Mental Health Coordinating Council

14 December 2009

The Hon Nicola Roxon MP
Minister for Health and Ageing
MG 50
Parliament House
Canberra ACT 2600

email: nicola.roxon.mp@aph.gov.au

Dear Minister,

Subject: Senate Community Affairs Committee Inquiry into Mental Health Services in Australia: Recommendation 24 & 25.

The Mental Health Coordinating Council (MHCC) is the peak body for mental health NGOs in NSW. Member organisations specialise in the provision of services and support for people with a disability as a consequence of mental illness. We provide leadership and representation to our membership and seek to improve, promote and develop quality mental health services to the community. Facilitating effective linkages between government, non-government and private sectors, MHCC participate extensively in public policy development. The organisation consults broadly across all sectors in order to respond to legislative reform.

MHCC wish to add our support to the initiatives described in Recommendation 24 of the Senate Inquiry Report. Mental health initiatives that recognise adult victims of childhood abuse as a priority consumer group is of the utmost importance since victims of childhood sexual, physical and emotional abuse manifest high rates of mental illness in very large numbers in the community.

Whilst the literature and research evidence have been clear in this field, little has been done by governments to address the needs of survivors in the past. The Senate Standing Committee on Community Affairs Report *Towards recovery: Mental health services in Australia*, is one of the few instances in which mental health issues for adult survivors of childhood abuse are specifically identified as an area of unmet need for consideration under COAG. MHCC congratulated the Committee for this acknowledgement and for taking the first step towards addressing the gaps in service delivery that exist for survivors of childhood abuse.

Recommendation 24

9.67 The committee recommends that the National Advisory Council on Mental Health be funded to convene a taskforce on childhood sexual abuse and mental illness, to assess the public awareness, prevention and intervention initiatives needed in light of the link between childhood sexual abuse and mental illness and to guide government in the implementation of programs for adult survivors. The committee recommends that the taskforce report its findings by July 2009 and that COAG be tasked with implementing the necessary programs and reforms.

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 in: *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.

We take this opportunity to draw the Minister'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 research project undertook to study capacity across and between non-government organisations to provide services to women survivors of childhood sexual abuse with complex needs, by evaluating existing service delivery. It sought to develop an understanding of safety issues, models of care and identify gaps, inequalities and barriers to access as well as provide recommendations for service delivery. The project also sought evidence in NSW to demonstrate the need for improved access and equity to this group marginalised and vulnerable as a consequence of mental illness, substance dependency, co-morbidity, ethnicity, socio-economic status, disability or sexual preference. [i] MHCC has continued this project by developing an Information Resource Guide and Workbook for Community Mental Health Service Providers, which is to be launched early in 2010.

Whilst supporting the Committee's call for Government recognition of adult survivors of childhood abuse, MHCC do not support such a strong emphasis on Borderline Personality Disorder (BPD) (Recommendation 25) in the context of childhood abuse, since it is but one of the possible impacts. If a nation-wide BPD initiative were to be established, we do not want COAG to conclude that this initiative will cover the support needs of adult survivors as a whole. What is required is a wide range of flexible services delivered in a holistic way.

Recommendation 25

9.68 The committee recommends that the Australian, state and territory governments, through COAG, jointly fund a nation-wide Borderline Personality Disorder initiative. The committee recommends that the initiative include:

designated Borderline Personality Disorder outpatient care units in selected trial sites in every jurisdiction, to provide assessment, therapy, teaching, research and clinical supervision; awareness raising programs, one to be targeted at adolescents and young adults in conjunction with the program in Recommendation 19 (Chapter 8) aimed at improving recognition of the disorder, and another to be targeted at primary health care and mental health care providers, aimed at changing attitudes and behaviours toward people with Borderline Personality Disorder; and a training program for mental health services and community-based organisations in the effective care of people with Borderline Personality Disorder.

The committee recommends that a taskforce including specialist clinicians, consumers, community organisations, public and private mental health services and government representatives be convened to progress and oversight the initiative.

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).[1] [2]

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). [ii]

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.[3] 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 in 2007, access to psychologists and social workers through the MBS scheme is also not (in most cases) appropriate for the long-term psychotherapeutic needs of adult survivors. We strongly urge Government to acknowledge the broad range of mental health needs of this long neglected group of consumers.

MHCC agree with the Committee 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 yet another investigative study, report and recommendations - the evidence is well established and appropriate interventions clearly identified.

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

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

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

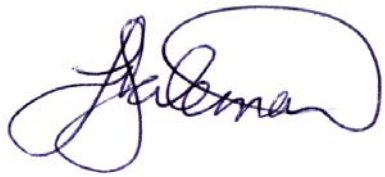
However, ongoing research must be an integral part of any implementation plan, in order to measure and evaluate outcomes for consumers who have participated in targeted interventions; whether individually; and/or as part of a group, both short-term and longitudinally. Accountability is a vital constituent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

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.

MHCC thank the Government for their interest and express their willingness to be consulted in the future concerning these matters.

Yours sincerely,



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[i] Mental Health Coordinating Council. (2006).Reframing Responses: Improving Service Provision to Women Survivors of Childhood Abuse who experience Mental Health Problems. Literature Review. Henderson, C. & Bateman J.
http://www.mhcc.org.au/documents/Reframing%20Responses%20Lit%20Rev%20_F_060906%20_1.pdf
Mental Health Coordinating Council. (2006).Reframing Responses: Improving Service Provision to Women Survivors of Childhood Abuse who experience Mental Health Problems. Report and Recommendations. O'Brien, L., Henderson, C. & Bateman J.
http://www.mhcc.org.au/documents/LOB%20Final%20Reportand%20Recommendations%20010806.pdf

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