something in the course of a consultation which may compromise their position in court. For example, in a custody battle some sorts of information may be seriously influential to the outcome of the dispute, notwithstanding that the revealed fact was unrelated to the patient's ability to parent.

Psychiatrists in this situation are faced with two, equally unsatisfactory, options. They may:

1) Ask the patient not to reveal information which they do not want revealed in court at a later date, and thereby compromise the therapeutic relationship; or

2) Not record information in the medical record which may compromise the patient if it was made known to the court, and, by doing so, risk being found guilty of professional misconduct by the Medical Board.

Worse still is the situation where a patient in need of psychiatric care refrains from seeking medical help because they fear it might compromise their position in a court battle. The erosion of doctor-patient confidentiality is a strong deterrent to accessing psychiatric care, particularly given the stigma already associated with mental health conditions.

The potential harm to patients when their (supposedly) confidential records are revealed in court should not be underestimated. Psychiatrists can identify many instances where patients have suffered significant setbacks in their treatment, often of a number of years, due to their records being publicly aired in court.

There is very little a doctor can do to protect the confidentiality of their patient's records once they have been subpoenaed. A subpoena is an order of the court and it must be complied with.

Although there are opportunities to object to a subpoena for the production of a patient's medical record, these options are limited, costly, time consuming and largely ineffective. Courts tend to err on the side of disclosure, on the basis that open disclosure is more likely to lead to a fair result.

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Where a doctor has received a subpoena and objects to the release of their patient's records, they may:

- Send the records to the court together with an objection notice, setting out the reasons why the records should not be released. Alternatively, some doctors send the records to the court in a sealed envelope, together with a covering letter stating the reasons for objecting to the subpoena; or

- Send the records to the court in compliance with the subpoena, inform the patient that the records have been subpoenaed, and leave it to the patient to object to the release of the records. This may be the most appropriate course of action in situations where the release of the records poses no medical risk to the patient, but rather the objection is based on the fact that the records are deemed irrelevant to the case being heard.

Where a practitioner lodges a notice of objection with the court, for the notice of objection to have any likelihood of success the practitioner is required to attend court on the day of the hearing to argue their case. This is prohibitively impractical for most practitioners.

As a result of these limited options, most practitioners are resigned to the fact that they must (albeit reluctantly) comply with subpoenas – and leave their patients to suffer the consequences.

This current practice appears to be significantly at odds with other areas of law which are moving towards increased emphasis on the importance of maintaining an individual's privacy.

For example, the recent amendments to the Commonwealth Privacy Act 1988, in March this year, have enhanced the ability of individuals to manage and control how their personal information is used by external parties. Individuals now have the right to withhold consent to their information being used in ways that they do not agree with – but unfortunately not where that information has been required to be produced under another law – for example, via subpoena.

Similarly, one of the key objectives of the Personally Controlled Electronic Health Record (PCEHR) is to put the individual in the driver's seat in terms of the sharing and dissemination of their personal health information. As stated on the Department of Health's PCEHR website: "You control what goes into it, and who is allowed to access it…[an] eHealth record gives you more control over your health information than ever before, placing you at the centre of Australia's health system."

It appears that the practice of subpoenaing health records is completely at odds with such initiatives.

It is hoped that the more light that is shed on this concerning issue, the more possibility there is to bring about change. Legislative amendments which prioritise the maintenance of doctor-patient confidentiality would ensure that patients can continue to receive optimum therapeutic care.

Melanie Earles
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1. Department of Health –Personally Controlled Electronic Health Record website, found at http://www.ehealth.gov.au/internet/ehealth/publishing.nsf/content/home. Accessed 26/9/2014.

Summary of meeting

RANZCP Victorian Branch Family Violence Roundtable

ENHANCING MENTAL HEALTH RESPONSE IN FAMILY VIOLENCE
A Systems Approach

The Victorian Branch of the Royal Australian and New Zealand College of Psychiatrists Family Violence Working Group held a cross sector roundtable in Melbourne on 27th February. Guest speakers included the Victorian Family Violence Prevention Minister Fiona Richardson and Australian of the Year Rosie Batty. The WG members are Dr Manjula O'Connor (Chair), Dr Can Tuncer, Dr Kym Jenkins, Dr Samir Ibrahim, Prof Kelsey Hegarty, Dr Lanka Cooray, and Dr Ric Haslam.

The aims and objectives of the Round Table meeting were to enhance the mental health response to FV; to align mental health services with mainstream FV services and establish pathways to facilitate interaction between mental health professionals, the FV service providers and the Justice System.

The discussions included how to offer education to non-health services on the generally unrecognised yet significant psychological impacts of FV on the victims and the family members of those experiencing or witnessing violence; and to improve cross sector collaboration to enhance outcomes for victims and perpetrators of FV.

The meeting was facilitated by RANZCP President Elect Prof Mal Hopwood with Dr O'Connor running through the presentation that included discussion points and questions for the group. Various not for profit and advocacy groups, including Domestic Violence Resource Centre, Women's Information Referral Exchange (WIRE), Men's Referral Service, and No To Violence, joined social workers, Victoria Police, a Magistrate, a Bishop, academics and bureaucrats met to work through some of the key issues in supporting and referring victims and perpetrators of family violence to the services they require.

The Minister explained how Victoria's recently announced FV Royal Commission, due to commence in March, would involve a systems approach to reform. The RC will not call for victims to provide evidence but rather for agencies and interest groups to make recommendations on reform, and to suggest ways to provide better referral and recovery pathways for both victims and perpetrators. The Minister said the Victorian Government recognised the system is broken and asked for those in attendance to help to fix it. Ideally this would involve representatives from across the sector having input into the desired changes. The WG will make a submission to the RC and incorporate the recommendations from the roundtable in that submission. The Minister also acknowledged the College's work and thanked Dr O'Connor for her work in the culturally and linguistically diverse (CALD) sector, particularly with the Indian community.

Rosie Batty is well known to Victorians for her advocacy work; she has made an immense personal sacrifice to have her voice heard since her son Luke was killed by his father a year ago. Ms Batty spoke plainly and passionately about agencies needing to work together, and how crucial it is to listen to families of people affected by mental disorder, as they best know the unwell individual, having watched them disintegrate over years (in chronic cases) into psychosis or paranoia (in the context of FV).

Mental Illness and Domestic Violence

Mental health issues in victims and perpetrators were discussed. FV is a social problem but its impact on victims can be serious especially when the victim is exposed to three to four types of abuse. Some figures estimate as many as 75% of victims suffer mental illness such as Depressive Illness, Anxiety Disorders, and Post Traumatic Stress Disorder (PTSD) (WHO 2013). The mechanisms that translate stress into physical and/or mental illness is most likely through certain neurobiological mechanisms whereby the biological, chemical and physiological changes negatively impede healing, recovery and rehabilitation of the sufferers back to a productive life (Fig 2).

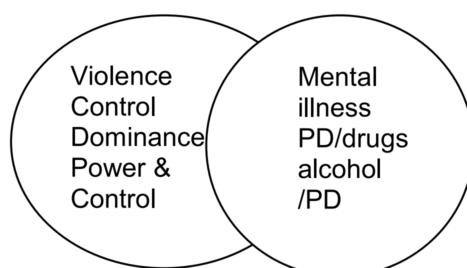
Summary of meeting

RANZCP Victorian Branch Family Violence Roundtable

The role of mental illness in perpetrators of domestic violence was also discussed. It can be difficult to recognise mental illness due to particularly subtle signs, nevertheless the impact of mental illness in perpetrators can be significant [the signs can range from subtle to overt]. The video of Rosie Batty's ex-partner Greg Anderson's police interview was shown to illustrate this point. The research in this area is limited; impulsive, emotionally immature and psychopathic personality disorders are considered to play a role. The role of alcohol and gambling is considered substantial (WHO 2013). A recent study from Norway surveyed a group of perpetrators involved in a men's behaviour change program. The authors report a majority of perpetrators suffered treatable mental illness. The findings of this study were debated and it was seen as controversial. It was deliberated that violence is a choice exercised by the perpetrator. Some possibly suffer mental illness but the driver of domestic violence remains the need to control and dominate the victim (Fig 1). There was discussion surrounding the possible negative impact of emphasising the role of mental illness in the perpetrators. It was agreed that the power and control hypothesis of NOT negated by addressing and treating the mental illness in perpetrators. The presence of unrecognised and or untreated mental illness impairs the ability to rehabilitate and may lead to re-offending.

Health is an underutilised pathway to healing and prevention of domestic violence (WHO 2013).

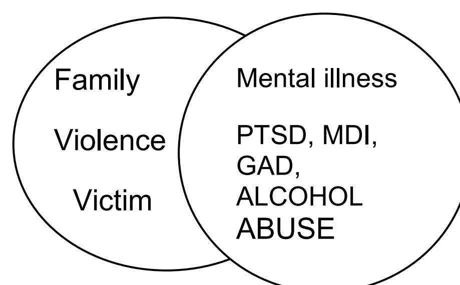
Fig 1: Perpetrators



Overlap between the need for coercive control/ violence and mental illness/drugs, alcohol in a proportion of perpetrators. Early detection and treatment is necessary to improve chances of rehabilitation and minimise harm.

Fig 2: Victims

Majority of victims suffer mental illness. Untreated it impairs their ability to return to normal living.



Summary of key discussion points:

Education, victims, perpetrators, policy and strategy, systems response?

- Professionals need to work collaboratively with the best interests of families at heart.
- Non psychiatric practitioners should consider the role family violence plays in developing mental health issues for the victim and make referral to the appropriate (mental) health services.

Summary of meeting

RANZCP Victorian Branch Family Violence Roundtable

- Consideration must be given as to what other services might be available and appropriate.
- The RANZCP work can translate across the professions, tapping into the knowledge, expertise and influence of other professional medical practitioners have.
- Acknowledge the societal patriarchal construct, the role that men's coercive control and power plays in perpetuating family violence.
- Gender inequality is at the heart of family violence thus women need to be better empowered and acknowledged in society.
- Community education regarding family violence is key to people's understanding; recognising that anyone can become a victim, it can occur across all social demographics, ages, races and income brackets.
- Teaching children to conform to gender stereotypes where boys are expected to be aggressive or strong and being 'girlish' or sensitive to be discouraged sends the wrong message.
- Encouraging children to talk about their emotions and how to deal with them is very important and needs to be a part of the educational curriculum does not have anything.
- Acknowledge that men make an active choice to be violence, even those who have a drug or alcohol issue or a mental health condition, decide how they will behave in a given situation. Dominating and violent responses as means of 'coping' with emotional or stressful situations need to be 'rewired' to more appropriate responses.
- Advertising and information leaflets should be provided in different languages to help the CALD community.
- Educating community leaders, such as clergy, who might be the first contact point for many, but who many not have the skills to deal with it.
- Systemic issues in the criminal justice system need to be addressed – police, courts, and support workers can be operating in silos whilst handling the same cases. Shared information systems plus working collaboratively, and including the mental health system to find better outcomes for both victims and perpetrators.
- Once a case goes to court it is important to discuss the details of the case with the victim, and keep them abreast of changes (e.g. charges, pleas, new information).
- Build in the capacity for recording red flags (even if it is subthreshold noise) in the justice system to make sure all stakeholder's perspectives are incorporated.
- Gathering all the relevant case information and sharing it, even across the same organisation, is important.

Points for further discussion and exploration:

- It is crucial that risk assessment for a victim is undertaken properly on every occasion in order to get this right. It should include mental health assessment and their (treatment) needs.
- Risk Assessment of perpetrators must be undertaken on every occasion and must include a mental health assessment. The difficulty with mentally ill perpetrators is in detecting their unwellness and intervening early enough to prevent adverse outcomes for the victims, themselves and others. Perpetrators can present as coherent and composed thus avoid diagnosis and treatment until they unravel to the point they commit a

serious violent crime (against their partner or ex-partner). Efforts should be made to obtain input /history from the family to reach accurate diagnosis and treatment.

- Any recommendations might draw on previously successful programs such as CRAF (Common Risk Assessment Framework) or RAMPS (Risk Assessment Management Panel).

- One risk is the potential for various vested interests groups defending their professional interests, and making decisions based on this.

- There needs to be an inter-disciplinary dialogue that may utilise the wealth of knowledge from different sectors to facilitate the development of shared objectives in FV interventions.

- By linking into Government agencies and working across the disciplines the needs of victims and perpetrators can be at the forefront of responses. The courts, police, women's support agencies, general practitioners, psychologists and psychiatrists all have an important role to play, and can complement each other in a coordinated way.

- The challenge lies in disentangling and managing the many threads that make up the complexity of FV.

Among the key recommendations to emerge from the roundtable were:

- Silos are impeding the best outcomes for the families affected by FV and need to be broken down - Police, Courts, FV services, Men's Behaviour Change Programs, Immigration Department, Office of Women's Affairs, CALD groups, Faith leaders, Health services including Primary Health Care, Mental Health care, Hospital services.

- Proposal for a 'cross sector reference group' to be established utilising representatives from the above mentioned groups from the roundtable.

- A systems approach in the training of health practitioners is likely to produce better results.