Submission No 156

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

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My name is Dr. Karen Williams. I am a consultant psychiatrist and a fellow of the Royal Australian and New Zealand College of Psychiatry. (FRANZCP) I have worked in mental health facilities, both public and private, for 20 years.

I am the founder of the charity Doctors Against Violence Towards Women. I am also the Medical Superintendent of Ramsay Clinic Thirroul the first women's-only mental health facility, designed exclusively to treat survivors of trauma. We have had over 800 women come through the clinic in just one year. Women fly from all over Australia, at their own expense to receive comprehensive and holistic trauma treatment here.

I would like to highlight 4 current patients who have given me permission to describe their case in order to demonstrate the inadequacies of NSW's Mental Health System. Some of these inadequacies are from lack of government funding. But not all can be explained by poor funding. Some of these inadequacies are from a culture of dismissiveness of the role of family and sexual violence on mental health by mental health professionals, and a lack of accountability by the profession, to demonstrate that what they are doing is actually beneficial, or even simply, not harmful. Unfortunately, these cases are in no way exceptional, and I would see women with similar stories every day.

Case 1

NJ was 1 month post-partum, living in rural NSW. She was depressed, suicidal, not bonding with her baby, she had been referred to the acute mental health team, but was told there were no mother-baby beds available anywhere in the state.
She was reviewed via via telehealth. Her assessment was conducted whilst her husband, her abuser was sitting right next to her. She was prescribed heavy doses of antipsychotics and told to 'sleep it off'. The dose was so high she could not walk and needed to be carried to the bathroom. She woke up with bruised thighs and her sutures torn. Her abuser gave her medications every night and would rape her as she was too sedated to move. This behaviour was going on for 7 years before I saw her. Her abuser tells her doctors to' keep prescribing' because 'she doesn't sleep without the meds' No one had ever asked her about family violence and no mental

health professional ever asked her to be assessed alone. She had not worked in 8 years when I first saw her.
Once she was taken off these medications, her PTSD could be treated and when this happened she was able to leave the abuser. She is now studying a double degree of law-psychology after receiving an HD in a university preparation course.

Case 2

RC was a ward of the state, her biological father raped her at 3 and went to jail. Her mother was always intoxicated so she was placed in care. RC was placed with over 20 short-term placements. She began self-harming from the age of 9. RC was raped on an adolescent mental health ward at the age of 13 by the male nurse who was meant to be supervising her. Her mental health deteriorated even further. RC could never complete high school as she was too sedated on the medications she was prescribed. Initially her teachers trialled her in a 'special needs' class, but she could not concentrate or remember what she learned. All relationships she had had been abusive. Last year she was diagnosed with Factitious Disorder because her treating team don't believe she is really suicidal. She cannot leave her abuser because she does not have the money or qualifications to support herself, and her abuser calls her 'crazy' her mental health file dating back to her teenage years means that she knows she will never win custody of her kids

Case 3

JR is on a $450,000 NDIS package. She is in a wheelchair and has a colostomy bag. She cannot afford to see her GP because of the $40 gap. She cannot afford to see her psychologist ($200 gap), psychiatrist ($300 Gap) or pay for the paste for her stoma care. She has to do sex work to afford food. *But* NDIS will cover an unqualified 'life coach' to help her book the appointments. Her life coach rings me to ask if an 'electric dog collar would help her',
JR is self -harming one day and the case worker calls 000. The police and ambulance arrive and they taser her whilst she is sitting on the toilet.
I do what I can to treat the trauma, but sex work triggers her PTSD. She is truly stuck.

Case 4

KC was abused her whole childhood. She became a high school teacher but was assaulted at work and forced to leave the school. Being a teacher was the only positive thing she had in her life. She became suicidal and overdosed. She was subsequently diagnosed with a personality disorder and told she was untreatable. She was placed on more and more medication. Over the next 8 years she was admitted FORTY FIVE (45) times to adult psychiatric units after attempts to hurt/kill herself.

Over a year ago we took her off the 9 different psychiatric drugs that had made her overweight, drool, sedated and unable to think. She's been engaged in trauma therapy.

One year after stopping the medications, she works for the Department of Community Justice and has had 2 promotions in that time.

Violence against women is a public health issue

The evidence shows child abuse, sexual violence, and family violence have a profound impact on mental health at both an individual and community level. In recent years, the public narrative has shifted from this being a personal or private matter, to acknowledging that whole-of-government, multi-sector response is needed to drive tangible change. A critical avenue for reform is the mental health sector.

In my clinical opinion, the reason our mental health system is failing to deliver the outcomes we would hope is because addressing the Relationship between Child Abuse, Sexual violence and Family Violence and Mental health is not a priority of the mental health practitioners /NSW Mental health System. This is evidenced in a number of ways including:

> ***" Only 15% of mental health professionals routinely ask about domestic violence"***

In addition, there is no established or targeted interventions to adequately address trauma caused from family and or sexual violence in the public system . Even when disclosure is made, referral to specialist services is low. (27%)

The absence of trauma informed approach in this space is startling when the evidence shows significant need.

1. ***In the course of a one-year period:***
   If a woman is not being abused, she has a 1% of being given a mental health diagnosis
   If a woman is being abused, she has a 37% chance of being given a mental health diagnosis.

2. ***70% of women in acute mental health facilities have a history of sexual assault.***

3. ***46% of women in acute mental health facilities have been assaulted whilst admitted to the ward***

4. ***Childhood trauma and domestic/intimate partner violence a major cause of Post Natal Depression, Major Depression, Anxiety, PTSD, Substance abuse, gender dysphoria, Self- harm and suicide***

5. ***1/4 of Australian women will experience childhood trauma***
   1/3 of Australian women will experience Intimate partner violence
   Half of these women will be given a mental health diagnosis.

improving the ability of mental health services and practitioners to respond to child, sexual, and family violence is paramount to improving community mental health outcomes at large.

RECOMMENDATIONS

Mental health professionals currently have less than 2 hours of family violence training

- Family violence training must be made compulsory in all medical and allied health students and staff
- The RANZCP needs to ensure that psychiatrists and trainee members are trained to i*dentify* and r*espond* to disclosures of abuse.
- The NSW Government should support and work with education providers and health services to embed family violence training for all medical and allied health students and staff, commensurate with the public health risk posed by family violence

Patients undergoing family violence should not be stigmatised in the emergency department.

- NSW Health continues to have no concussion protocol for survivors of family violence. Repetitive head injury, choking, strangulation, water boarding all place women at greater risk of death, PTSD and other psychological consequences. NSW health should take head injuries of victims of family violence as seriously as they do head injuries in sports players.

- Patients in the mental health system should not be traumatised by the agency treating them. All health professionals, especially mental health professionals need to be trained in providing trauma-informed care to all patients

- Development of a ***Trauma Centre of Excellence*** to conduct research and development to enhance our knowledge of evidenced based methods to deliver trauma informed care

Point of Entry

All patients must seek the support and advocacy of a General Practitioner or Emergency physician in order to access a mental health professional. Both of these specialities are time poor, under- supported and under-resourced to provide the time and environment required to obtain a full and comprehensive mental health history and assessment and obtain the information that is required to provide a holistic treatment plan.

For example, a GP with a full waiting room, with an average *6 – 12 minutes* to see the patient will not find out how the woman in front of them is in an unsafe relationship, is socially isolated, is self-medicating with alcohol. Yet, even if they do manage to obtain this history, they do not have the specialised training to manage

trauma disclosures safely in a short period of time, nor access to support services to refer the patient to in a reasonable period of time.

Should she disclose risk of suicidality to the GP, the GP is then faced with only a few inadequate options:

1. Suggest she present to the Emergency Department
2. Suggest she book in to see a psychologist and or psychiatrist (most of whom have closed books or extremely long wait lists)
3. Suggest she ring Community Mental Health Team
4. Try and manage the situation themselves by offering another appointment and an antidepressant

Attending the Emergency Department

With the ongoing reduction in public acute inpatient beds we are at the lowest rate of bed availability per 100,000 in Australia's history . A direct consequence of this is that the rates of Emergency Department presentations is increasing rapidly and the wait time for mental health assessment is growing longer than the wait time for any other medical condition triaged at the same category.

Historically, the ideology behind reducing bed numbers was that there would be improved outpatient mental health services. This has not happened and instead, patients requiring both inpatient and outpatient care have to rely on a mish-mash of services that have very unclear intake criteria or goal directed outcomes.

Acute Mental Health Referral

Should the patient be assessed as suitable for referral to Mental health – they will then be seen by a Mental Health Nurse, who then takes a history and will then distil the history to the Psychiatric Registrar or Consultant.

In essence, if the at-risk, often traumatised and distressed patient will have to tell their story to:

1. Their General Practitioner
2. The Triage nurse
3. The ED physician
4. The Mental Health Nurse
5. The Psychiatric Registrar

All Before they will be able to access a psychiatric assessment by a specialist.

Recommendations

- Consider the cost-benefit of an acutely unwell patient having to go through 5 different professionals to simply speak to a psychiatrist, particularly when none of those interactions will provide ANY long-term therapeutic benefit
- The roles of each of the parts of the system (GP. ED, CMHT) need to be clearly defined with transparent target patients, non-ambiguous objectives of treatment and outcome measures
- Instead of investing in 5 non-therapeutic, potentially damaging interactions, remunerate one professional/ service to properly take the history and provide comprehensive care with continuity. This is preferable for the patient, is more meaningful for the provider and has improved outcomes for the patient

Admission to a psychiatric unit

Once a patient is assessed, it is only the patient who is either acutely psychotic and or IMMINENTLY at risk who will be admitted. That is, the patient must have plans and or intent

to kill themselves or is a risk to others. Any patient who can possibly be managed by an outpatient service is referred back into the community, regardless of whether the community have the capacity to manage this person.
Many patients will also tell you they were told by the community service 'you are too acute for our service' which results in patients being referred back and forth between services.
In NSW patients expressing thoughts of self-harm may receive a referral to the Gold Card Clinic – a Project Air Strategy. Despite millions spent on the research to develop this, there is no evidence base to suggest any benefit to the patient's long-term outcome, and there has been no reduction in ED presentations. In fact, the developers of the program have released data indicating that these therapies are not effective and have suggested more money invested into understanding why they are not effective.

At present, a psychiatric unit does little more than physical containment. Diagnosis has usually been made before they arrive, medication has often already been started. Admitted patients will placed in a locked unit, with all objects they could harm themselves with removed from their person. At times a medication may be commenced or ceased but given the potential benefits of pharmacological agents takes months to be come into effect, the benefit of hospitalisation in the acute unit is minimal to none. There is rarely an available psychologist, social worker or counsellor available on the acute wards, and even if they are, there is no time for patients to build a relationship of trust so that the interaction can be therapeutic.
Consequently, at this stage most patients opt out, and agree to go home and only 30% of presenting patients will be admitted.

However, we need to also remember that the 'at-risk' patient would have been encouraged by their GP or family to seek help. Being told that they have made a mistake in seeking help damages the patient's relationship with their GP / family and is psychologically damaging. It can result in the patient deciding against further involvement with mental health. In fact, the highest risk patients, who do complete suicide, stop attending mental health services in the year prior to the suicide, suggesting that these patients do not trust that the mental health services available will help them.

Recommendations

- Understand survivors of trauma frequently require and benefit from inpatient care if that treatment is safe and therapeutic
- Recognise some patients will always need inpatient care, and that simply shutting beds down without viable alternatives is dangerous
- Increase the number of acute inpatient beds with adequate, appropriately trained staffing to make the environment safe
- Inpatient care needs to be structured, holistic and purposeful. Simply holding them 'in a pen' is not just non-therapeutic, but detrimental
- Development of specialised trauma services, particularly for those who have experienced gendered violence
- Single gender wards available to all women, and an abolishment of all mixed gender bedrooms
- Victoria Health has opened a 24 bed women's-only facility in collaboration with a Ramsay Health Care as a direct response to the Royal Commission. NSW Health is funding one bed at Ramsay Clinic Thirroul, this could be increased to treat a more substantial number of women without private health insurance.

Social Implications of the under-recognition and management of Trauma

The failure of the mental health system to recognise and respond to family and sexual violence has far reaching impacts.

Misdiagnosis of trauma results in polypharmacy, delayed care, worsening symptoms, lack of consistent therapy. Misdiagnosis worsens the mental health outcomes for women and it also worsens physical health outcomes. Misdiagnosis can result in women *staying in dangerous relationships* far longer than they would otherwise.

Misdiagnosis has enormous impacts in the Family law court, where we are seeing women being incorrectly labelled with serious mental health and personality disorder resulting in their having children removed from their care and being given to the abuser.

Examples of this include women describing abusive behaviour described as having pseudo-scientific psychiatric labels such as' "false memory syndrome' or 'parental alientation syndrome'. These labels are then used to deny a woman access to her children.

Failure to recognise the psychological impacts of abuse also has far reaching impacts in the criminal court – where a survivors *appropriate* trauma responses are not recognised by the legal system - eg

1. a woman '*freezing'* and not screaming out 'stop it' is evidence that she did not want the abuser to stop
2. A woman 'returning to her abuser' is evidence that the abuse is not severe and that she 'obviously wanted to be in the relationship'
3. A woman 'returning to her abuser' is used not to grant an Apprehended Violence Order, or other restraining order
4. A woman *forgetting certain details* of an assault is indicative she is 'an unreliable witness' or a 'liar'
5. A woman *collapsing* on the stand has 'been caught in a lie' and or 'an unreliable witness'
6. A woman '*acting 'normal'* immediately post trauma is evidence the event was not traumatic or fabricated
7. *Delayed reporting* of an assault indicates she is lying about the event

Excerpts from the literature

ZANNARINI ET AL

Reported pathological childhood experiences associated with the development of borderline personality disorder.

Of the 358 patients with borderline personality disorder, 91% reported having been abused, and 92% reported having been neglected, before the age of 18.

Table 2
Reported rates of childhood traumatization in the borderline group and the control groups before the age of 18.

Type of traumatization	BPD (N = 80)	Depressed (N = 73)	Healthy (N = 51)	Analysis	
				χ^2	P
Neglect	69 (86.3%)	36 (49.3%)	20 (39.2%)	35.88	<0.001
Separation	64 (80.0%)	48 (65.8%)	41 (80.4%)	5.19	0.075
Emotional abuse	70 (87.5%)	42 (57.5%)	20 (39.2%)	34.36	<0.001
Physical abuse	52 (65.0%)	14 (19.2%)	6 (11.8%)	51.58	<0.001
Sexual abuse	45 (56.3%)	15 (20.5%)	2 (3.9%)	45.52	<0.001
Witnessing	62 (77.5%)	37 (50.7%)	9 (17.6%)	45.02	<0.001

Recent metanalysis 0f 97 studies, Porter et all 2020

- diagnosis of BPD were **over thirteen times** more likely to report childhood adversity than non-clinical controls
- 48.9% of people with BPD reported physical neglect in their childhood, 42.5% reported a history of emotional abuse, 36.4% reported physical abuse, 32.1% reported sexual abuse, and 25.3% reported emotional neglect.
- Overall, more than **71%** of the people with BPD in the studies said that they had experienced at least one traumatic event during their childhood.
- The findings support the importance of trauma-informed care for individuals accessing mental health services and forensic settings, where prevalence rates of BPD are high

I would like to end with a question to the Committee:

I have a woman in front of me, she was raped by her brother when she was a little girl. She has found out that he has raped his young daughter and he is now facing jail. She believes it is her fault because she never reported it to anyone, and if she did, maybe he would not done the same to her niece.

She is suicidal, she plans to kill herself – she has written me a letter telling me that she wants me not to feel guilty, not to feel like I did something wrong, but that she cannot do it anymore. She has not been eating, she has not been sleeping. She is determined.

My question is this:

Do I send her to a place where I know the following:

1. She *will* in a locked facility with mentally ill, mentally disordered men – some will be yelling, some will be psychotic, some will be violent,
2. She *may* have to share a bedroom with a man
3. She has a *45% chance* of being sexually assaulted whilst she's there
4. She is likely to be over-sedated which will worsen her PTSD
5. She will NOT receive any therapy
6. She will NOT see a psychologist
7. She will NOT have an opportunity for exercise, relaxation, yoga, mindfulness, art therapy or anything else that may make her mental health condition improve
8. She may have medications reviewed, but she will not be there for long enough to see if the changes worked
9. The staff that will be looking after her are not trained to respond to someone with her condition (complex PTSD)
10. The staff that will be looking after her will be in a locked glass office, who will almost always be unavailable to her
11. The bedrooms are down a long corridor away from the nurses' station and her door will be left unlocked all night, I know she will not sleep
12. If she is scared on the ward, she will likely end up sedated and at even greater risk, and I know she will be scared on the ward.
13. Almost always her mental health will deteriorate after this admission, and she will be sent home no better than before

Or do I send her home?
She may kill herself.
And I will be deemed personally responsible, not the health system that does not provide safe and effective support for women like her