Gippsland Family Violence Alliance

2023

Mental Health and Family Violence

A Community in Focus Resource

www.gippslandfamilyviolencealliance.com.au

What is Mental Health

Good mental health is characterised by more than the absence of symptoms. It is the capacity to manage life successfully and to deal with the obstacles it unavoidably presents us with in a relatively robust manner. It involves being able to find happiness and enjoyment in daily activities. This covers the variety of emotions and thoughts we experience in reaction to life's events. It is common to feel emotions such as sadness, loneliness, disappointment, or confusion on occasion. We all understand these emotions. They are inherent to being human. Mental health issues arise when these feelings persist and impede a person's ability to lead and enjoy their life.[i]

Mental health issues are difficult experiences, and include painful emotions and thoughts that we all experience at times, such as grief, hopelessness, and fear. Mental health issues are reactions to what is, or has, happened to us and around us. [ii]

[i] What is mental illness? (sane.org)
[ii] About mental health problems | Mental Health Foundation

The Mental Health Impacts of Family Violence on Adult Victim/Survivors

As stated by Anne-Laure Couineau, Director, Policy and Service Development at Phoenix Australia, "the mental health impacts of family violence are significant." Anne-Laure reports that victim survivors have a higher probability of developing post-traumatic stress disorder (PTSD), depression and anxiety. Victim survivors frequently feel shame, are on edge much of the time, and all areas of their lives are impacted, including parenting, their employment, maintaining relationships with family and friends. Family violence can have substantial effects on a person's self-esteem and ability to cope with and manage everyday responsibilities and decisions.[i]

The ANROWS WITH study reported on the complex interrelationship between sexual violence experiences and mental health:
From timeline interview analyses conducted by the University of New South Wales research team, several patterns (models) were evident over women's lifetimes. The following were important factors leading from sexual violence to mental health problems:

Disclosure issues:

- disclosure of sexual abuse being ignored or blamed on the child or young woman by a family member, absence of a trusted other to disclose sexual violence, disclosure of sexual violence being minimised or ignored by others; isolation issues:

- early childhood sexual abuse or parental neglect heightens risk of future experiences of sexual violence and then, with anxiety symptoms, alcohol and drug use in later life; and
- isolation from significant others during their lifetime increasing the risk of being "targeted" by potentially abusive men.[ii]

Developing resilience, protective coping strategies and having support are crucial to recovery from trauma which can be a protracted and arduous process, one that abusers actively seek to sabotage. [iii]

[i] https://www.phoenixaustralia.org/mental-health-impacts-family-violence/
[ii] https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2019/02/WITH_Compass_UPDATE_FINAL.pdf
[iii] https://safelives.org.uk/practice_blog/navigating-language-listening-words-women-use-describe-their-mental-health-and-hearing

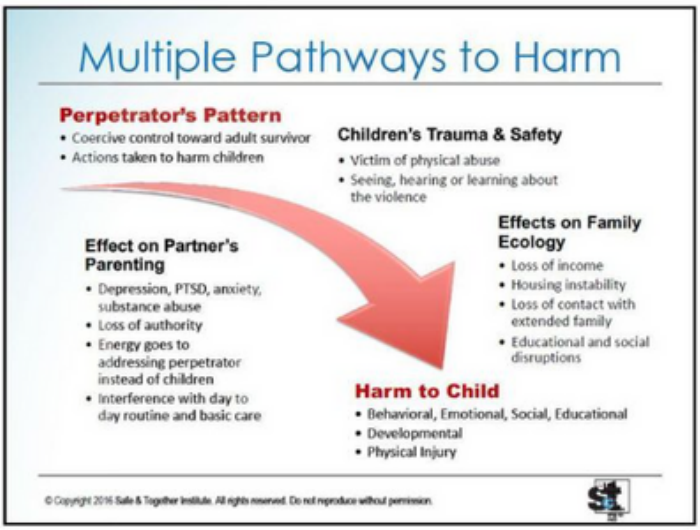
The Mental Health Impact of Family Violence on Infants, Children and Young People

Approximately one in four children experiences family violence.[i] Recent data reflects that more than half of the women who experience violence had children in their care when the violence occurred, with more than three-quarters of children witnessing the violence.vi

Children can be direct and indirect victims of family violence. The terms 'living with' and 'experiencing' family violence best describe the circumstances for a child in this environment.

Experiences of family violence include:

- suffering physical harm; for example, if a mother is holding a child when she is attacked; if a child is trying to protect his or her mother; or the child is the target of the violence
- feeling scared of those who they love
- seeing the consequences of physical violence
- having belongings destroyed
- distress caused by harm to a pet or threats that their pet will be harmed
- not being allowed to bring friends home or being unwilling to bring friends home because of shame they will witness family violence
- isolation from extended family
- feeling responsible for the violence
- disruptive schooling because of absences or changing schools
- having a parent who is struggling in their parenting role due to experiencing violence.



Some perpetrators use children or young people to maintain power and control. For example, a father who is perpetrating family violence might:

- use the child as a means of ensuring the mother returns home
- force the child to watch or participate in assaults
- interrogate or involve the child in spying on their mother

undermine the mother by encouraging the child to have negative opinions of her.[ii] [iii]

Family violence trauma can disrupt child development and healthy attachment and compromise brain development.[iv] The notion of children 'being too young to understand' has been challenged in the research literature on the impacts of family violence trauma. Children do not need to understand or have language to feel the impact of violence. Even if it is experienced before birth (during pregnancy), family violence has enduring detrimental impacts and significantly increases the risk of mental health disorders at all stages of life. ix

Manifestations of this trauma include regression – for example, a child wetting the bed after previously having bladder control, developing sleep problems, withdrawing, being anxious or becoming aggressive. Some children develop chronic somatic problems. Older children and young people might engage with risk-taking behaviours such as using drugs or alcohol or experience suicidal ideation or other mental health difficulties.

Experiencing childhood trauma, especially severe trauma, is likely to have many effects on a person, including long-term effects on their mental health. Many people, especially women, who receive a diagnosis of borderline personality disorder have experienced childhood trauma. Complex trauma-related disorders such as borderline personality disorders are frequently not well understood within a trauma framework. This can lead to women with such a diagnosis to move between mental health, sexual assault and family violence services without coordinated support that assists with the impact of early childhood trauma.

(Chief Psychiatrist's guideline and practice resource: family violence, p.9) [i] Australian Bureau of Statistics 2017, Personal Safety Survey 2016, ABS, Canberra.
[ii] State of Victoria 2016, Royal Commission into Family Violence: report and recommendations, Melbourne.
[iii] The Royal Australian College of General Practice 2014, Abuse and violence: Working with our patients in general practice, 4th edn, RANCGP, Melbourne.
[iv] James L, Brody D, Hamilton Z 2013, Risk factors for domestic violence during pregnancy: a meta-analytic review, Violence and Victims, vol. 28, no. 3, pp. 359–380.

MYTH: Mental health causes Violent Behaviour

People living with mental illness are no more violent than anyone else. It is a myth that mental illness makes a person violent. Movies, television, and other media often promote a false, highly stigmatising picture that people with mental illness are violent.

The reality is people with mental illness are more likely to be victims of violence. People with mental illness experience much higher rates of violence than the general population, especially people with complex mental illness. They are also more at risk of homicide, suicide and self-harming behaviours.

Studies suggest people with a psychotic illness who use violence are more likely to do so if they are abusing drugs or alcohol, not receiving proper care, or have a history of violent behaviour which is independent of the illness. [i]

[i] https://www.sane.org/information-and-resources/facts-and-guides/fvm-mental-illness-and-violence#:~:text=People%20living%20with%20mental%20illness,It's%20not%20true.

An Intersectional Lens

Women with mental illness have reported that they are often disbelieved if they report physical, sexual or psychological violence to police, service providers or health professionals. Research has shown that women with a history of sexual assault or abuse may feel vulnerable in acute psychiatric inpatient units and other unfamiliar treatment environments, particularly if their admission is on an involuntary basis.[i]

Some groups of Australian women are at particularly high risk of experiencing sexual assault, family violence and associated mental health problems. Notably, Aboriginal women have a very high rate of assault. [ii]

The Victorian Government Partnerships Project found that mainstream agencies often struggle to respond in culturally appropriate ways to the complex health and mental health needs of Aboriginal women. Combined with the entrenched disadvantage and racism that many Aboriginal people have experienced, Aboriginal women may feel disempowered to leave or change abusive situations and to recover from trauma.

Women from culturally and linguistically diverse communities may also be more likely than 'mainstream' Australian women to be victims of violence and sexual assault. Experiences of trauma or torture, including rape and sexual violence, are frequently reported in many newly emerging refugee communities.

Additionally, many migrants have past experiences that affect both their long term mental health and their ability to trust government services. Mental health issues, including post-traumatic stress disorder, and difficulties in adjusting to Australian life may contribute to high rates of domestic violence in some ethnic groups.

The Partnerships Project found the following factors impede appropriate service access for women from non-English speaking backgrounds:

- lack of knowledge of services
- the language barrier, and failure of mainstream services to make appropriate use of interpreters
- greater rates of family care and reluctance to involve government agencies
- reluctance to seek treatment due to stigma and shame.

Other groups of women with greater vulnerability to violence and/or mental health problems include sex workers, homeless women, and women in institutional settings.

Women with a disability have been identified as being at particularly high risk of violence, with evidence of a much greater prevalence of sexual assault among this group than the mainstream community. [iii]

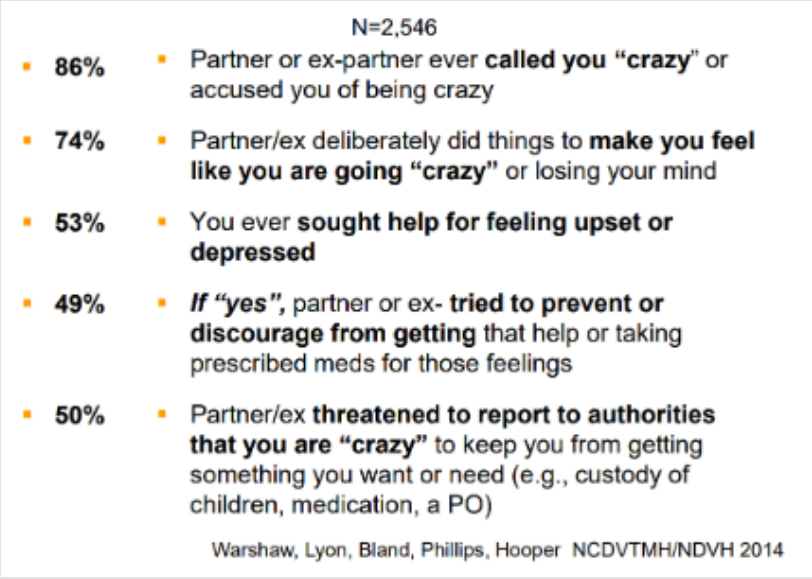
[i] ANROWS-RtPP-VAW-in-mental-health-units.pdf (anrowsdev.wpenginepowered.com)
[ii] 060607_Partnerships Project.indd (nifvs.org.au)
[iii] 060607_Partnerships Project.indd (nifvs.org.au)

Mental Health Coercion

Mental health coercion, along with substance abuse coercion, is an extremely common form of abuse. It is critical to keep this in mind when working with victim survivors of family violence.
According to Warshaw[i], mental health coercion involves 'abusive tactics targeted towards a partner's mental health as part of a broader pattern of abuse and control. This often involves the use of force, threats, or manipulation. Abusive tactics targeted towards a partner's mental health as part of a broader pattern of abuse and control. This often involves the use of force, threats, or manipulation and can include deliberately attempting to undermine a survivor's sanity.'

Tactics of mental health coercion may include:

- efforts to undermine the persons sanity
- efforts to create disability and dependency
- efforts to control a person's access to treatment and support services
- efforts to control a person's treatment, including medications
- efforts to undermine the person's recovery
- undermining a person's ability to maintain custody of their children; and
- using a survivor's mental health to discredit them with sources of protection and support, such as friends and family
- leveraging a person's mental health to manipulate services systems, such as Police and Child Protection.[ii]



[i] http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2018/03/NCDVTMH_MHSUCoercionToolkit2018.pdf
[ii] http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/NCDVTMH_NDVH_MHSUCoercionSurveyReport_2014-2.pdf

Asking about Mental Health Coercion

There are a number of ways that questions about mental health coercion can be woven into family violence risk assessment or mental health history:

- Be mindful when engaging with family members in the gathering of collateral information – many people who use family violence take these opportunities to minimise or deny the abuse. They may lie about their partner's symptoms, behaviour, and stability;
- It is important to ensure that you talk with the person privately at each visit to find out who they feel safe having present during their appointments;
- Be careful not to make assumptions about the gender identity or sexual orientation of your clients or the gender identities of their intimate partners.
- Gaslighting: Does your partner do things to make you feel "crazy" or like you are "losing your mind"?
- Undermining: Does your partner tell you that you are lazy, stupid, "crazy," or a bad parent because of your mental health condition? That no one will believe you because of your mental health condition?
- Blaming: Has your partner blamed you for the abuse by saying that you're the one who is "crazy"?
- Discrediting: Has your partner ever used your mental health condition to undermine or humiliate you with other people
- Threatening: Has your partner ever threatened that you will lose custody of your children because of your mental health status?
- Jeopardising: Has you partner ever done things that cause your mental health symptoms to get worse?
- Has your partner ever tried to prevent or discourage you from accessing mental health treatment or taking your prescription medication?
- Prevent you from eating or sleeping?
- Controlling: Has your partner ever tried to control your prescription medication (such as by forcing you to take an overdose, giving you too much or too little medication, or preventing you from taking it at all)?
- Does your partner restrict or interfere with your ability to speak for yourself with doctors or mental health professionals?
- Does your partner have control of your finances or guardianship?
- Is your partner legally able to make decisions for you?
- Threatening: Has your partner ever threatened to have you committed to a psychiatric inpatient unit?

More detailed information can be found in this excellent toolkit:
Toolkit: Coercion Related to Mental Health and Substance Use in the Context of IPV

Safety Planning

A coordinated, collaborative approach between family violence and mental health services is essential for effective safety planning:

Seek secondary consultation:

Specialist Family Violence Advisor – Mental Health – 5128 0084
Mental Health Triage - 1300 363 322

Where a person has mental health or AOD issues, additional considerations include:

- Mental health issues and substance use can make it difficult for victim survivors to assess the severity of the abuse they are experiencing.
- Is the safety plan realistic for the client? Can they implement the plan when they're intoxicated or unwell?
- Consider changes to patterns of substance use that may increase safety. For example, using at times of day that their partner is unlikely to be around.
- Does the safety plan incorporate strategies to promote access to AOD treatment or mental health services?
- What response might survivors receive from services, the police, etc. when they make calls under the influence of alcohol/drugs or when they are unwell? What previous contact have they had with services (including child protection and police) relating to their substance use or mental health? What advocacy is required to access family violence support services?
- Accessing safe refuge accommodation has added barriers for women with drugs and/or alcohol use. Be prepared to work in partnership with the staff there and support them to maintain the woman's safety.
- Do they have sufficient prescribed (psychiatric) medication? Where is a safe place to keep prescriptions? How easily can a new prescription be arranged?
- Discussion of harm minimisation, e.g. learning to self-inject safely, smoking rather than injecting or managing self-harm and suicidal thoughts.
- Anticipating partner's substance use – how to keep safer when they have been using/drinking?

- Detox/withdrawal/relapse on the part of the perpetrator can be dangerous times in terms of safety.
- Does the victim survivor have a relapse prevention plan? Can any actions be incorporated into the safety plan?
- Include the safety plan in the AOD treatment plan [i]
- Include the Mental Health Helplines relevant to them in their Safety Plan. For a full list of Helplines, go to https://www.healthdirect.gov.au/mental-health-helplines

Refer to the MARAM Practice Guides: https://www.vic.gov.au/maram-practice-guides-and-resources

[i] https://www.vaada.org.au/family-violence-risk-management-safety-plan/

Helplines

Safe and Equal: Identifying and Responding to Elder Abuse in Inter-generational Households

Seniors Rights Victoria: Resources and Education To build relationships with those working directly with older people, Seniors Rights Victoria provides limited Professional Education sessions to service providers, agencies and other organisations. This enables professionals and staff to identify incidences of elder abuse and respond appropriately.

Beyond Blue aims to increase awareness of depression and anxiety and reduce stigma. **Call 1300 22 4636, 24 hours/7 days** a week, chat online or email.

Blue Knot Foundation Helpline is the National Centre of Excellence for Complex Trauma. It provides support, education and resources for the families and communities of adult survivors of childhood trauma and abuse. **Call 1300 657 380, Monday – Sunday between 9am – 5pm AEST or via email helpline@blueknot.org.au.**

Butterfly Foundation's National Helpline is a free, confidential service that provides information, counselling and treatment referral for people with eating disorders, and body image and related issues. **Call 1800 33 4673, 8am-midnight AEST / 7 days a week**, chat online or email.

eheadspace provides free online and telephone support and counselling to young people 12 – 25 and their families and friends. **Call 1800 650 890, 9am – 1am AEST / 7 days a week**, chat online or email.

FriendLine supports anyone who's feeling lonely, needs to reconnect or just wants a chat. You can **call them 7 days a week on 1800 424 287**, or chat online with one of their trained volunteers. All conversations with FriendLine are anonymous.

Kids Helpline is Australia's only free 24/7 confidential and private counseling service specifically for children and young people aged 5 – 25.
Call 1800 55 1800.

Lifeline provides 24-hour crisis counselling, support groups and suicide prevention services. Call 13 11 14, text on 0477 13 11 14 (12pm to midnight AEST) or chat online.

MensLine Australia is a professional telephone and online counselling service offering support to Australian men. **Call 1300 78 99 78, 24 hours/7 days a week**, chat online or organise a video chat.

MindSpot is a free telephone and online service for people with anxiety, stress, low mood or depression. It provides online assessment and treatment for anxiety and depression. MindSpot is not an emergency or instant response service. **Call 1800 61 44 34**.

QLife provides nationwide telephone and web-based services for lesbian peer support and referral for people wanting to talk about a range of issues including sexuality, identity, gender, bodies, feelings or relationships. **Call 1800 184 527, 3pm – 12am** (midnight) AEST/7 days a week.

PANDA (Perinatal Anxiety & Depression Australia) supports women, men and families across Australia affected by anxiety and depression during pregnancy and in the first year of parenthood. **Call 1300 726 306, 9am – 7:30pm** AEST (Mon-Fri).

SANE Australia provides support to anyone in Australia affected by complex mental health issues, as well as their friends, family members and health professionals. **Call 1800 18 7263**, 10am – 10pm AEST (Mon – Fri), or chat online.

Suicide Call Back Service provides 24/7 support if you or someone you know is feeling suicidal. **Call 1300 659 467.**

Open Arms — Veterans and Families Counselling provides 24/7 free and confidential counselling to anyone who has served at least one day in the ADF, their partners and families. **Call 1800 011 046**.

Head to Health provides free advice, assessment and referral into local mental health services. **Call 1800 595 212** between 8:30am to 5pm on weekdays (public holidays excluded).

Print or download this mental health helplines infographic.

Gippsland Family Violence Alliance

We would like to thank Cathleen Staats, Specialist Family Violence Advisor to Mental Health, Latrobe Regional Hospital who wrote this resource.

www.gippslandfamilyviolencealliance.com.au