DAVTW *Doctors Against Violence Towards Women*

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Inquiry into Mental Health

The Productivity Commission

Australian Government

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To whom it may concern,

This petition is submitted on behalf of Doctors Against Violence Towards Women, a group of 350 doctors across Australia and New Zealand, with a mix of psychiatrists, specialists, general practitioners and medically trained survivors of previous domestic abuse. It is indisputable that domestic trauma is pervasive, especially amongst women and children. Yet, we attest that the current mental health system is entirely insufficient to support victims of trauma, including domestic abuse, at great short and long term cost to the community.

According to the latest Australian Institute of Health and Welfare (AIHW) Data, 1 in 6 women have experienced physical and/or sexual violence by a current or previous partner, compared to 1 in 16 men. 1 in 5 women and 1 in 20 men have been sexually assaulted and/or threatened. Intimate partner violence causes more illness, disability and death than any other risk factor for women aged 25-44. These statistics do not include victims of emotional and financial abuse and coercive control, which are also major causes of domestic trauma. In addition, children are often exposed to or become victims of family, domestic and sexual violence. This is a risk factor for developmental trauma, mental illness, behavioural and learning difficulties and placement of children in out of home care and homelessness. In addition, it is a cause of intergenerational trauma and perpetuation of the cycle of violence. Compounding this, history of physical or sexual abuse is also linked to higher risk of substance abuse, crime, suicide, physical ill health, smoking and its sequelae and disengagement with preventative health care (Taylor, 2010) (The Blue Knot Foundation, Accessed April 2019.). We also acknowledge that Aboriginal and Torres Strait Islanders, disabled and pregnant women and women suffering financial hardship are at greater risk of domestic abuse (Australian Institute of Health and Welfare, 2018).

It is impossible to accurately estimate the cost of domestic abuse to the individual, their children, their immediate and extended family and friends and to the community in terms of lost productivity, burden on the health, legal, correctional and social systems. Any estimate is likely to be a gross underestimate, due to underreporting across services available to victims (Australian Institute of Health and Welfare, 2018) (Department of Social Services, KPMG, 2017). However, the AIHW estimated the cost of violence against women and children at $22 billion in 2015-2016. Another $4

billion may be added if Aboriginal and Torres Strait Islanders, pregnant women, women with a disability and women experiencing homelessness are accounted for (Australian Institute of Health and Welfare, 2018). Of the $22 billion, premature death, treatment of physical and mental health constitutes the largest proportion at $10.4 billion annually. Moreover, it is also estimated that domestic violence results in a decrease in productivity of $1.9bn, that it reduces an individuals ability to work by at least 64%, largely due to reduced productivity and performance (Corporate Alliance to End Partner Violence, 2005). 60% of these victims go on to quit, lose their jobs or reduce their number of hours (Ridley et al, 2005).

Despite the pervasive nature of domestic abuse against women and children, the mental health system is entirely unequipped to support this patient cohort. The Adults Surviving Child Abuse (ASCA) Practice Guidelines for the Treatment of Complex Trauma were compiled from evidence from multiple disciplines, and has accumulated over many decades. These guidelines unequivocally support long term and intensive treatment of patients with complex trauma with psychotherapy (a minimum of 10-20 sessions within 12months of 50 to 75mins, or 1-2 sessions per week), supplemented by "sensorimotor therapies", such as trauma informed Yoga, art, sandplay and creative dance therapies. Most importantly, the treatment needs to be adaptable to the individual, as something which is helpful for one, might be triggering and retraumatising for another. Due to the multimodal therapy required and the well proven, distressing and complex impact of trauma upon the patient's brain and automatic bodily responses, this process will necessarily be prolonged (Stavropoulos, 2012). Numerous studies confirm the need for regular psychiatric care for trauma victims (Iverson et al. 2011, Najavatis et al., 2004, Creech et al., 2018) and numerous researchers and medical bodies worldwide have called for comprehensive integration of psychiatric care into domestic violence treatment pathways (Masiacha et al., 2017, Gregory et al., 2010). A prime example is the UK, where domestic violence referral pathways to psychiatry are being piloted (Gregory et al., 2010). This makes sound economic sense, since randomised controlled trials show 3.5 to 4.5 fold improvement in 3-6month employment data when psychiatric treatment for trauma is combined with access to shelters (Johnson et al., 2016).

Currently, the burden of care for these women and children falls disproportionately on general practitioners who are both inadequately trained and remunerated for their time. The Royal Australian College of General Practitioners (RACGP) explicitly endorses the ASCA guidelines, but there is no evidence that they are in widespread use. Rather, providing trauma informed care is often driven by individual effort, including participation of motivated GPs in masters programs and weekend training courses. In NSW, Medicare provides partial support for access to 10 psychology sessions in 12months, with no public access to psychotherapy across Australia and New Zealand. This again, is more appropriate for mild to moderate depression and anxiety, than trauma. Whilst the government funds short term treatment models, such as Project Air (Grenyer, 2018), these models are supposed to be temporary supports as a stepping stone to appropriate long term therapy, which at this time, does not exist. To access appropriate care, patients must obtain psychotherapy, psychiatry support and other supportive therapies through the private system, at great personal expense. This clearly

excludes a large swathe of the population from any appropriate care. In addition, inadequate provision of care for trauma patients, puts unnecessary burden upon emergency departments and inpatient and psychiatric units (Taylor, 2010).

One of our brave patients who suffers from complex trauma agreed to share her story in order to illustrate the difficulties of negotiating the current public mental health system as it stands:

> My name is Maya*, I am a 30 year old wife and mother of two children: aged 3 and 5, and am a casual English & History high school teacher. Despite building a life that I am proud of, achieving a degree and postgraduate studies, raising a family, purchasing our first home and marrying my best friend, my early years were not easy.
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> I am a survivor of early childhood sexual abuse, domestic violence, intimate partner violence and emotional abuse within the family home for 17 years.
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> When I left home after my HSC at 17 and moved to Sydney, I thought that I would be leaving the stresses of my childhood behind. However when I began my life in Sydney I noticed the stress didn't leave me, and in fact became worse. I experienced severe mental and emotional distress leading to weeks being unable to eat, sleep, or feel safe or "normal". I was trapped in a place of harrowing inner distress and didn't even know that it was something I could receive help for. I had no language or understanding what was happening to me. I began to think I would have to end my life, but did not want to. I just couldn't cope with how I felt anymore.
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> Somehow by what I thought was a miracle I emerged from that scary place and began to feel "normal" again.
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> When I was 20 I enrolled in university and began to enjoy the fulfilment of studying, working and achieving great marks. Throughout my university years, particularly during periods of heavy workload, I would experience a triggering of the same symptoms; insomnia, somatic symptoms, high anxiety, depression and I would skip work and be late on assignments. I even had to take a year off in the middle of my grad Dip Ed because of these symptoms.
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> I sought help for my symptoms from several doctors during these years. I was never asked about my childhood. I was told I had "major depression" by one doctor I had never met before within the first five minutes of a consultation; no mental health check conducted. He prescribed me antidepressants and offered no further help. Another doctor within a ten minute consult simply wrote a prescription for an antidepressant and said it was "a happy pill" that would make me better; again, no referral to further help. I declined the pills.
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> Another doctor finally did a mental health checklist and referred me to a psychologist.
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> The psychologist gave me ten sessions of CBT and concluded that I did not have depression and sent me on my way.
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> From other doctors I was prescribed temazepam and stilnox to manage my insomnia. These helped the symptoms temporarily but my problems continued to repeatedly surface. Nobody identified trauma as a link to my symptoms.
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> After having a miscarriage and having my second child in 2016 I developed a heightening of all of the previous symptoms, including severe health anxiety. Because my symptoms were so somatic I believed my body was failing me. I had repetitive visits to the doctor fearing all kinds of illnesses. I stopped working and developed high anxiety and panic attacks; waking in the night and feeling the need to run;

cognitive delusions, paranoia, severe somatic symptoms including the feeling that my body was being electrocuted for months, inability to sit down to rest, racing heart and severe insomnia where I would only sleep every second night for a couple of hours. My husband had to care for me and the two kids while his performance dropped at work. My children detached from me as they knew mummy wasn't herself anymore, and wasn't present.

I was sent to a highly regarded clinical psychologist who treated me for anxiety. I was on a ten visit mental health plan and she cost $250 per session. I was out of pocket around $120 with the ten visit plan and had to see her twice weekly. Anxiety heightened as I wasn't improving and I knew we could not afford the therapy in the long term. My GP prescribed me an antidepressant called Effexor. However my symptoms were getting so out of control and I was experiencing flashbacks, so I decided to seek the option of admitting myself to the public mental health unit.

I contacted a psychiatrist who identified my symptoms were indicative of complex trauma. She told me to get off the drug I was prescribed and to avoid the public mental health unit as it would not be a safe space for me whilst experiencing a severe traumatic response; our public system could potentially make me worse as doors would be locked on me, I would be stripped and searched and there would be frightening sounds and nurses and doctors untrained in complex trauma and Complex Post Traumatic Stress Disorder.

This psychiatrist, was a trauma informed practitioner who took a detailed history of my trauma; educated me on the biological responses I was experiencing and prescribed new medications. She normalised my experiences for me but unfortunately could not offer me any safe space to recover because I did not have private health insurance.

I purchased top hospital and top extras cover to give me access to the private health system but had to wait an absolutely horrible two months of all of the mentioned symptoms while medication was setting in. Our family went through financial distress and I had to move to my husband's parents' house in a suicidal state with my daughter so that my husband could continue to work.

After suffering terribly between April and October, the medications began to take effect and I saw a trauma specialist counsellor who ended up offering me free sessions because she could see I needed twice weekly sessions and it was not financially viable at the time. My GP has who normally charges, bulk bills me my sessions as he can see the huge cost trauma has on our family. My psychiatrist has also offered me free care for the same reason. I have learnt that in order to see someone with complex post-traumatic stress truly recover, the health professionals who are committed to this work have to take money from their own pockets because our government does not provide them incentive to spend the time required to care for people with mental health issues stemming from a complex trauma history.

I am doing very well now one year later after a colossal combined input of health practitioners, family and community support. I consider myself lucky for what my social connections have allowed for me. We are still recovering the finances lost as my husband had to take time off work and I am only now just able to begin working again after one year of lost income. I still pay $150 per week out of pocket for my medications, hospitals and extras cover, regular fortnightly therapy and gym membership.

I hope this example shows what it has taken for me to get well; the years of misdiagnosis, the years of lost productivity for work and study, the lost finances, the many corners of the health system I had to encounter before discovering trauma informed care and practice; the input it has taken from selfless health practitioners, family and community members to see just one person recover from a very dark place, and to move forward from a past that I did not ask for and that still affects my health today.

* Names have been changed

As Maya's case illustrates, the public mental health system does not provide for patients with complex trauma. They must seek this care within the private system, at their own expense, and they are reliant in many cases on the generosity of their general practitioners, psychiatrists and therapists. Many patients simply cannot afford private care and thus, will be left in a dark mental state, unable to work or care for their families. At DAVTW we consider the lack of public access to psychotherapy and trauma appropriate care indefensible. It neglects highly traumatised adults and children, at immeasurable cost to the community and the public purse and unfairly places the burden of care upon general practitioners and hospitals, who are under resourced to complete this task due to the complexity of this patient group and the intensive treatment required. We call upon state governments to address this inadequacy promptly, with funding for public access to psychotherapy and trauma appropriate multimodal care. At the same time, we emphasise the need for adequate planning of this service to maximise accessibility, whilst avoiding the fragmentation and disorder which already predominates in the mental health sector. Moreover, federal and state governments often fund short term pilot programs which save money at the expense of trials of long term, intensive treatment models. This shows a complete lack of understanding for the complexity of trauma and the intensive treatment required, a lack of compassion for victims and makes little economic sense. Have no doubt, continued short sightedness will lead to preventable death, morbidity and economic losses. There are no excuses.

Sincerely,

Doctors Against Violence Towards Women

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