Senator Claire Moore
Community Affairs Committee
Department of the Senate
Parliament House
Canberra ACT 2600
Australia

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16 July 2008

Dear Senator Moore,

Subject: Senate Community Affairs Committee Inquiry into Mental Health Services in Australia

The Mental Health Coordinating Council (MHCC) wish to add its voice in support of the call for action from the Coalition of Australian Mental Health National Consumer and Carer Advocacy Peak Bodies (the Coalition); with regards to the urgent need of Government, through the COAG process, to recognise as a priority consumer group, adult victims of childhood abuse who experience mental illness,.

Victims of childhood sexual, physical and emotional abuse

Sexual, physical and emotional abuse and neglect have significant mental health repercussions. Research studies consistently demonstrate that adult survivors of all forms of childhood abuse manifest high rates of mental illness: depressive and anxiety symptoms, substance abuse disorders, eating disorders, post-traumatic stress disorders, suicidality as well as poor physical health.

Extensive research suggests that Complex Post Traumatic Stress Disorder looms large amongst the variety of negative mental health effects that survivors experience. Abusive behaviours and assault, whether physical, sexual or psychological can also create long-term interpersonal difficulties, distorted thinking patterns and emotional distress. The complex needs of adult survivors often overwhelm the capacity of mainstream services.

In a National report published by the Kids First Foundation (2003) into the cost of child abuse and neglect in Australia, it was estimated that the cost to Australian taxpayers was approximately $5 billion per annum. The long-term human cost and cost of public intervention was estimated at three quarters of the annual cost, and the long-term human and social cost at $2 billion per annum.

Child abuse and neglect are the root cause of many of Australia's social ills – substance abuse; welfare dependency; homelessness; crime, relationship and family breakdown; chronic physical and mental illness. If not effectively targeted, the life-long impact of child abuse will continue unabated, putting increased pressure upon already stretched government health and social services.

The Senate Select Committee on Mental Health, *A national approach to mental health: from crisis to community,* (First Report: March 2006), recommended that access to effective non-pharmacological treatment options be improved across the mental health system through better access to 'talking therapies' provided by psychologists, psychotherapists and counsellors, for people with histories of child abuse and neglect.

MHCC addressed this issue in its submission to the Inquiry (August 2007, p.23 -24), recommending that:

- That COAG urgently review the plethora of existing evidence supporting service provision of evidence based therapeutic interventions for adult survivors of childhood abuse (MHCC, 2007).

- That both Commonwealth and State Governments urgently address the gap in service provision to adult survivors of childhood abuse in both mainstream and community based services as a matter of urgency. (MHCC, 2007)

We take this opportunity to draw the Committee's attention to a MHCC research project, *Reframing Responses: Improving Service Provision to Women Survivors of Child Sexual Abuse who experience Mental Health Problems* (2006). The project was a recipient of a Mental Health Association "Mind Matters" Award in 2006. We enclose the two report documents for the Committee's reference.

The study reviews the abundance of international and Australian evidence identifying the barriers to service delivery survivors almost universally experience. Research confirms that adult survivors need access to long-term counselling/psychotherapy and group counselling, and characteristically need to have/ or be undergoing individual therapeutic work to enable them to engage in a group process; and to ensure safety, clients need access to individual therapy for support/ debriefing whilst processing group material.

The study acknowledges the effectiveness of successful group programs; albeit that they have been few in number, and rarely funded for more than a pilot study of one or two year's duration. A particularly successful group program was the Jacaranda Project (Royal North Shore Sexual Assault Service) that operated as an across agency collaboration between counselling; drug and alcohol; supported accommodation; employment and other community mental health services. This model is entirely transferable to an across non-government service context.

> *Adult survivors remain some of the most marginalised people with mental health problems in the community across all cultural contexts. Services available for adults who have childhood related trauma are seriously limited and often, they are triaged out of the system due to assessments that focus on, for example, a substance abuse issue. To gain access they have to pay in the private sector. For most, self funding is not an option.*
>
> (McMaugh, K., 2001).

Group therapy interventions designed to promote a reduction in symptomatology; encourage long-term stability and provide strategies for improving quality of life; breaking the cycle of re-admission into hospital; social exclusion; homelessness and unemployment and provide an opportunity to enhance social skills; connection; adopt new strategies and model favourable behaviours has been found to be highly beneficial for this client group.[1]

[1] McMaugh, K. (2001). The Jacaranda Project: for survivors of child sexual abuse. Evaluation Report. Northern Sydney Health Sexual Assault Service.

Whilst supporting the Coalition's call for Government recognition of adult survivors of childhood abuse, MHCC do not support such a strong emphasis on Borderline Personality Disorder (BPD) in this context, which is but one of the possible impacts of childhood abuse. BPD is the name given to one of a group of psychiatric conditions called 'personality disorders', characterised by distressing emotional states, difficulty in relating to other people and self-harming behaviour.

The causal relationship between BPD and CSA is hypothetical, and subject to reservations concerning the reliability of a BPD diagnosis, and the frequent co-occurrence of: CSA; neglect; physical abuse; emotional abuse and exposure to domestic chaos in families of those diagnosed (Nurcombe, 2005; Barnard et al., 1985).[2] [3] Louis Cozolino (2005), Professor of Psychology, and expert on the neuroscience of psychotherapy suggests that BPD may be one variant of complex Post Traumatic Stress Disorder (PTSD), citing widespread evidence of early abuse, trauma and the presence of dissociative symptoms. Individuals with this diagnosis are characterised by, *"hypersensitivity to real or imagined abandonment; disturbances in self-identity; intense or unstable relationships; alternating idealization or devaluation of themselves or others; compulsive, risky and sometimes self-damaging behaviours,"* (p.31). [i]

Judith Herman, Professor of Clinical Psychiatry at Harvard University Medical School and Director of Training at the Victims of Violence Program in the Department of Psychiatry at the Cambridge Health Alliance in Cambridge, Massachusetts, whose ground-breaking work on the understanding and treatment of trauma has been widely influential, advocates the alternative diagnosis of Complex PTSD (CPTSD) to describe the symptoms of long term trauma, particularly applicable to survivors of CSA.[4] This evidence is questioning the diagnosis and application are clearly analysed in *Trauma and Recovery: From Domestic Abuse to Political Terror,* (Herman, J. Pandora, 1998).

As discussed in our submission to the Inquiry (2007), access to psychologists and social workers through the MBS scheme is not (in most cases) appropriate for the long-term psychotherapeutic needs of adult survivors. We strongly urge Government to acknowledge the mental health needs of this long neglected group of clients.

MHCC agree with the Coalition that a Taskforce needs to be established to include experienced practitioners and researchers in the field. We suggest that the Taskforce terms of reference should 'guide Government in developing strategies and implementation plans using evidence based practice, based on plethora of existing research evidence, for the implementation of adult survivor programs in community based services'. What we do not want to see is investigative study, report and recommendations - the evidence is well established and appropriate interventions clearly identified.

However, ongoing research must be an integral part of any implementation plan, in order to measure and evaluate outcomes for consumers who have participated in targeted interventions; whether individually; and/or as part of a group, both short-term and longitudinally. Accountability is a vital constituent of any implementation strategy and plan.

Likewise a key component of any strategy is assessment of practice improvement and the availability of appropriate workforce development. This client group are frequently neglected or overlooked, and workers across government and community services need to be trained to assess and refer. Such needs are particularly problematic in rural and remote locations where services are limited.

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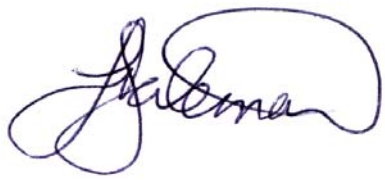
[2] Nurcombe, B. (2005). Paper Presented at Ausinet Workshop. Brisbane. Available: http://auseinet.flinders.edu.au/resources/auseinet/workshops/csapre51.php

[3] Barnard, C.P. & Hirsch, C. (1985). Borderline personality and child sexual abuse. Psychological Reports, 1985, 57, 715-718.

[4] Herman, J.L. (2001). Trauma and Recovery: From Domestic Abuse to Political Terror. USA: Pandora, Rivers Osram Publishers Ltd.

Central to removing long-term barriers to access, is a need for consumers to have the option to be referred directly via community services rather than necessarily via clinical services. We propose that in line with the Government's social inclusion agenda and a strong theme of prevention and early intervention, there needs to be an unambiguous acknowledgement of the absolute necessity to provide a wide range of services operating collaboratively to provide for the complex needs of people with mental illness in the community, and that this should not exclude adult victims of childhood abuse.

Yours sincerely,



Jenna Bateman
Chief Executive Officer

For further information regarding the MHCC Reframing Responses Project, please contact Corinne Henderson, Senior Policy Officer at corinne@mhcc.org.au or telephone 02 9555 8388 ext 101.

[i] Cozolino, L. J. (2005). The Impact of Trauma on the Brain. Psychotherapy in Australia 2005, (11), 3, 31.