

## 10 year Roadmap for National Mental Health Reform – Adult Surviving Child Abuse Consultation Response

The following paper incorporates suggested changes to the stated key directions of the 10 year Roadmap for National Mental Health Reform. It also incorporates the addition of a number of pivotal principles and issues. We also note that the current reform document while inclusive of high level short and long term actions and comments about measuring progress, would benefit greatly from the addition of timelines, deliverables and outcomes to support each of the key directions, once finalized.

### Discussion around key directions with suggested amendments

#### 1. Amended key direction 1: Promoting good mental health and wellbeing for individuals, communities and Australian society with inclusion of the need to address trauma in this context

A rapidly expanding research base attests to the substantial *public health* costs of unresolved trauma; it is well established that the majority of mental health consumers have been impacted by the lived experiences of trauma.

This means that any national mental health reform agenda must prioritise identification and responsiveness to the centrality of trauma i.e. recognition, treatment and funding of trauma are a *national mental health reform priority* which needs to be incorporated here. Not addressing trauma comes at significant cost to individuals, communities and society in health, welfare and economic terms.

While highlighting the centrality of trauma in mental health presentations it is important to also specifically acknowledge the prevalence of *complex trauma* (as opposed to single incident trauma). Complex trauma (childhood abuse in all its forms, neglect and the impacts of living with family violence and/or dysfunction) underpins the presentation of an estimated 2/3 of consumers to mental health services.<sup>i</sup>

Currently the high prevalence of complex trauma is frequently unrecognized and subsumed within other diagnoses, where presenting problems are considered in isolation from the unacknowledged *underlying* trauma. There is an urgent need for understanding and appropriate treatment of *complex trauma* as it is compounded when unrecognized.

In current systems the underlying trauma is frequently not asked about, identified or addressed. In fact current systems often 're-traumatise' consumers, compounding the impacts of pre-existing trauma. ASCA advocates for the incorporation of a *trauma informed approach to care* as a priority for this reform agenda. Doing so would help promote recovery and reduce re-traumatisation in consumers. It would also minimize the possibility of vicarious traumatisation of workers and health professionals and promote better outcomes for workers.

In a trauma informed approach, organisations, programs, and services are based on an understanding of the particular vulnerabilities and/or triggers that trauma survivors experience (that traditional service delivery approaches may exacerbate), so that these services and programs can be more supportive, effective and avoid re-traumatisation.<sup>ii</sup>

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A trauma informed approach to care requires a cultural and philosophical shift which moves from a medical model which asks the question “What is wrong with you?” to asking the question “What happened to you?” It focuses on the lived experience of trauma as a defining factor in the mental distress of the majority of consumers.

A variety of studies and pilot programs, that utilize a trauma-informed model, report a decrease in psychiatric symptoms, substance use and trauma symptoms, as well as an improvement in consumers’ daily functioning. Some studies have found decreases in the use of intensive services such as hospitalization and crisis intervention following the implementation of trauma-informed care.

Trauma-informed integrated services do not cost more than standard services and have improved outcomes. Services report greater collaboration with consumers, enhanced skills, and a greater sense of self-efficacy among consumers, as well as more support from their agencies. Supervisors report more collaboration within and outside their agencies, improved staff morale, fewer negative events, and more effective services.<sup>iii</sup>

### **Additional actions to include:**

- Public education and stigma reduction campaign around trauma, specifically complex trauma (child abuse in all forms) and its impact on mental health and wellbeing, while delivering positive messages around recovery
- Incorporation of education and training around identification of and responsiveness to complex trauma into curricula (Universities and Colleges)
- Development of trauma specific services able to respond to needs of complex trauma survivors (child abuse, neglect, family violence) , integrated and coordinated with existing mental health and substance abuse services
- Implementation of trauma informed care and practice approach (national agenda with broad-based collaborative implementation)
  - across service systems
  - within agencies, organisations
  - within individual practitioner/worker response

## 2. Amended key direction 2: Taking a life cycle approach

Extensive research has established the profound effects of extreme experiences not only on the developing brain in infancy but *throughout the life cycle*.<sup>iv</sup> Additionally it has been shown that the effects of trauma are *transgenerational* i.e. children are negatively impacted by the unresolved trauma of their parents. Trauma seriously impacts mental and physical health, well-being and behaviour, and affects not only those who experience it but those with whom they have contact.

Trauma is often characterised as single incident trauma – PTSD yet the majority of trauma is compounded or complex and the impacts are far more pervasive than those characterised by PTSD alone. The current classification of ('single incident') PTSD to describe *complex* (cumulative, interpersonally generated) trauma (e.g. child abuse, neglect, family violence and dysfunction) and service responses based on this diagnosis are manifestly inadequate.

The majority of traumatized children do not meet the diagnostic criteria for PTSD and current psychiatric diagnostic classification systems do not capture the lived experiences of these children. The narrow PTSD diagnosis is often used and a range of other labels are also applied to establish co-morbid pathology.

Each of the diagnoses used cherry-picks an aspect of the child's experience rather than holistically considering the context of the child's trauma and the child's attempts to manage their traumatic stress. Such diagnoses and treatment responses often focus on particular behaviours or symptom complexes rather than on the core impacts of the trauma on the child.

In adulthood consumers who have experienced complex trauma from childhood rarely carry only one psychiatric diagnosis. This is a reflection of the fact that the effects of their complex trauma of childhood have been multifaceted and pervasive. They can include depression, the gamut of mental health impacts, various medical illnesses, as well as a variety of impulsive and self-destructive behaviours. The current approach looks at symptoms and diagnoses in isolation and fails to take a whole of life approach to consumers of all ages with the lived experience of trauma.

All presentations of mental health distress need to be considered in the context of the lived experience of the trauma, regardless of the person's age. All workers and professionals need to remain cognisant of the possible impacts of traumatic stress and the systemic internal disorganization it often causes and respond appropriately.

Early detection and intervention are important tenets but we also need to see recognition of the impacts of adverse childhood experiences on adult mental health and a public health response informed by awareness of the lived experience of trauma at all stages of the life cycle and in the health of the next generation.

Research shows that *it is possible for even severe early trauma to be resolved*<sup>v</sup> with appropriate working through. Research has also shown that when adults who have experienced *complex trauma* (extreme, repeated interpersonal trauma most commonly of childhood) have made sense of their lives their children form secure attachments and do well. It is time to put this research into practice with incorporation of its evidence base into this national mental health reform document.

### **Additional actions to include:**

- Implementation of a *public health* approach to trauma i.e. the provision of the right services at the right time to support vulnerable families and reduce the effects of trauma and harm and its intergenerational transmission.
- Delivering a *wide range of flexible services holistically* with an understanding of the behaviours at different ages which characterise presentations. Understanding presentations in terms of traumatic stress, disrupted attachment, personal invalidation and adaptive coping strategies will better meet the needs of consumers and communities.
- *Accessible affordable and appropriate services* to reduce the effects of complex trauma (child abuse, neglect and living with family violence/dysfunction) on the mental health, physical health and wellbeing of children, adolescents and adults.

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### 3. Amended key direction 3: Putting the lived experience of consumers at the heart of services and supports

National Mental Health Reform needs to be consumer driven i.e. it needs to be informed by the lived experience of those it seeks to support.

A *trauma informed approach to care and practice* moves away from prioritising the search for a diagnosis to recognition of the person's traumatic life experience and that it is the consumer's lived experience which may have resulted in an individual's contact with mental health services through adoption of extreme coping strategies. We propose that this national mental health reform agenda integrates a trauma informed care and practice approach which has consumers at the centre of a model of recovery.

A trauma informed approach to care must also be supported by trauma specific services, providing specific interventions designed to address the consequences of trauma in the individual and facilitate recovery.

While conversations and program delivery around TIC are occurring in small service pockets we need to see broad based systemic change across the mental health service system. All programs and services need to clearly acknowledge *'that no one understands the challenges of the recovery journey from trauma better than the person living it'*. The underpinning philosophy of TIC is informed by an understanding of the particular vulnerabilities and 'triggers' that trauma survivors experience, with services delivering better outcomes; minimising re-victimisation and ensuring self and community wellness and connectedness can be promoted. It is a paradigm shift in service delivery culture.

This means true collaboration with consumers and carers where consumers become equal partners in the recovery process.

#### Additional actions to include:

- The voice and participation of consumers, including those who identify themselves as trauma survivors, *should be at the core of all systems activities* – from policy and financing to training and services<sup>vi</sup>
- Consumers with trauma histories should be *significantly involved and play a lead role* in the creation of State Mental Health Plan, the improvement of access and accountability for mental health services, and in orienting the mental health system toward trauma and recovery<sup>vii</sup> (While the points under this heading are addressed to the context of the United States, their pertinence and applicability to the Australian context should likewise be noted.)
- Special attention should...be paid to the *rights of people with trauma histories* (eg, right to trauma treatment, freedom from re-traumatization) and to the ways in which these rights may be systematically violated<sup>viii</sup>

#### 4. Amended Key direction 4: Focusing on recovery

Mental health consumers share the same needs and aspirations of others in society. The focus of any national mental health reform agenda needs to be on recovery and all that full recovery encompasses. Any focus on recovery needs to be focused on *recovery* from the underlying trauma. While the proposed reform document refers to ‘recovery focused services’ it falls short of embracing the true principles. Recovery-oriented services ask the question: What does this person need to live a meaningful and satisfying life? They move away from the traditional approach of “How do I treat this patient?”

#### Additional actions to include:

those which focus on each of the elements of recovery-oriented practice and a holistic approach as specified below:

- *Promoting a culture of hope*
- *Promoting autonomy and self-determination*
- *Collaborative partnerships and meaningful engagement*
- *Focus on strengths*
- *Community participation and citizenship*
- *Holistic and personal care,*
- *Incorporating a diversity of supports including family, carers, support people and significant others,*
- *Responding to diversity*
- *Reflection and learning.*<sup>ix</sup>

## 5. Amended key direction 5: Holistic, accessible, affordable and coordinated mental health services for all Australians

A large percentage of those seeking help at a diversity of health and welfare settings have trauma histories which are severely affecting their health and wellbeing. People can be impacted by trauma through a diversity of experiences which know no boundaries with regards to age, race, ethnicity, social or economic status, gender, disability; geography or sexual orientation.

A system which is dependent on a particular diagnosis as a means to access services is stigmatising and discriminatory. Our current health system, services and practitioners generally approach people in piecemeal ways rather than approaching individuals holistically.

### Additional actions to include:

- Development and implementation of *trauma-informed systems (recognition of trauma in clients and establishment of systems that are aware, responsive and do not exacerbate it)* and *trauma specific services (specialised capacity to address trauma per se)*.
- *Systems integration/coordinating between and among systems of care* which serve people with trauma histories, and should include a life-span perspective.<sup>x</sup> `Because abuse trauma may result in multiple vulnerabilities and affect many aspects of a survivor's life, coordination across systems is essential. Integration of trauma, mental health and substance abuse is absolutely critical'
- `Systems integration should also include the health care system, educational system, criminal justice, social services, and the full range of human services'<sup>xi</sup> as mental health care needs to be responsive to the diversity of consumers' needs.
- Trauma policies and services should *respect culture, ethnicity, gender, age, sexual orientation, disability and socio-economic status*.<sup>xii</sup> Some Australian service-providers are attuned to the significance of gender and cultural `difference' in the context of trauma-informed care,<sup>xiii</sup> but such sensitivity remains to be extended and developed systematically and on a wide scale

## Appendix 1

### Suggested additional principles

- National mental health reform to operate under a public health model
- Adopt and implement the principles of recovery-oriented practice
- Prioritise recognition, treatment and funding of trauma, specifically complex trauma related to child abuse, neglect and family violence and/or dysfunction
- Integrate a trauma informed approach to care across systems
- Recognise and respond to the full range of consumer needs incorporating identification and responsiveness to trauma related mental distress (expanding current definitions and responsiveness to serious mental illness to incorporate trauma specific presentations e.g. dissociative disorders, and the trauma underlying bipolar and schizophrenia)

The comments in this paper have been prepared on behalf of ASCA, Adults Surviving Child abuse by Dr. Cathy Kezelman (Head of Stakeholder Relations) in response to the consultation around the 10 year Roadmap for National mental Health Reform.

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## **The following additional comments to the document “10 year Roadmap for Mental Health Reform) have been provided by Professor Warwick Middleton**

"Numerous studies dating from the early 80's have demonstrated that between 40% and over 70% of psychiatric in-patients, when enquiry is made, will give a history of childhood sexual and/or physical abuse (Husain & Chapel. 1983; Enslie & Rosenfeld, 1983; Mills et al. 1984; Bryer et al. 1987; Jacobson & Richardson, 1987; Craine et al. 1988; Swett et al. 1990.) Similar trends have been reported with psychiatric outpatients (Jacobson, 1989). Read et al. (2004) compared 40 studies published between 1984 and 2003 that examined the prevalence of child abuse among female psychiatric inpatients and among outpatients where at least half the patients were diagnosed with a psychosis.

Collectively the studies included 2,396 subjects. In 50% there was a history of child sexual abuse, in 29% there was a history of incest, and in 48% a history of child physical abuse. No less than 69% had a history of either sexual or physical abuse, while 35% had a history of both. Read et al. also compared 25 studies complete between 1987 and 2003 that examined the prevalence of child abuse among male psychiatric in-patients and outpatients where at least half the patients were diagnosed with a psychosis. Collectively there were 1,356 subjects of whom 28% had a history of child sexual abuse and 7% had a history of incest. 515 gave a history of child physical abuse, while 60% had a history of sexual or physical abuse and 19% had a history of both. In short, approximately two thirds of mental health patients (inpatients & outpatients) have a history of childhood sexual &/or physical abuse.

When emotional abuse and neglect is added to the consideration the percentage of mental health patients who are abused and neglected is even higher, yet as far as I can tell, the Roadmap doesn't even begin to address trauma. (The word "trauma" does not even appear.) Trauma is the single factor that above all others most positively predicts that an individual will end up accessing the mental health care system. The single most pathogenic factor in the causation of mental illness is not the "schizococci" or the gene for bipolar disorder but mankind itself. The suicide rate for patients with untreated complex trauma syndromes is as high or higher than for any other syndrome that one will encounter in psychiatry.

For the past 16 years I have directed a Trauma and Dissociation inpatient and day hospital program at Belmont Hospital, Brisbane and I have researched, published and spoken extensively nationally and internationally on the issues of patients in the complex trauma spectrum. I am one of the professional advisory panel members for ASCA. Dr Cathy Kezelman, on behalf of ASCA has sent a lengthy submission regarding the Roadmap. I would like to add my endorsement to her excellent and well-informed commentary."

Professor Warwick Middleton MB BS, FRANZCP, MD.  
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- <sup>i</sup> Read, J., Goodman, L., Morrison, A., et al (2004) Childhood trauma, loss and stress. In *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia* (eds J. Read, L. Mosher & R. Bentall), pp. 223-252. Hove: Brunner-Routledge.
- <sup>ii</sup> Corinne Henderson & Jenna Bateman. 2010. *A National Strategy for Trauma Informed Care*. Mental Health Coordinating Council.
- <sup>iii</sup> Cited in *Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings* The Open Health Services and Policy Journal, 2010, 3, 80-100 Elizabeth K. Hopper, Ellen L. Bassuk, and Jeffrey Olivet
- <sup>iv</sup> Hesse et al, 'Unresolved States Regarding Loss or Abuse Can Have 'Second Generation' Effects...', in Solomon & Siegel, ed. *Healing Trauma* (New York: Norton, 2003), pp.57-106.
- <sup>v</sup> Daniel J. Siegel, *Parenting from the Inside Out* (New York: Penguin, 2004), p.123
- <sup>vi</sup> Appendix: Criteria for Building a Trauma-Informed Mental Health Service System', Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems
- <sup>vii</sup> Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems...'
- <sup>viii</sup> Ibid (emphasis added)
- <sup>ix</sup> Mental Health, Drugs and Regions Division, Victorian Government 2011 *Framework for Recovery oriented practice*.  
[www.health.vic.gov.au/mental\\_health](http://www.health.vic.gov.au/mental_health)
- <sup>x</sup> Administrative Policies/Guidelines Regarding the System', in 'Appendix: Criteria for Building a Trauma-Informed Mental Health Service System', Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems...', p.66
- <sup>xi</sup> ibid
- <sup>xii</sup> Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services'
- <sup>xiii</sup> Service Guidelines on Gender Sensitivity and Safety: Promoting a Holistic Approach to Wellbeing'(Department of Health, Victoria, 2011

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