ANROWS

AUSTRALIA'S NATIONAL RESEARCH
ORGANISATION FOR WOMEN'S SAFETY
to Reduce Violence against Women & their Children

Department of Health
50 Lonsdale Street
Melbourne VIC 3000

By email: mhwa.independentreview@health.vic.gov.au

Re: Independent Review of Compulsory Treatment and Decision-Making Laws

Dear Department of Health

ANROWS thanks you for the opportunity to respond to the Independent Review of Compulsory Treatment and Decision-Making Laws.

ANROWS is an independent, non-profit company established as an initiative under Australia's *National Plan to Reduce Violence against Women and their Children 2010–2022* (the National Plan). Our primary function is to build the evidence base that supports ending violence against women and children in Australia. ANROWS is embedded in the National Plan architecture and will continue to deliver and develop this function across the next decade under the *National Plan to End Violence against Women and Children 2022–2032*. Every aspect of our work is motivated by the right of women and children to live free from violence and in safe communities. We recognise, respect and respond to diversity among women and children, and we are committed to reconciliation with Aboriginal and Torres Strait Islander Australians.

Primary funding for ANROWS is jointly provided by the Commonwealth and all state and territory governments of Australia. ANROWS is also, from time to time, directly commissioned to undertake work for an individual jurisdiction, and successfully tenders for research and evaluation work. ANROWS is registered as a harm prevention charity and deductible gift recipient, governed by the Australian Charities and Not-for-profit Commission (ACNC).

ANROWS is pleased to provide a brief submission highlighting the potential impact of compulsory treatment and decision-making laws on victims and survivors of family, domestic and sexual violence in response to Question 1 of the consultation paper. We would be very pleased to assist the Department further, as required.

Yours sincerely

[redacted]

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Overall comments

ANROWS commends the Department of Health for conducting an independent review of compulsory treatment and decision-making laws. ANROWS is pleased to make a brief submission to this consultation that, consistent with our remit, focuses upon the potential impacts of compulsory treatment on victims and survivors of family, domestic and sexual violence (FDSV).

Question 1: There are many different perspectives on compulsory treatment. One of these is that compulsory treatment should be abolished/eliminated entirely. Do you agree with this?

Compulsory treatment has the potential to mimic tactics and experiences of FDSV and coercive control, and in doing so, impact the recovery of victims and survivors. Key to recovering from experiences of FDSV is the restoration of agency and choice, and every effort should be made to avoid practices that strip victims and survivors of these capacities.

With recovery elevated to one of four domains in the *National Plan to End Violence against Women and Children 2022–2032* (National Plan) the Australian Government has made it an essential component of Australia's holistic approach to end violence against women and children within one generation (Commonwealth of Australia, 2022). Supporting consumer control, choice and autonomy is also a key component of trauma-informed care (Cleary & Hungerford, 2015, as cited in Salter et al., 2020).

The following ANROWS evidence may assist the Department in keeping victims and survivors of FDSV in view when making a decision about compulsory treatment.

FDSV can impact the mental health of victims and survivors

Experiencing FDSV can result in significant negative mental health consequences, including long after the violence has stopped (ANROWS 2020). Fifty-two per cent of people who self-reported a history of intimate partner violence also reported having a diagnosis of mental illness (Moulding et al., 2020, as cited in ANROWS, 2020). Of these women, only 13 per cent reported having a diagnosis prior to the IPV occurring (Moulding et al., 2020, as cited in ANROWS, 2020).

In a different ANROWS study, women who had experienced sexual violence reported worse physical and mental health than women who had never experienced sexual violence (Townsend et al., 2020). This included poorer general health, increased risk of chronic conditions, sexually transmitted infections, anxiety, depression, and psychological distress (Townsend et al., 2020). For women in the study with experiences of sexual violence, better mental health was related to social support, physical activity, and mental health service use (Townsend et al., 2020).

When victimisation is repeated across a lifetime, victims and survivors of FDSV can also experience complex trauma and its resulting health and psychosocial challenges (Salter et al., 2020). This cohort has a "high level of healthcare utilisation linked to mental illness, suicidality and substance abuse" (Salter et al., 2020, p. 6). Ongoing victimisation compounds trauma-related mental illness, and unmet health and safety needs can make these victims and survivors vulnerable to more abuse (Salter, 2017, as cited in Salter et al., 2020).

Multiple studies have shown a strong and complex relationship between experiencing sexual violence, in particular, and poor mental health (Hegarty et al., 2017). This research indicated that the mental health

needs of victims and survivors need to be addressed through a trauma- and violence-informed model of care that takes into consideration the traumatic impacts of historical violence and actively seeks to avoid re-traumatisation (Hegarty et al., 2017). Negative experiences with systems can influence a victim and survivor's decision to seek future support (Salter et al., 2020). To support recovery and reduce revictimisation, the mental health service system needs to provide trauma-informed and appropriate care to victims and survivors that avoids exacerbating pre-existing trauma.

Compulsory treatment and decision-making can mimic tactics of FDSV

Restrictive practices can compound existing trauma

ANROWS research highlights that restrictive practices can result in trauma for victims and survivors of FDSV. A report by Watson et al. (2020) on gender-based violence in mental health inpatient units found that some women reported experiencing gender-based violence from staff through restraint and seclusion practices. Some participants reported experiencing excessive physical force by male staff members during restraint; one participant reported having her underwear removed as part of restraint and seclusion; and another reported that her experience of restraint and seclusion was accompanied by threats of sexual assault from security guards (Watson et al., 2020). Restraint that involves physical force or replicating actions used in sexual assault, like removing underwear, particularly by male staff members and/or security guards can also trigger memories of previous sexual assaults and compound existing trauma (Watson et al., 2020).

Removal of autonomy can mimic coercive control

Perpetrators of domestic and family violence can utilise a pattern of coercive control tailored to the individual that limits their choices, freedom and autonomy, effectively stripping them of their personhood (ANROWS, 2021). Denying women choice during care – that is, in compulsory treatment – can thus be (re-)traumatising because it "replicates those dynamics of abuse" (Salter et al., 2020, p. 104). For example, one victim and survivor in this study explained:

> I've had maybe 17 or 18 hospitalisations, maybe four or five of which were being scheduled, and I would say that the public ones [hospitals] were really bad… They were particularly prone to what I've found many hospitals are prone to, which is they recommend an antipsychotic [medication], and I would say, "I've tried that antipsychotic, it has really bad side effects for me, I would prefer to try a different route", and they would look at me, look at their notes, look at me, and then write down "borderline, manipulative, defiant, oppositional, noncompliant", and sometimes they would just say, "Oh, sorry, you're here involuntarily so you don't have a choice."
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> (Salter et al., 2020, p. 77).

The women in this study found the "lack of autonomy and the degree of surveillance" they were subjected to during involuntary hospitalisation was humiliating, often leaving them determined not to return to hospital (Salter et al., 2020, p. 77). The consequences of poor or re-traumatising responses to mental health needs impacting help-seeking behaviour can be catastrophic (Salter et al, 2020). With self-harm and suicidality common in this cohort, it is thus very important that the mental health system avoid actions that impact an individual's future choices to engage in care.

Restoring autonomy and choice is central to recovery

Victims and survivors of FDSV benefit from restored autonomy and choice in recovery. Healing from gender-based violence is best achieved when women are enabled to "work in partnership with others to define their own recovery journey" (Watson et al., 2020, p. 59). The evidence suggests this should be done

by embedding the principles of safety, recovery, gender sensitivity, dignity, autonomy and choice into inpatient care (Watson et al., 2020). This research recommends that all systems that disempower women by denying them autonomy and choice need to be dismantled (Watson et al., 2020).

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