NorthWestern Mental Health

Submission to the Royal Commission into Family Violence

Background

NorthWestern Mental Health (NWMH) is the largest public mental health service in Melbourne covering a population of over 1.3mil people over 12 LGAs across the North and West of Melbourne. NWMH is a clinical division within Melbourne Health. NWMH receives approximately 700 new referrals a month. NWMH provides bed based and community based clinical services to people with severe mental illness or who present in crisis. We provide a 24 hour, 7 days per week triage, four adult mental health programs, a large aged persons program and a youth program through Orygen Youth Health. In 2013-14 we had over 18.200 registered clients and 4.300 admissions. NWMH also provides a specialist mental health service to the Emergency Departments (ED) of the Royal Melbourne, Sunshine and Northern Hospitals. These busy EDs see many people in situational crises impacted by family violence.

There are many associations between mental illness and family violence, both as victims and/or perpetrators of family violence. While there are often different issues depending on whether the person is the victim or the perpetrator of family violence, we believe that access to appropriate clinical services with the ability to provide recommended levels of engagement including access to inpatient services and community based treatment is of crucial importance. While treatment of the mental illness is likely to reduce the risk of family violence, the exposure to family violence may also call for treatment specifically directed at the emotional and psychological consequences of family violence.

We believe that increasing the focus on family violence within mental health services is a practical and effective means to reduce the occurrence and impact of family violence. The three main avenues to do this are through improved channels of communication and information sharing, increased specialist clinical expertise in the area of family violence, and improved access to assertive outreach treatment services.

We would like to highlight some issues we think important for the Royal Commission to consider in relation to mental illness and family violence.

Issues

1. **Prevalence**. The experience of family violence is more common amongst those with mental illness than the rest of the population, (Trevillion et al, 2012). Access economics 2004 p.24 noted that nearly 18% of all female depression and 17% of female anxiety disorders in Australia were associated with family violence. It is reported that 77% of women experiencing partner violence have attempted suicide. (Golding 1999, p. 112). Rees et al 2011, p.513, stated that of all Australian women who had reported family violence, 77% had anxiety and 52% a mood disorder. Although these studies have focused on adults, family violence is also associated with mental illness in young people and in older persons.

Although collection of data in this area is variable, there is considerable evidence of increased rates of mental illness among perpetrators. For example, we work with police in reviewing high risk cases and found that approximately one third of perpetrators were identified as being clients of mental health services. Up to 10% of calls to local police each month can be identified as a perpetrator of family violence who has a mental illness.

We undertook a review of adverse event data over a period of almost 7 years. During that time there had been 10 homicides involving clients of our service. In half of these the victim was a close relative or partner. While it is not invariable, it is more likely that such tragic incidents occur when a person is not engaged with treatment services or has ceased taking prescribed treatment. Forensic mental health populations also report high levels of family violence. Carers who refer a family member to our service often cite aggressive behaviour as a reason for the referral.

2. **Current Solutions and Interventions**. There are current examples of good practice with formal links between agencies and service systems. However, there is not consistent practice or clear protocols to guide health services when interacting with family violence agencies, child protection/child FIRST and the police. Within NWMH, we have noticed that where there are close linkages with community agencies which focus on family violence, there is an increased rate of referrals. When one of our adult services formalised their arrangement with the High Risk Review Program (HRRP) the number of referrals identified as related to Family Violence increased fourfold. We have also noted that where a relationship is established between a mental health clinician or service and police, there is greater likelihood of informal contact for advice on services and how to access them. There is also improved provision of relevant information from police to clinical services, such as awareness of access to weapons.

   A relatively recent service initiative that is of relevance to this area is the Mental Health and Police response (MHaP). Mental Health services have received additional funding to support one shift per day of a senior clinician who goes with police as a secondary response to situations where it is believed mental illness or disorder is a contributing factor. A significant number of calls to MHaP involve family violence. The clinician is able to undertake an assessment with police present to determine whether the person should be referred for further treatment, or admitted to an inpatient unit, or indeed whether a criminal justice outcome would be more appropriate. An indirect benefit of this service is an improved understanding of the roles and modes of working by police and mental health practitioners and greatly improved sharing of information.

3. **Barriers to Intervention**. There are situational and systems issues that perpetuate those with a mental illness staying in situations of family violence. A lack of resources to state funded mental health services means that often assistance and intervention can only be provided in a crisis situation. The ability to provide ongoing intensive treatment and support is extremely constrained with most services now provided on a time limited basis. This runs counter to good clinical practice in situations where the underlying problem is an illness that is likely to be chronic or relapsing such as schizophrenia. The risk of relapse is greatly increased if the person ceases taking prescribed medication, which is also more likely to occur if engagement with services is intermittent.

   The decision to leave a situation of domestic violence, or even to report it, is a difficult decision for many women to make, for a number of reasons. For a woman with a mental illness it can be much harder due to the symptoms of the illness, and especially if the perpetrator is also the person whom the woman relies on for the care of her mental illness. Where the perpetrator is a young person

with mental illness, it is common for clients to minimise their behaviour. Family members who are the victims also tend to minimise or deny aggressive behaviour. In many situations, we advise families that the only option is to call police which can be extremely difficult for parents – the legal consequences of which are compounded if the family comes from a country where police/government are not to be trusted.

Another barrier is that some support services exclude those with severe mental illness. For example, women with a mental illness may not be accepted to safe houses when leaving situations of family violence. The family violence service may be in a different geographical area than the usual mental health service, or the service can be reluctant to accept people who need psychotropic medication.

4. **Suggestions for better interventions**. The establishment of pathways for secondary consultation links between Family Violence agencies and mental health services could address these issues. For example, having a representative from family violence services attend the mental health service on a regular basis. This worker could ~~to~~ share information about family violence and provide specific family violence counseling for victim and their children. This may lessen the risk of victims failing to report the abuse or engage with appropriate services. Such engagement would also assist family violence services to understand when and how mental health services can intervene and the limitations of the services available.

   As noted above, having mental health specialist on high risk review committees where all the members of these panels are coming together as experts in their field appears to be of benefit, but would require resourcing. These panels have taken time to establish but are bearing fruit. Not all regions have a Risk Assessment and Management Panel (RAMPS) or HRRC equivalents. Victoria has a number of examples where additional resource has allowed the development of expertise and support within each area mental health service. The Dual Diagnosis initiative and Forensic Clinical Specialist program are two such examples. It would be possible to develop a response whereby experienced mental health clinicians trained in family violence are able to work across mental health, police and family violence support agencies.

   Developing protocols that provide an ability to share relevant information in a timely manner could also be considered. Any proposal to share information raises concerns of privacy and confidentiality, but initiatives such as the MHaP do enable sharing of relevant information in a controlled manner.

   One of our adult mental health services has been involved in a pilot project for the past year in which a community legal centre conducts a pro bono weekly ‘drop in centre’ in the acute inpatient unit. This service involves a legal practitioner attending the inpatient unit and seeing patients who have a range of legal issues, most of which are directly or indirectly linked to family violence. Typically, the issues range from child custody issues, resolution of child payment arrears, tenancy problems, provision of advice about intervention orders, or advice about attendance at court for minor criminal matters - either as a victim or as a complainant. This pilot project is a good example of the value of providing timely, expert advice and of linking victims or perpetrators of family violence (in all its forms) with agencies best placed to help.

Conclusion

Family violence has a recognised association with mental illness. Mental illnesses such as depression, anxiety and post-traumatic stress disorder have an increased prevalence in victims of family violence. Illnesses such as schizophrenia, bipolar affective disorder and other psychotic illnesses are associated with increased propensity to family violence. The risk of violence is increased where there is associated use of alcohol and illicit substances. Mental health services have an important role to play in the recognition of family violence when associated with mental illness.

Most important is access to assessment and treatment of those with a mental illness who are the perpetrators of family violence. In those illnesses where relapse is very likely if treatment is discontinued, access to longer term and more intensive or assertive treatment is important to not only increase the chance of compliance with treatment but also of ongoing assessment of risk. In the context of progressive funding constraints, it is more and more difficult for services to provide such treatment and care. While better access to intensive treatment and support is most desirable, there could be significant improvement through the development of improved communication and information sharing between clinicians, police and family violence agencies. Having clinicians with special interest and expertise in the area of family violence could further enhance the treatment response.

References

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