Mental Health
Coordinating Council

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Subject: Guidelines for Physical Health of Mental Health Consumers

Dear Rochelle,

MHCC would like to thank MHDAO for inviting us to comment on the Draft Guidelines for the Physical Care of Mental Health Consumers (0.3). We welcome the initiative to provide guidelines for a model of holistic care representing a consistent state-wide approach to service delivery that has the potential to improve physical health of mental health consumers and prevent disease.

We commend the Department on what presents as a very solid document. However, we highlight that throughout the document where the focus is on collaboration, partnership and information sharing with service providers, the importance of building capacity and inclusion of relationships with NGOs (who may be the primary service provider to a consumer), is not mentioned. NGOs delivering a broad range of services to consumers may well be in a position to share appropriate information with health care professionals assisting in the ongoing healthcare of consumers.

We also attach a tracked version of the Draft 0.3 Guidelines with comment as to where specifically feel such collaboration should be emphasised, and include some other suggestions where greater clarity is needed.

Consumers rights

MHCC suggest inclusion of a section on consumer rights providing information about capacity (should that be in question). Likewise, regarding confidentially and disclosure and assisting consumers to understand their rights to information about medical procedures and interventions in particular contexts.

Issues such as cultural appropriateness and availability of interpreters could also be included.

Impact of child sexual abuse on physical health

Consumers, whose specific needs MHCC consider important for inclusion under **Special Populations**, are people with sexual assault and abuse histories.

The evidence clearly shows that women adult survivors of childhood sexual abuse (CSA) particularly present with physical health problems with greater frequency than those women who have not experienced sexual abuse. They are reported to experience higher rates of numerous problems including: diabetes; obesity; arthritis; asthma; recurrent surgeries; poor reproductive outcomes; digestive problems and hypertension. Venereal disease; pelvic inflammatory disease; respiratory problems and neurological problems,[i] have also been highlighted in this group.

The Illinois Coalition against Sexual Assault reporting on the long term consequences of CSA referred to a study by Golding (1994) into the physical health consequences of CSA on a large random cohort in Los Angeles. [ii] They found that 29.3% of women with a sexual abuse history reported at least six somatic symptoms compared to 15.8% of other women.[iii]

Gastrointestinal (GI) problems may be second only to depression as the most frequent long term consequence of CSA. As many as 71% of female adults and adolescents who have experienced sexual abuse for more than two years, may later develop GI disorders.[iv] Another common complaint is irritable bowel syndrome, as is chronic abdominal pain. Almost one third of women with these conditions have been victims of childhood rape or incest (Drossman, 1995). [v]

Citing a study by Springs and Friedrich, Forrest (1994) found that CSA survivors are two and a half times more likely to experience: pelvic pain or pelvic inflammatory disorder; breast diseases ranging from fibrocystic changes to cancer; yeast infections and one and a half times more likely to have bladder infections. They also found that survivors were more likely to have complications during pregnancy and chronic pain including backaches and headaches. It was evident that the more serious and prolonged the abuse, the more chronic the resulting medical problems. [vi]

MHCC are not in a position to reference findings around health impacts prevalent amongst male survivors of sexual abuse. Nevertheless, we suggest that this group should be included with the same degree of emphasis.

We acknowledge that information about a consumer such as disclosure of abuse may not be available to health practitioners. However, we suggest that providers be well informed about the possible impacts of invasive medical interventions that might otherwise seem tolerable to consumers who have not experienced trauma.

Relationships with NGO providers may provide particularly useful insights into what might represent re-traumatisation for this group of consumers. An increased likelihood of PTSD symptoms observed in a medical setting with certain types of procedures such as pelvic examinations, colonoscopies, endoscopies, gastrointestinal exams, and gynaecological examinations, which insert an instrument into a bodily orifice, may be sufficiently reminiscent of sexual trauma to provoke a post-traumatic reaction in patients who have experienced sexual trauma.[vii]

Invasive procedures are the most dramatic examples of 'trigger' events occurring in a medical setting. Even in a typically non-threatening environment, a number of other triggers may evoke traumatic responses including: being touched; the power differential between patient and medical practitioner; the removal or absence of clothing and the focus on bodily pain (Robohm & Buttenheim, 1996).[viii]

Advocates for Survivors of Child Abuse (ASCA) identify dental procedures as a trigger for memories of oral rape.[ix] Survivors anticipating such reactions may be reluctant to undergo such procedures further increasing risk to physical health.

Similarly, MHCC would like to draw attention to special populations such as victims of terror and torture and war veterans with PTSD and/or mental illness or co-morbidity. We suggest that their complex needs be considered in a similar way to adult survivors in the Guidelines.

Nominated Carer

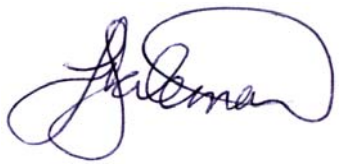
MHCC recommend that since the ability now exists for a consumer to nominate a carer in the *Mental Health Act 2007*, this role be made clear in the Guidelines. It would seem appropriate to include the description of the role, the rights of, and limitations to the role described, referenced from the Act itself.

Referencing

Lastly, MHCC recommend that Guidelines are referenced in standard academic Harvard format, with the reference either in a footnote or endnote configuration (as shown in this letter) with a full list as an addition to the appendices. In this way, users of the Guidelines will be able to access a list of available reference material in one place rather than sift through an entire document.

We trust that you find our input useful and apologise for the delay in responding to your request for feedback.

Yours sincerely



Jenna Bateman
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References

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[ii] Moeller, T., Bachman, G. & Moeller, J. (1991). The Combined Effects of Physical, Sexual and Emotional Abuse during Childhood: Long Term Consequences for Women. USA: Child Abuse & Neglect, 17, 623 – 40. Information from Illinois Coalition Against Sexual Assault. Available: www.icasa.org

[iii] Golding, J. (1994). Sexual Assault History and Physical Health in Randomly Selected Los Angeles Women. Health Psychology, 13, 2, 130 – 138.

[iv] Ibid.

[v] Drossman, D.A., Talley, N.J., Olden. K.W. & Barriero. M.A. (1995). Sexual and Physical Abuse and Gastointestinal Illness: Review and Recommendations. Ann. Internal Medicine, 123, 10, 782 -794.

[vi] Forrest, M.S. (1994). The Relationship of Child Sexual Abuse to Medical Problems in Adulthood. The Healing Woman. Studies F. E. Springs and W.N. Friedrich.

[vii] Robohm, J.S., & Buttenheim, M. (1996). The gynecological care experience of adult survivors of childhood sexual abuse: A preliminary investigation. USA: Women and Health, 24, 59-75.

[viii] Ibid.

[ix] ASCA. (2006). Update for Medical Professionals: Child abuse can affect anyone. Available: www.asca.org.au