

Education Centre

Against

Violence



Health

The Politics of Believing: working towards a consumer centred system

**Lorna McNamara, Director
Education Centre Against Violence**

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Preamble: I would like to acknowledge the traditional owners and custodians of this land. I offer my respect to the Elders past and present.

I would also like to recognise Jenna Bateman and the Mental Health Coordinating Council for their commitment to this very important area of work and for providing a platform to discuss the issues surrounding Trauma Informed Care (TIC) and the development of best practice.

Trauma is a broad topic that covers a wide range of events from “Acts of God” to “Acts of Humans”. My presentation is focussed on the second of these ‘acts’ – the act of interpersonal violence, and in particular, adult and child sexual assault, domestic family violence and child abuse. I will emphasis three main factors: Firstly, though all traumas have the potential to leave lasting negative impacts, it is the Act of Humans – the betrayal of one person by another, particularly if that betrayal is by someone in a position of trust or a caregiver role, that consistently results in a greater proportion of people experiencing long term psychological consequences (Charuvstra & Cloitre, 2008). Secondly, it is well established that sexual assault and domestic violence are gendered crimes. Literature has consistently identified that 92-98% of perpetrators of sexual abuse against children and 98% against older adolescent girls and women are male. This is not to deny that women also sexually abuse or to minimise the sexual abuse of boys and men, but to acknowledge that even in this latter context, the offender in the vast majority of cases is also male.

Thirdly and finally, the issues of sexual assault, domestic violence and child abuse experienced by women and children require mental health service intervention that

focuses on safety. Failure to do so continues to place women and children at ongoing risk. For mental health services to take account of these critical concerns there needs to be a shift in the way services are provided. That shift is the capacity to believe. Through out this presentation I will explore the importance of 'belief' - belief in the stories of women, - of children and young people and of men. According to the Oxford English Dictionary belief means;

1. An acceptance that something exists or is true, especially one without proof.

I suggest that the overwhelming evidence regarding the high rates of violence and abuse experienced by consumers of mental health services as children and as adults, requires us to hold belief at a range of levels, from personal engagement to the organisational context, through to the structures and systems of accountability that underpin the public mental health sector. If we are moving towards TIC then belief, which includes the capacity to listen and respond, becomes the cornerstone to addressing the needs of consumers of mental health services who are also victims of violence and abuse.

I will begin by providing a brief overview of the context that led to the emergence of services addressing violence and abuse followed by a more detailed history of service provision in NSW.

I will also examine the role of mental health services over the past twenty years and the resistance as a system, to responding to the overwhelming needs of consumers with past and current abuse experiences.

Slide 2: Movement for Women's Rights

Movement For Women's Rights

Because the Personal IS Political

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1. Development of Responses

The emergence of the second wave of feminism in the 60s, 70s and 80s saw women's groups across the Western world take action to highlight their oppression. In particular, they began to focus on the extraordinary levels of violence and abuse suffered by women and children at the hands of the men in their lives. For the first time in western society, domestic violence and sexual assault were publicly discussed in terms of power and control rather than family systems theory or in the case of sexual assault, as an issue of sexuality. Patriarchy, the gendered imbalance of power embedded in societal systems such as the law and religion, became a valid target of academic critique and political activism.

Brownmiller's 'Against Our Will: Men, Women and Rape' (1975), provided a scathing examination of masculinity and the attitudes of men to rape.

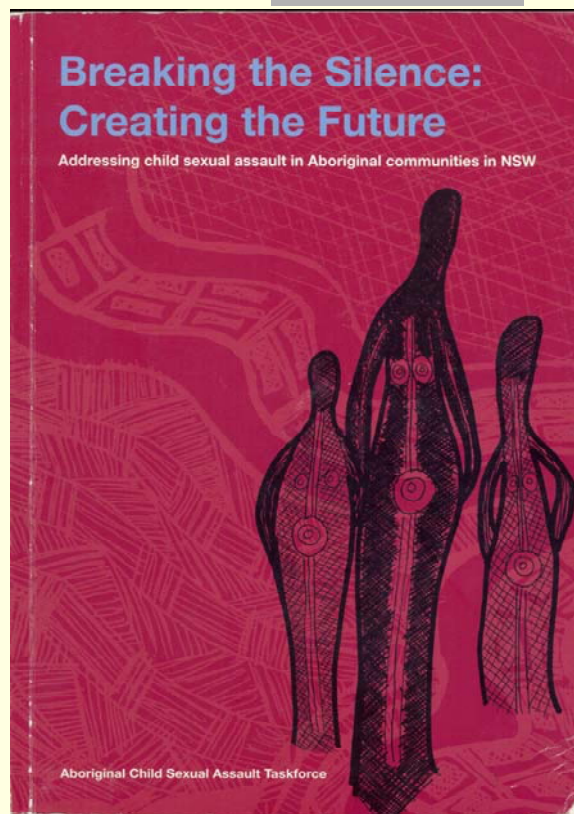
Slide 3

- 'It [rape] is nothing more or less than a conscious process of intimidation by which all men keep all women in a state of fear' (1975:15).
- In her book she also noted the issue of incest: 'The unholy silence that shrouds the inter-family sexual abuse of children and prevents a realistic appraisal of its true incidence and meaning, is rooted in the same patriarchal philosophy of sexual private property that shaped and determined historical male attitudes to rape' (1975:281).

■ Brownmiller, S. (1975) *Against our will: men, women and rape*, Secker & Warburg, London

Breaking the Silence Report: 2006

- Child sexual assault is 2.5 to 3 times more likely for Aboriginal children (84.8 against 31.6 per 100,000) (**Fitzgerald and Weatherburn, 2001**).
- 70% of Aboriginal Women who were interviewed identified as victims of child sexual assault. (**AJAC, 2002 Aboriginal Justice Advocacy Committee**)
- Women who had been sexually abused were likely to use drugs, particularly heroin.
(**Aboriginal Child Sexual Assault Taskforce 2006, Breaking the Silence: Creating the Future**)
- The Aboriginal Child Sexual Assault Taskforce identified that child sexual assault in Aboriginal communities 'is a grossly underreported crime'. It also noted that: 'When asked if they could think of a family in their community that had not been affected by child sexual assault, no Aboriginal person who took part in the consultations could.'
(**Aboriginal Child Sexual Assault Taskforce, 2006, p. 60**)



As women sought justice and empowerment, they began to speak out about their histories of abuse both as children and as adults. The metaphor that exemplified this often liberating process was that of 'Breaking the Silence'. Notably, in NSW in 2006, the report by the Aboriginal Child Sexual Assault Taskforce led by Marcia Ella Duncan, carried this same metaphor in its title: *Breaking the Silence: Creating the Future* and highlights I think, the ongoing struggle, particularly for Indigenous Australians to be heard and believed, and for governments and institutions to recognise and effectively respond to what is a large and pervasive social problem. (I would also add that the struggle to be heard and to be taken seriously by society and the systems charged with providing support and response – is as relevant today for groups such as refugee and asylum seekers, people with disabilities, the elderly, men who have experienced either adult or child sexual assault, and consumers of mental health services, as it was for women in the 70s and 80s.)

Brownmiller's book rallied women internationally to demand recognition by governments of gender-based violence and as governments slowly began to take notice of the growing social unrest, funding for women's domestic violence refuges and rape crisis centres began to be provided. It is important to identify that these services were established because of the failure of mainstream and mental health services to recognise and respond to violence against women and children. In other words, to believe their stories of abuse.

World Health Organization 2010

- 'Intimate partner violence and sexual violence are serious and widespread problems worldwide. Apart from being violations of human rights, they profoundly damage the physical, sexual, reproductive, emotional, mental and social well-being of individuals and families.
- The immediate and long-term health outcomes that have been linked to these types of violence include physical injury, unwanted pregnancy, abortion, gynecological complications, sexually transmitted infections (including HIV/AIDS), posttraumatic stress disorder and depression, among others'.

- World Health Organization and London School of Hygiene and Tropical Medicine. (2010) Preventing intimate partner and sexual violence against women: taking action and generating evidence, World Health Organization, Geneva

<h2 style="text-align: center;">Health Outcomes of Interpersonal Violence</h2>		
<p><u>Fatal Outcomes</u></p> <ul style="list-style-type: none"> •Murder •Suicide •Mother and infant mortality •Child death <p><u>Physical health</u></p> <ul style="list-style-type: none"> •Injury •Functional impairment •Failure to thrive •Poor subjective health •Permanent disability •Severe obesity <p><u>Chronic Conditions</u></p> <ul style="list-style-type: none"> •Chronic pain/migraines •Irritable bowel syndrome •Somatic conditions 	<p><u>Reproductive Health</u></p> <ul style="list-style-type: none"> •Unwanted pregnancy •STI's/HIV •Gynaecological disorder •Unsafe abortion •Pregnancy complications •Miscarriage •Low birth weight •Impaired brain & physical development of infants <p><u>Negative Health Behaviours</u></p> <ul style="list-style-type: none"> •Smoking •Alcohol & drug abuse •Physical inactivity or hyperactivity •Overeating 	<p><u>Mental Health</u></p> <ul style="list-style-type: none"> •Post traumatic stress •Suicidal ideation •Depression •Anxiety •Phobias/panic disorder •Eating disorders •Low self-esteem •Substance abuse •Poor physical and intellectual development •Difficulties with self control •Self harm / self mutilation •Regressive behaviour

I received this table in the late 1990s from Queensland Health. It is a great overview of the global health impacts of interpersonal violence. ECAV developed the following slide on Adverse Life Impacts of Interpersonal Violence to demonstrate how extensive the legacies of violence and abuse can be, and how impacts outside of health, such as unemployment, low levels of literacy and homelessness, can in themselves lead to mental health and drug and alcohol problems, resulting in a downwards spiral for many with abuse histories.

Slide 7

Adverse Life Impacts of Interpersonal Violence

- Sexually transmitted debt
- Low school retention & performance
- Low level literacy and numeracy
- Truancy
- Lack of higher education opportunity
- Running away or leaving home prematurely
- Limited work options
- Subject to child welfare systems and OOHC
- Chaotic family life
- Poor parenting skills
- Difficulty maintaining and trusting in relationships
- Dependence on welfare
- Criminality: Juvenile justice or Corrections
- Homelessness
- Low socio-economic status
- Ruptured family systems
- Gambling problems or addiction

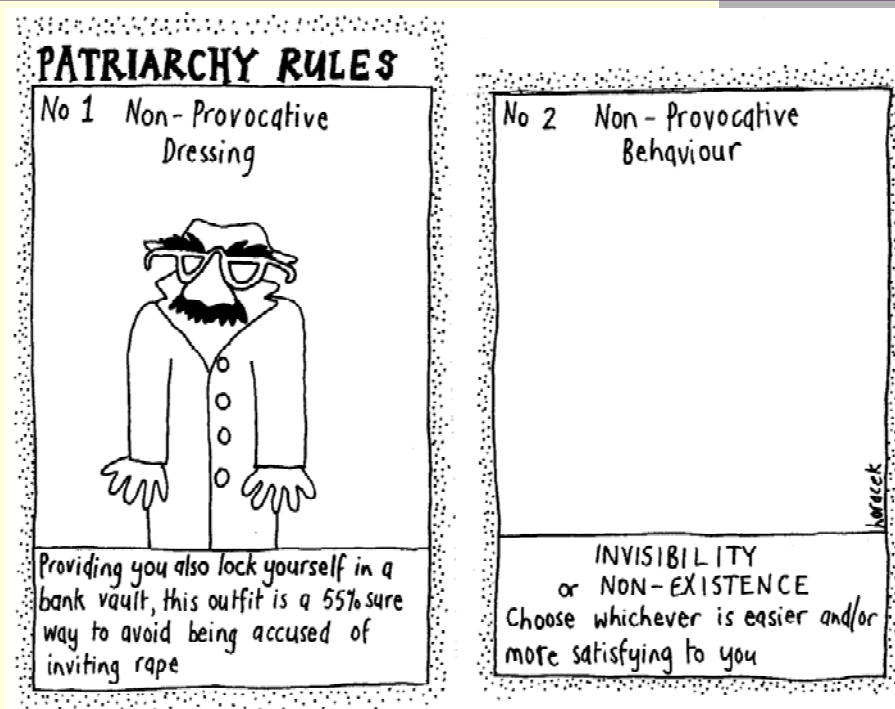
2. History of Service Provision for Abuse and Violence Against Women and Children in NSW

The political groundswell behind the development of sexual assault services in NSW began in the 1960's. At this time there was perceived societal concern about 'moral decline', and unease in the face of increased reports of rape of women. In 1968, 14 youths were goaled for a total of 140 years for the pack rape of 2 girls aged 14 and 16. There was public outrage and a Committee on Violent Sex Crimes in New South Wales was set up to examine causal factors in violent sex crimes, particularly gang rape.

Rather than linking causal factors with the behaviour of the offenders, the committee focused heavily on victim-precipitated rape. That young women who engaged in sexually permissive behavior created a climate conducive to mass rape. The Chairwoman of the committee also considered clothing to precipitate rape.

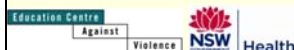
One of the newspapers quoting her headlined: 'Immodest dress', 'mini skirts draw packs'

'Immodest dress', 'mini skirts draw packs'



Cartoonist: Judy Horacek

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Reprinted with kind permission from Judy Horacek

There was no attempt by the committee to locate current concerns about rape in a political, social or historical context. Anne Summers' book 'Damned Whores and God's Police' drew attention to the dichotomy drawn about women of the time. Cartoonist Judy Horacek has satirized the issue of provocative dress in *Patriarchy Rules*.

1971 saw the establishment of the Sydney Rape Crisis Centre and in 1974 Elsie Women's Refuge was founded with other refuges funded overtime across the state. The Women's Movement, along with the Rape Crisis Centre also brought attention to the very poor treatment and victim blaming cultures within Health, Police & Legal Services. They described 'secondary trauma' occurring as a result of interaction with agencies. Staff within these services held the same negative and disbelieving attitudes to women seeking services for violence and abuse as in the wider community. Then as now, one of the most important factors for women and children seeking support is the fear of not being believed.

Adult Sexual Assault

- 57% of surveyed women report at least one incident of physical or sexual violence over their lifetime
(Mouzos * Makkai, International Violence Against Women Survey, 2004)
- 19% or 1 in 5 women have experienced sexual violence since age 15
(ABS Personal Safety Survey, 2006)
- 17% of all recent adult sexual assault victims reporting to NSW Police are men.
(Doak, P. et al, NSW Recorded Crime Statistics, NSW Bureau of Crime Statistics and Research, 2002)
- A review of studies since 1987 reveals that up to 76% of women living with severe and persistent mental illness experience sexual abuse as an adult
(Weinhardt, LS et al, Aggression & Violent Behaviour 1999)



Full reference slide 9:

Australian Bureau of Statistics (2006) Personal safety survey, Australia: cat. no.4906.0. Australian Bureau of Statistics, Sydney
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As the political struggle continued and belief grew regarding the levels of interpersonal violence experienced by women and men, governments began to enact reforms. 1978 saw the formation of the NSW Task Force into Care of Victims of Sexual Offences. Under the Wran government new law reforms were enacted which for the first time recognized that men could be raped, and that rape was a crime of violence. Rape and sexuality were still often confused, so this was an important milestone under the law.

Metropolitan services called HELP Centers' were established by the Department of Health, followed by a roll out across the state in following years. Services were first established in hospital emergency departments because it was thought that victims of rape must be badly injured. It became clear soon after their establishment that physical injury was not a primary issue, as coercion and threat were more commonly used as a tactic of perpetrators, and services were later set up in community health settings. Most importantly, these services were set up with feminist based understandings.

Slide 10: Child protection

Child Protection

- By the age of 18, one in four – five children will have experienced some form of abuse and neglect. For the vast majority of these children this abuse will be at the hands of a member of their family i.e. father, mother, step parent, de-facto, older sibling, extended family (grandparent, uncles etc)

(Fergusson and Mullen, Mazza et al, Felitti & Anda)

- A growing body of research indicates that most child abuse takes place in the context of experiences of present or past domestic violence

(McKernan McKay, 1994, Burke, 1999, O'Leary et al 2000, Renner & Shook Slack, 2006)

- Emotional or psychological harm of children was the most frequent type of actual harm reported (37%) and the most frequent risk of harm (46%).

- Psychological harm is the risk to the child or young person that is often associated with reports about domestic violence in the home.

(NSW Department of Community Service – Annual statistical report 2004/05)



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Full reference: slide 10

*Australian Women's Weekly (1980) Women talk about the trauma of rape, Australian Women's Weekly, 23 July 1980
Burke, C. (1999) Redressing the balance: child protection intervention in the context of domestic violence in Breckenridge & Laing (eds.) *Challenging silence: innovative responses to sexual and domestic violence*, Allen & Unwin, St. Leonards, NSW
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New South Wales Child Sexual Assault Task Force (1984) Community consultation paper, Sydney
New South Wales Child Sexual Assault Task Force (1985) Report of the New South Wales *Child Sexual Assault Taskforce, Women's Coordination Unit, NSW Premier's Department, Sydney
*New South Wales Sexual Assault Committee (1984) Report of the Sexual Assault Committee, 1983-4, New South Wales Sexual Assault Committee, Sydney
NSW Department of Community Services (May 2006) Annual statistical report 2004/05 Department of Community Services, Ashfield, NSW
O'Leary, K. D., Slep, A. M. S., & O'Leary, K. D. (2000) Co-occurrence of partner and parent aggression: research and treatment implications, *Behavior Therapy*, 31: 631-648
Renner, L.M. & Slack, K.S. (2006) Intimate partner violence and child maltreatment: understand intra- and intergenerational connections, *Child Abuse & Neglect* 30: 599-617

For children, the process has been more complicated. Historically (much as with women), children have been viewed as the 'property' of the father or more recently, the property of parents particularly in relation to the Family Law Court. Though child abuse and child sexual assault were known to exist, there was a wall of silence around it until adult survivors of child sexual assault spoke out about it in the early 1980s.

In fact, sexual assault services were primarily established to address adult sexual assault. It wasn't until the Australian Women's Weekly invited women to respond to an open survey on broad social issues including a series of questions about incest, that the extent of the problem was uncovered. Over 30,000 women wrote in about their

experiences of being sexually abused as children and this survey was then followed by a number of nationwide phone ins'.

To highlight the struggle faced by women and children regarding abuse it is worth noting that when I was working in the 1970s, children that had been sexually abused were commonly charged with being in moral danger and removed from the home. It was thought by the authorities that it was more important for the father or step father as the primary breadwinner, to remain with the family to provide financial support. The disbelief that surrounded disclosure and/or the punitive responses from justice and human services ensured that victim/survivors often carried the burden of their abuse silently throughout their lives. To highlight the extent of the silence on this issue, it is worth noting that in 1980 there were 16 notifications in NSW for child sexual assault. By 1986 this had grown to 3,000.

The extent of the response and the seriousness of the issues triggered by the Women's Weekly survey helped galvanize action, but it is important to remember that this action was based on the capacity for those with influence to believe the stories submitted or spoken about by women. In 1984, child advocates and the women's movement were successful in having the Wran Government institute the NSW Child Sexual Assault Taskforce. Recommendations from this report were supported by Cabinet and resulted in the provision of child sexual assault programs across the state as well as the introduction of mandatory reporting. An integrated model for response was signed off by the Premier and this is the model that we still work under today, though it has had many modifications.

The Education Centre Against Violence was established as the Sexual Assault Education Unit in 1985 with two trainers, to provide training and resource development in the areas of child and adult sexual assault. This followed the findings of reports of the New South Wales Sexual Assault Committee and later the New South Wales Child Sexual Assault Task Force, both of which were convened by the Women's Co-ordination Unit in the Premier's Department.

In 1990, the Centre's brief was extended to include domestic violence education and in 1997, the Centre's brief was further expanded to include provision of professional training in the area of physical and emotional abuse and neglect of children. The unit was renamed the Education Centre Against Violence. In 1998 the Centre was funded to develop and deliver the Certificate IV in Aboriginal Family Health (Family Violence, Sexual Assault and Child Protection) and that has been expanded to include the Advanced Diploma in Aboriginal Specialist Trauma Counselling. (I would like to acknowledge Judy and Caroline Atkinson from Southern Cross University who have been very supportive of this process). ECAV has been delivering programs by Aboriginal educators to Aboriginal workers and communities since 1989.

3. History of Mental Health Service Response to Violence Against Women in NSW

Despite the high number of survivors of child and adult sexual assault, child abuse and domestic violence using mental health services, mental health practitioners and policy makers here in Australia, America and the United Kingdom, remained resistant to changes brought about by the Women's Movement of the 70s and 80s. Disclosures of sexual abuse in particular, were often framed as evidence of mental illness or disorder. Despite the release of psychiatrist and feminist author Judith Herman's ground breaking book *Trauma and Recovery* in 1992, little changed in NSW regarding mental health service provision.

In 1992 after extensive consultation with the mental health sector, the Education Centre Against Violence began to deliver a 3 day workshop on adult and child sexual assault into the mental health sector. I joined the organisation in 1994 and was surprised to find that it was not uncommon for entire workshops of mental health professionals to declare that they had never worked with anyone that had experienced sexual assault, either as a child or as an adult. Staff attending training mainly did so in their own time and at their own expense as mental health managers did not see the relevance of sexual assault training to mental health practice.

For some time I attempted to engage policy makers around the issue of sexual assault however I was remarkably unsuccessful. To engage with a network of like minded women I joined the community organisation Women and Mental Health which was established in 1993. The women on the committee were consumer activists, concerned family members and committed service providers. Everyone came together in the recognition that women's needs were not being met through the mental health service provision of the time.

This committee applied for and were awarded a grant in 1995 to attempt to break the public silence around the topic of the sexual abuse of women patients during admissions to psychiatric hospitals and units. Though The Burdekin report (Burdekin et al. 1993) had brought into the Australian public arena the information that women were being sexually abused during psychiatric institutionalisation, this reality was confirmed by women consumers speaking out at the small WAMH conferences held annually. The *Safety for Women in Mental Health Services Project* resulted in the research report **Every Boundary Broken**, (Davidson, 1997) which was launched by Women and Mental Health Inc in December 1997.

Slide 11

Every Boundary Broken

- Sexual abuse, as defined by the participants, and discussed in the research, included a continuum ranging from sexual assault, sexualised touching, exposure and masturbation, sexual remarks, through to sexual intercourse couched in terms of a "relationship" (the latter almost exclusively perpetrated by staff).
- Some of the victims had been abused on one occasion; some had been abused more than once by different perpetrators and some had been re-abused by the same perpetrator on different admissions, the abuse continuing for many years. All of the latter type were perpetrated by staff members (Davidson, 1997).

Belief was linked to action

Davidson, J. (1997) Every boundary broken: sexual abuse of women patients in psychiatric institutions, Women and Mental Health Inc., Rozelle, NSW



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(Note: the full Every Boundary Broken Report can be found on the ECAV web site)

A central finding of the inquiry into responses to disclosure or witnessed events was that **belief was linked to action**. If staff (other than those that participated in the research) did not believe the victim's disclosure then no positive action to respond to the sexual abuse was taken. Usually the disclosure was perceived by staff to be acting out or manipulative behaviour or an exacerbation of the mental illness. Negative consequences such as an increase in medication, ECT or delayed discharge, were the common responses. Another interesting finding was that the staff (in this research all women) who believed and supported the women consumers regarding sexual assault, sometimes found themselves isolated and targeted by other team members. Both the consumers and staff talked about the mental health system as a 'boy's club or culture'.

From this research and the draft **Model of Best Practice in Identifying and Responding to Sexual Assault** (McNamara & Wilson 1998) which was developed and distributed at the time of the launch (and became the foundational document of the 'Guidelines' [1999] see below), funding from the Centre for Mental Health was made available to the Education Centre Against Violence for training into the mental health sector on adult and child sexual assault. The training was supported by the release in 1999 of the *Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services*. The funding enabled an expansion of the training and with direction from the CFMH, staff were released to participate.

The guidelines provided a wedge into the system that enabled and encouraged discussions to take place about sexual abuse, both within mental health services and more broadly. The guidelines included information on child sexual assault as well as

adult survivors, and over time and as interested clinicians began to engage with the issues, some services started to offer groups for adult survivors and to develop local policies and procedures to better meet the needs of this client group.

One of the recommendations of the Guidelines was that Area Health Services establish Sexual Safety Committees, which would include representation from consumer workers as well as sexual assault services. I participated on a number of these committees, and found myself in the role of interpreter between the violence response services and mental health. It was quite amazing to see that though the services spoke the same language, their meanings, values and attitudes were almost incomprehensible to the other.

For Sexual Assault Services a critical intervention in abuse dynamics is to support the victim to place the responsibility and the often devastating impacts of the abuse onto the perpetrator. In mental health services, responsibility is spoken about in terms of consumer responsibility for their mental health and wellbeing. Also, a critical focus of Sexual Assault Services is to stand beside the client and believe the stories of trauma, rather than to take an expert position that questions the validity of the client's narrative, particularly as it relates to their mental health. Though this is a simplification of the issues, it does provide a small window into why collaboration between services can be so fraught.

Slide 13 – 18: Links between violence and abuse and mental health

Trauma and Mental Health

- ¾ of the people who were accessing community mental health service had experienced traumatic events in their lives (Howego et al, 2005).
- Review of inpatient studies show that **65%** of female inpatients and **55%** of male inpatients report either sexual or physical abuse as children (Read et al, 2008).
- Mental health problems associated with past histories of child abuse and neglect include personality disorders, post-traumatic stress disorder, dissociative disorders, depression, anxiety disorders and psychosis (Afifi, Boman, Fleisher, & Sareen, 2009; Chapman et al., 2004; McQueen et al., 2009; Springer et al., 2007).

Child Abuse

Adults who had experienced child abuse were:

- **2 ½ times** more likely to have major depression (Afifi et al., 2009).
- **6 times** more likely to have post-traumatic stress disorder (Afifi et al., 2009).
- **5 times** greater risk for the development of PTSD (in a 12 month period), **2 ½ times** the risk for anxiety disorder and a greater risk for substance abuse (Scott, 2010).
- **9 times** more likely to develop 'pathology level psychosis' Those suffering most severe levels of abuse **48 times** more likely to develop psychosis (Janssen et al, 2004)

Child Abuse Cont'd

- **63 %** of those with a diagnosis of Bipolar disorder reported exposure to childhood trauma, compared to 33% of the control group (Etain et al, 2010).
- Child Abuse significantly related to substance abuse and suicide attempts, and, crucially, that the trauma preceded the psychosis in **98%** of the cases (Conus et al., 2009).
- Psychiatric disorders were more likely among children exposed to family violence [**81.8%** versus **40.0%**, respectively (Briggs et al, 2010).

Child Sexual Assault

- Female victims have a **40 times** higher risk of suicide & **88 times** higher risk of fatal drug overdose. Male victims have a **14 times** higher risk of suicide & **38 times** higher risk of fatal drug overdose (Cutajar, Mullen, Ogloff, Thomas, Wells & Spataro, 2010).
- Where history of CSA, **17 times** more likely to develop a psychosis, and almost **9 times** more likely to develop schizophrenia (Cutajar et al, 2010).
- Those with psychosis were **3 times** more likely than those with other disorders to have been sexually abused, and **15 times** more likely than those with no disorders (Bebbington, 2004).
- Studies cluster around **71%** of those with a diagnosis of Borderline Personality Disorder had a history of CSA (Links 93, Goldstein 95, Everett & Gallop 01, Zanarini et al 02)

Domestic Violence

- In one study **84%** of women seeking treatment for battering were diagnosed with posttraumatic stress disorder (PTSD) (Kubany et al. 2000).
- DV may account for as much as **12%** of psychological distress among adult women in New Zealand (Kazantzis, 2000).
- DV is **3.7 – 10.9 times** (dependant on severity of abuse) more likely to develop depression (Nancarrow et al, 2009).

Adult Sexual Assault

Those who have experienced adult sexual assault: In addition to PTSD, the review found that:

- many sexual victimization survivors (**13%– 51%**) meet diagnostic criteria for depression.
- Most sexual assault victims develop fear and/or anxiety (**73%–82%**),
- **12%–40%** experience generalized anxiety.
- Approximately **13%–49%** of survivors become dependent on alcohol
- while **28%–61%** may use other illicit substances.
- It is not uncommon for victims to have suicidal ideation (**23%–44%**), and **2%–19%** may attempt suicide.

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As you can see from the slides, the links between current and historical experiences of violence and abuse and mental health outcomes has a strong and comprehensive foundation.

Research into this area has grown exponentially over the past 20 years. This has been further supported by the research in neuroscience (Perry, BD, 2006., van Der Kolk , B, 2003) which has confirmed what many already knew, and that is also contributing to new understandings and insights. Despite the research and improvements in understanding of the impact of trauma on mental health generally, there continues to be difficulty for many mental health services to listen and respond to consumers disclosing current and historical abuse and to take account of these issues in treatment responses.

I began this presentation talking about belief and the central role it can play in responding to victims of violence. It remains a consistent finding that not being believed is the uppermost fear of most survivors of interpersonal violence and abuse. Studies from services for sexual assault, domestic violence and child abuse note that fear of disbelief is pervasive and heightened when clients interface with government systems, including health services. How mental health responds to that fear is critical in establishing services and environments capable of hearing and asking about violence.

In the report They Never Asked Me Anything About That (2010), women who had experienced domestic violence and then came into contact with the mental health system – had this to say:

Slide 19

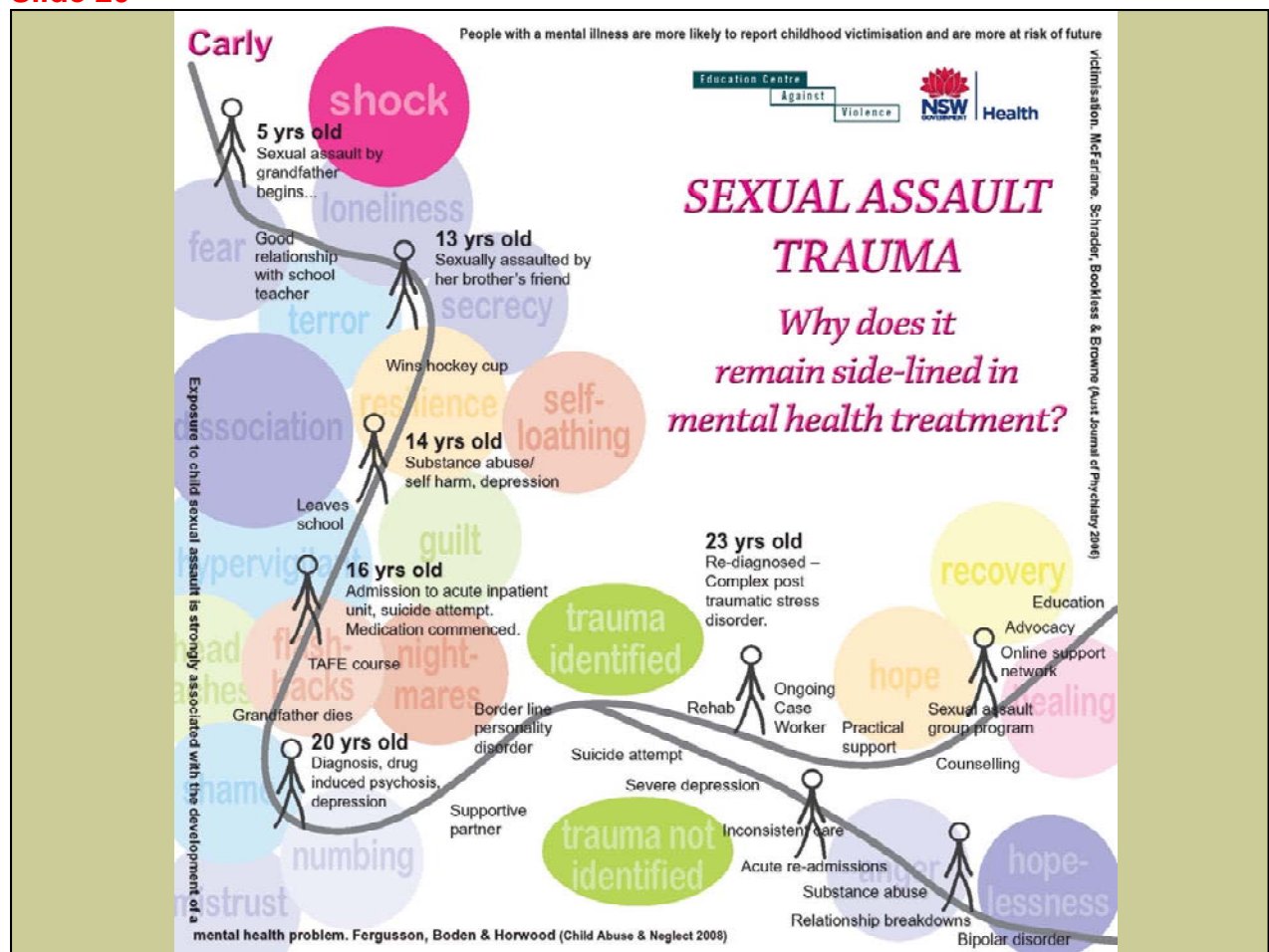
Experience with Mental Health Services 2010

- *“They mentioned to me the strategies of getting rid of the idea of killing myself. They haven't mentioned to me about how to help myself as a victim of domestic violence”.*
- *“Psychiatry hasn't come that far since performing lobotomies. One (psychiatrist) didn't know whether I drank because I was depressed or I was depressed because I drank and I tried to tell them that the old man was bloody punching me over and being cruel to the kids and I was too scared to escape and they didn't want to know”.*
- *“Um, so those professionals that I went to? I mean they are psychiatrists for Christ sakes. They're psychologists, they're therapists. Why did it take my son, and why did it take the cops and why did it take me coming to this centre (to name the domestic violence) after I had lived it? ...if I had gone to the first couple of therapists and if they'd picked it, well that would have been..., that would have been like 10-11 years ago. I would have been out of there, instead of being with him. It would have been ten years with him, not twenty years” (Laing, L et al, 2010).*

The frustration of this last comment highlights the dilemma for clients when trauma is either not believed, is discounted or minimised. It risks leaving consumers exposed to ongoing violence and abuse, as well as escalating serious mental health symptoms such as suicidality, depression and psychosis. And for some, it means prolonged and ineffective treatment in the system.

Further and importantly, we know that most children who have experienced abuse, particularly child sexual abuse, will carry the secret of the abuse into adulthood. Studies examining disclosure consistently find that less than 25% of children disclose after sexual abuse. Most will not disclose until they are adults, if at all. We also know that the longer the abuse continues, the longer the secret is kept, the greater the severity of the symptoms.

Slide 20



This is a poster presentation of Carly who has a history of abuse. As you can see resilience is also part of her story however her abuse history is so significant, she enters the mental health system. The poster represents two pathways. One demonstrates the trajectory Carly might take if her abuse is **not identified** and she continues to be treated incorrectly. The other, which demonstrates a system capable of hearing, believing and responding to Carly's abuse, offers the possibility of appropriate treatment, healing and recovery.

When we look at this poster, one could argue that the risk of **not believing** due to our fear that someone might be lying, poses a greater threat to the vast majority of consumers who do have current and past abuse experiences, than providing a response

that is believing, respectful and compassionate. Disbelief promotes a context of silencing, leaving consumers isolated, vulnerable and at risk of further abuse, at the hands of perpetrators and of the mental health system.

In the book *Addressing Violence Abuse and Oppression* (Fawcett, B., 2008, p12), women who had experienced domestic violence and who then became involved with mental health services found themselves subject to three main types of responses. The first was 'silencing' the second was not enquiring about or wanting to know about domestic violence and the third was about a mental health diagnosis being used to discredit the woman's claim of domestic violence.

Slide 21: The responses

Addressing Violence Abuse and Oppression


Mental Health Services:

- The first was 'silencing'

- the second was not enquiring about or wanting to know about domestic violence and

- the third was about a mental health diagnosis being used to discredit the woman's claim of domestic violence. (Fawcett, B., 2008, p12)

Fawcett, B., & Waugh, F. (2008) *Addressing violence, abuse and oppression: debates and challenges*, Routledge, London: p.12

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These three responses clearly encapsulate the difficulties facing consumers who are trapped within what amounts to - a catch 22. That is that being exposed to violence and abuse will commonly result in mental illness or disorder, with the mental illness or disorder, then used by health professionals to discount or disbelieve the abuse.

Therefore, mental health workers need to be aware that they too are operating within a culture, one that is too often disbelieving of consumer's disclosures and not based on the overwhelming evidence now available. Their clinical practice may be contrary to the best interests of this client group. Indeed the practices may be counter productive to effective mental health treatment. The evidence is clear that the legacies of interpersonal violence and abuse are the day to day reality for many consumers. This is not conjecture, it is a fact.

If disbelief is the greatest fear of most victims, then **belief by professionals** can become a powerful tool in developing safe, trusted and supportive relationships. With effort and

commitment to policy development and training, this will promote trauma informed environments. But it requires political action and like all political movements, changing entire systems requires a groundswell of like-minded people.

The women from the report *They Never Asked Me anything About That* (2010), made recommendations to service providers. The first was:

Slide 22

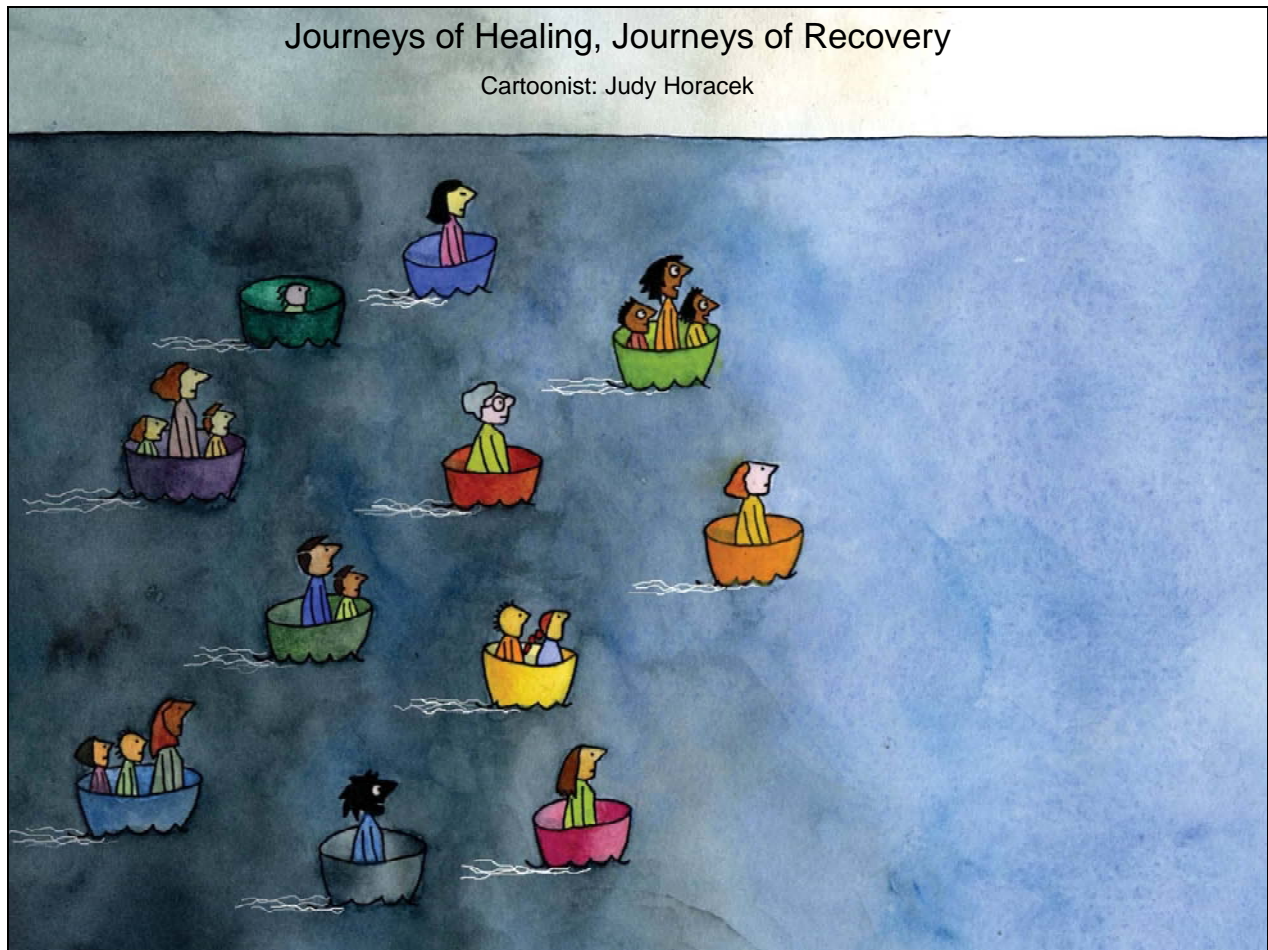
Recommendations from the women to service providers

- **Believe us and treat us with respect**
- **Respect our own understanding** of our mental health concerns/mental illness and work with us on our recovery, rather than establishing a controlling relationship over us
- Don't blame us for our situation, either our mental illness/health concern or for the relationship where we experienced domestic violence. Don't blame us for staying in the relationship
- Be aware of the mental health implications for us when we have experienced domestic violence – that way addressing probable causes of the mental illness/health concern rather than just treating the symptoms
- Be aware of the abuser's tactics to use the mental illness/health concern to further entrap us. Be aware of abusers interference in our mental health treatment and to **help us through these times by supporting and believing us**

Laing, L., et al (2010) *They never asked me anything about that: the stories of women who experience domestic violence and mental health concerns/illness*, Faculty of Education and Social Work, University of Sydney

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Slide 23



Developed by Judy Horacek for NSW Education Centre Against Violence

So how do we implement these recommendations into an already congested system, how do we introduce these ideas into our work and our practice? To date there has been a struggle for many within the system to locate the increasingly high levels of mental illness and disorder as commonly resulting from Acts of Humans. If we are to support clients and consumers on their journeys of healing and recovery, then I argue that trauma informed care requires **a politics of belief**.

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