Discussion paper on caring for family members,

mental illness and the impacts of family violence

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Carers ACT acknowledges that modern day Canberra has been built on the traditional lands of the Ngunnawal people. We offer our respects to their Elders past and present and celebrate the Ngunnawal people's living culture and valuable contribution to the ACT community.

Who is Carers ACT?
Carers ACT is a non-profit, community-based registered charity dedicated to improving the lives of the estimated 48,850 carers living in the Australian Capital Territory.
These carers provide ongoing unpaid care for people with disabilities, mental illness, chronic conditions, who have palliative care needs, or who are aged and frail. Carers ACT currently provides direct support through our counselling, information, respite support, education, social support and case coordination services. We continue to meet national accreditation standards for delivery of our services to carers at a high level.
Carers ACT has a mandate to represent the voices of mental health carers to government and the wider community. We actively consult with a wide diversity of caring families on an ongoing basis to enable improved understanding of their needs and enable better inclusion for them and the people they care for. Policy work in consultation, research and representation is kept separate from service delivery to ensure that the privacy of individual service recipients is respected. All carer participation in policy work is voluntary.

Carers ACT is the Peak Body in the ACT for Mental Health Carers

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Abstract

In the push towards a community focused mental health service, Australia has seen a greater demand made upon families to provide care for people with severe and enduring mental health issues. For some families, this is impacted by violence and/or abuse. The aim of this paper is to review the literature on family carers, mental illness and family violence to explore how these three concerns situate within families. This paper explores four key patterns that these factors can assemble into, namely;

1) Carer as a victim of violence or threats of violence, perpetrator has mental illness and has violent episodes **with no** evidence of power, coercion or control.

2) Carer as a victim of violence or threats of violence, perpetrator has a mental illness and has violent episodes **with** evidence of power, coercion and control.

3) Carer as a victim of violence or threats of violence, perpetrator is not the primary care recipient, carer and care recipient are both in danger of trauma impacts and mental ill-health.

4) Carer as a perpetrator of violence or threats of violence, care recipient has mental illness and is the victim, with or without evidence of power, coercion and control.

From this paper it is demonstrated that there is a great potential for the ACT to lead Australia in developing modern and non-stigmatising interventions in mental health and violence. In order to undertake this there is a need for further research into prevalence and experience of violence and accessing services. The extent of family violence within mental health caring in Australia is unclear and the identification of violence faces strong barriers both legally and socially. Greater understanding of the mental health carers' and consumers' experiences and beliefs regarding family violence will assist families in disclosing violence and improve therapeutic and legal interventions. However, there is sufficient evidence to begin implementing policy changes now in mental health and family violence service delivery to ensure that these families are assisted by the current mental health and family violence services.

***Key words*:** carers, families, consumers, mental illness, mental health, violence, family violence, domestic violence, abuse, situational violence, coercive controlling violence

Background

Family Carers

In Australia approximately 2.7 million people are in unpaid caring roles for a friend or family member (Australian Bureau of Statistics, 2012), these carers provide ongoing unpaid care for people with disabilities, mental illness, chronic conditions, who have palliative care needs, or who are aged and frail. Carers ACT is the major service provider for carers in the Australian Capital Territory, including those who care for someone with a physical disability, intellectual disability and/or mental ill-health/psychosocial disability and is also the peak body for mental health carers in the ACT. While many carers describe their role as rewarding, caring does involve cost and can involve relationship breakdown, financial difficulties and chronic stress or grief (Young et al. 2004). Reupart, et al. (2012) found that people caring for someone with a mental illness may also be at risk of experiencing trauma and developing mental health conditions themselves. Mental health carers are also more likely to experience isolation as a result of experiences, or perceptions, of stigma alongside the demands of the caring role (Cleary et al., 2006). With the roll out of the National Disability Insurance Scheme, it has been said that Australia is currently undergoing 'the largest social reform since Medicare' (O'Rourke, 2015). As part of the NDIS implementation, the unique difficulties that people with psychosocial disability experience have been brought into the spotlight and so to have the unique challenges for carers of people with psychosocial disability. It has been an issue in the NDIS planning process regarding the episodic nature of psychosocial disability compared to other long term disabilities that are either stable or deteriorating. This has also drawn attention to the discussion of capacity for decision making and choice or control. Those with psychosocial disability may experience severely reduced capacity for decision making, however with treatment or simply with time, their capacity can increase. In understanding the situation for carers this can mean that they experience hope and hopelessness, where recovery happens but is transient which can lead to experiences of grief that do not wane but recur. This carer experience is volatile with healthy episodes tainted with the fear of the illness returning.

In relation to violence, it has been demonstrated that those with a mental illness are more likely to be victims of violence than to perpetrate violence (Desmarais et al., 2014). If they are violent, they are more likely to assault a carer than an acquaintance or stranger, with mothers of adult sons with a severe mental illness in the highest at-risk category (Band-Winterstein, 2015). The carer/care recipient relationship is one of dependence and can become one of power imbalance. Carers can also be perpetrators of abuse against the person they care for with mental illness. For the carer/care recipient relationship there are significant barriers to either person seeking help for violence within the home.

Mental Illness

People who experience mental illness can face unique and significant disadvantage within the community. A *mental illness* is a health problem that significantly affects how a person feels, thinks, behaves and interacts with other people. A *mental health problem* also interferes with how a person thinks, feels and behaves but to a lesser extent than a mental illness. People with mental illnesses are seen in a variety of unfavourable ways. They are viewed as unpredictable, dangerous and untrustworthy, (Fracchia et al., 1976; Morrison, 1980; Rabkin,1972, 1974).

In the media, mental illness has often been used as an explanation or justification for violent crimes occurring, with narratives of unpredictability and lack of motive to explain how such a terrible crime could occur without the police intervening prior. There is a strong fear that people with a mental illness are a 'danger to society', which has been perpetuated in part by the media. In 2015, when Germanwings flight crashed into the French Alps, there was significant discussion on the co-pilot, Andreas Lubitz's mental health. It was reported by CNN, following the Freedom of Information Act requests from news organisations, that he had recovered from an episode of depression the year before (Brown et al., 2015). This suggestion that mental health was a factor in this horrific incident began an international debate on whether the flight industry needed to screen more thoroughly for mental illness, whether they needed to screen more regularly and also whether people with mental ill-health should be allowed to be pilots at all. In January 2016, Obama announced gun control

reforms that included a large amount of funding to be put towards mental health in the United States (Roberts & Smith 2016). Rationale behind this decision was that people who undertake mass shootings must have a mental illness. However, in studies examining commonalities between people who commit mass murder with guns, the risk factors are being male, under 40 years old, socially isolated, unemployed, bullied as a child and fascinated with guns, *not* mental illness. Although some mass murderers do have histories of mental health problems, reports also suggest that most of them do not have an active mental illness at the time they commit their crimes (Fazel et al., 2006).

In Australia, in mid-2015, well known football coach Phil Walsh was killed by his son, who experienced a psychotic episode on the night of the murder. It was determined that Cy Walsh suffered from undiagnosed and untreated schizophrenia. He was found not guilty of murder by reason of mental incompetence in 2016. In comments in the media from Phil Walsh's wife Meredith, she said "*Our son Cy is also shattered by what has happened, and has to live with the consequences of his illness, an illness that has destroyed our loving family.*" (Prosser, 2016)

In recent decades there has been a slight decrease in stigma in the general public associated with increased anti-stigma campaigns and education programs (Jorm et al., 1999). As part of these education campaigns there was a push to examine the counter-arguments to concepts such as 'people with mental illnesses are dangerous' and important evidence became available. It has now been demonstrated that people with mental illnesses are far more likely to be victims of violent attacks than perpetrators. They also contribute negligibly to the homicide statistics in both the US and Australia, accounting for 4% of homicides in Australia with mental illness alone and 10% when drug and alcohol use are also involved (National Council to Reduce Violence against Women and their Children, 2009). However, an unintended consequence of the stigma reduction campaigns is that it has led to a lack of research examining mental illness and violence. Whilst the research that has been undertaken has reinforced important public education, demonstrating that the vast majority of people with mental illness do not pose a 'danger to society', it has led to a lack of research examining when mental illness *is* associated with violence. In research conducted

by Steadman et al. (1998) it was found that the targets of violent acts by adults with severe mental illness are overwhelmingly family members. In a study conducted in the psychiatric unit of a hospital in Melbourne, Australia it was found that 32% of family members had been struck on at least one or two occasions (Vaddadi et al. 1997). And in another study by the same researches of family carers in the community setting it was found "*40% had been hit or struck at some point – 24% in the last year*." (Vaddadi et al., 2002, p.151).

Those with mental illness are also particularly vulnerable to being abused by others, including carers. When one person is perceived to have greater power in a relationship there is a danger of the other feeling dependent or trapped. When disclosing domestic violence those with a mental illness are also more concerned about being believed (Feder et al., 2006). Due to these key issues, it is essential to examine family violence and mental health in greater details in order to determine what interventions or supports are necessary for both carers and care recipients.

Domestic Violence and Family Violence

Definitions of domestic and family violence within Australia are largely based upon the State and Territory domestic violence specific legislation. In 2009, the National Council to Reduce Violence against Women and their Children's report, *Time for Action*, acknowledged the complicated interaction between State and Territory domestic/family violence and child protection laws and the Family Law Act 1975 (National Council to Reduce Violence against Women and their Children, 2009). They also stressed the importance in consistent interpretation and application of these laws. Laws are overwhelmingly in agreement on many aspects of what acts constitute domestic/family violence, including violence, threats of violence and behaviours that are coercive, intimidating or controlling and what relationships domestic/family violence can occur within, including intimate partner relationships (spouses, partners [including same-sex couples] and ex-spouses/partners) and between siblings, children and parents (including adult children) and other family members. Within the ACT, there is a more direct family violence provision, whereas in most states and territories the focus is on intimate partner violence (IPV) (Skelton, 2016). This has meant

that in common usage the term domestic violence is used predominantly to discuss intimate partner violence and family violence is used as an umbrella-term for any violence (or other behaviours deemed as coercive, intimidating or controlling) towards any family member, although, by definition, domestic violence and family violence are the same.

Within the last decade, understanding of family violence has evolved from the belief that it was an aberrant act that was perpetrated by deviant individuals. The Australia Government officially acknowledges the gendered nature of the crime (Senate Finance and Public Administration Committees, 2015). It is known that the majority of those who are victims of family violence are women and contemporary research and conceptualisations of violence within families and intimate relationships suggest that family violence is best understood as a gendered issue. Whilst men are also victims of physical, emotional and sexual violence from their partners and family members (Dunkley & Phillips, 2015), this is to a lesser extent than female victims. And overwhelmingly, most instances of family violence involve male perpetrators (Dunkley & Phillips, 2015). It is believed that there are three levels of 'causation' behind motivations for domestically violent perpetrators. Some perceive it primarily coming from the individual, some from their environment, such as upbringing etc. and some from society as a whole that pushes masculinity as authoritarian and femininity as submissive. The most widely accepted view is that it is a combination of all three factors that can motivate someone to perpetrate family violence. Understanding why people are violent and what factors contribute to violence are key to identifying and providing good interventions for perpetrators and victims.

In 2015, the Australian Federal Government announced a $100 million package to tackle family violence (Henderson & Keany, 2015), targeting measures to assist victims of family violence to disclose the violence they experience and to stay safe when they do so. There has also been an increased push to open up the discussion on family violence more broadly. Traditional models of family violence interventions and supports are largely based on a woman fleeing an abusive male intimate partner. However, other relationships within families can be associated with violent behaviours and they have unique barriers to accessing support services that need to be addressed. The focus for services has also begun

to look more in depth at assisting perpetrators to cease violent behaviours, which also would be best undertaken through examination of the motivating factors of violence.

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Introduction

Discussions of domestic and family violence have advanced beyond the evaluation of the violent act itself (such as severity and frequency), towards understanding the motivations and/ risk factors behind the act and defining family violence based on different motivating factors. Commonly, violence is typed as either *situational violence* or as *coercive control violence* (Hardesty et al., 2015). This refocus began with Johnson's (2010) discussion on typologies of domestic violence in which he defined that there are three types of violence that involve coercive control (collectively referred to as coercive control violence) and one type in which this is not an aspect of the violence (situational violence). In coercive controlling violence a partner is using violence as part of a collection of actions aimed to control and maintain dominance over the individual. In situational violence, the violence occurs as a result of escalating arguments, emotions or situations and there is no intention for either party to have control over the other.

These terms have been fairly exclusively used to refer to intimate partner violence and little research has examined these typologies in relation to other family violence dynamics, such as child abuse, sibling abuse, parental abuse or elder abuse. Situational violence is considered aberrant from the traditional model for domestic violence where coercive control is present yet in this article the term *situational violence* shall refer to any family violence in which the violence is not an attempt to control or have dominance over the other family member. In the first chapter there is a focus on whether mental illness contributes to violence occurring and to what extent. Following, Chapter 2 shall be an examination of coercive control violence within the family. The first two chapters are closely related in that both are concentrated upon violence by someone with a mental illness against a carer. Chapter 3 shall examine how a carer's mental health is impacted by domestic violence, and how their caring role impacts on their choices within an abusive relationship. Chapter 4 examines situations of carers being violent towards care recipients who have a mental illness and how that can occur as traditional or non-traditional family violence.

These discussions shall also examine the association of blame and domestic violence identification within the mental health context. When examining this topic, a great amount of research was forensic in its examination of the perpetrators' responsibility for their actions and the focus was on determination of the perpetrators' capacity to control their actions and be held criminally accountable. Whilst this paper shall examine the evidence for mental illness to be a factor in violence occurring within the justice context, it will be argued that it is crucial for interventions to expand upon this model of 'blame'. The rhetoric surrounding domestic violence perpetrators is still very much fixated into the 'social-deviant' category whereby identifying as having been violent or in an abusive relationship is heavily stigmatised, and often seen as unrecoverable. This is despite knowing that many of the risk factors for being violent include experiencing child abuse, witnessing abuse as a child, drug and alcohol addictions and poverty (Riggs et al., 2000). This area needs to have strong political and social intervention. To be clear, suggesting that we move beyond blame does not mean that violence is reasonable, justifiable or excusable. However, the greater our understanding is for what motivates or causes people to use violence, what strategies can decrease that violence and ways in which we can improve the capacity of those who are victims of violence to seek help, the closer we will be to tackling domestic violence in a comprehensive manner. There will always be cause for the criminal justice system in this space, and we do not wish to imply that any violent act is not an assault and a crime.

In conclusion, this article shall summarize these four frameworks for understanding mental health, caring and family violence and make recommendations for improving service response, further enquiry and awareness raising.

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Chapter 1: Situational family violence within mental health caring

Carers of people with severe mental health conditions are experiencing non-traditional family violence in Australia. In a study conducted by Vaddadi et al. in Melbourne, Australia (2002) the researchers investigated the frequency with which family carers had experience violence or threats of violence from relatives with a mental health condition. One hundred and one clients and their family carers were interviewed for the study and were selected from accessing community mental health service. It was found that 40% of carers had been threatened by violence at some point in the relative's illness, 22% in the 12 months preceding the research. Furthermore, 40% had been hit or struck at some point in the course of the relative's illness,

> *40% of carers had been hit or struck at some point in the course of their relative's mental illness.*

with 24% in the 12 months preceding the research. The researchers concluded that violence and threats of violence whilst caring for a family member with a severe mental illness were not infrequent problems. In conjunction with this however, there are substantial differences with how carers understand and explain these violent events and attribute blame for the violence. In an Israeli qualitative-phenomenological study conducted by Band-Winterstein et al. (2015) older parents of adult children with mental health disorders and violent behaviour were interviewed on their experiences. Some parents' narratives of their experience perceived the person they cared for as being more '*harmed*' (by their mental illness) and others considered them '*harmful*' (dangerous). In the quote from carer Joshua aged 85 he described his son as;

"My son…is mentally ill. (…) He is like that. These are the symptoms they have…If someone irritates him, he can kill, he is dangerous…well what can be done with him? Nothing can be done…" (Band-Winterstein et al., 2015; pp.10).

This statement demonstrates themes that Joshua believes his son has no control over his actions and that the mental illness is responsible for his violence. The carer appears also to have become resigned to this situation being unchangeable and untreatable. In this

example, the carer sees the violence as not being a mechanism for exerting control but rather an unpredictable and unintentional symptom of his son's illness.

In another qualitative paper by Wendt et al. (2015), victims of domestic violence explained the experience to the children and attributed the violence to the mental illness.

"I have explained to them it's in a way, it's not totally his fault because he does have a mental problem, the problem is also that he won't himself get help for it and they do understand that." – Dee (Wendt et al. 2015 pp. 10)

Dee also acknowledges the mental health problem contributing to the violence, however she also demonstrates belief that treatment could help him to no longer be violent and that he won't *'help himself'*. This raises the question, how do people with mental illness think about their own past violent actions? In a study conducted by Stanton et al. (2000) the researchers interviewed mentally ill mothers who had killed their children and were found not to be legally responsible due to their mental state. Within the interviews, they described their thoughts and feelings around the time of the filicide, including deep feelings of depression, paranoia and delusions. When interviewed, the women were in recovery and had good insight about their illnesses at the time of their child's death, however this did little to assuage their feelings of guilt.

"Even though that is what I have been diagnosed as, and, I can't just say, Oh, I wasn't in my right mind, everything is fine. You know, I still blame myself and feel a lot of guilt. I really hate myself that I didn't get the right sort of help." (Stanton et al. 2000; pp.1457).

From this woman's experience, we can see that despite the statement, "I still blame myself" she does see the violence as being caused by her mental illness. Her feelings of guilt surround her illness and that she did not receive treatment. She believes that if her illness had been treated, she would not have been violent towards her child.

It is again important to note that the prevalence of violence amongst people with mental health issues, including severe mental illnesses, is low and currently research suggests over a period of 10 years, not a significant factor in whether someone will commit a violent

crime. However, it is also demonstrated in the research that carers are the main victims of violence when it *does* occur with 64.3% of community mental health service users who were violent having it directed towards family member (Solomon et al., 2005). Carers may also experience different reactions to the violence and feel differently about reporting the incident. In the study by Band-Winterstein et al. (2015) '*He is still my son'*, parents varied from calling the police and banning their abusive adult child from the property to dedicating their life to looking after and protecting their child from their illness. Therefore, it is possible that the rates of family violence with mental illness could be higher due to underreporting. As this is a neglected area of research and discussion, it is important to have more details around the prevalence of non-traditional family violence and mental illness. It is also important to understand and explore the detachment of the mental illness from the person's identity, to the family. When violence occurs, especially when the family attributes it to the mental illness, it may not be seen as violence in the same capacity as domestic violence and family violence. This is due to the highly prevalent traditional views of domestic violence as a 'controlling husband intentionally beating his wife'. As the violence moves further away from this schema, this label of domestic violence/family violence becomes confounded by the mental illness and lack of coercive control and it becomes much more difficult to identify it.

The majority of literature that examines this area of enquiry is focused upon adult children with mental illness abusing their older or elderly parent. This is hypothetically because, within the mental health caring role, these relationships are more commonly identified as carers. And, as the most researched of relationships in this area, there is a bias to assume that it is a common relationship in which non-traditional family violence occurs. However, there are other caring relationships that are generally not considered within this discourse. As stated above, parents with a mental illness killing or abusing their children commonly falls within child abuse but not within family violence and carers. However, children can also be in the role of carer for their parent with a mental illness and experience a complex association with seeking help for violence. Disclosing the violence within the household could result in child protection involvement and could mean the removal of themselves and

their siblings. Also, as above, children can also perceive the violence as being caused by the mental illness and to sit 'external' to the person's identity, furthering their unwillingness to report. In an American retrospective study conducted by Dunn (1993) adults whose were raised by mothers who had psychotic episodes were interviewed and three of the nine participants were physically abused. One woman recalled her fourth-grade year as being very distressing. Her mother was experiencing a severe paranoia episode, believing that people were planning to kidnap her three children:

"That was a terrible year. She was just in a constant delusion for a full year. She wouldn't let us go to school, we couldn't even leave the house, she used to lock us in our rooms because she was so scared people were gonna get us. And we were really abused. . . I remember the bruises, and no one ever noticed that. . . I had this dream that I was going to jump out the window and break my leg. Just so they could see what was going on. So many people didn't see, so many people that should've seen" (Dunn, 1993; pp.180).

Much of the research surrounding intimate partner violence and mental illness focuses on the coercive control violence or traditional family violence rather than 'situational' or non-traditional forms. In a study undertaken by Penney et al. (2015) the researchers examined the assessment of illness and non-illness based motivations for violence. Their concern was the large focus on the psychotic symptoms that were present at the time of the act and did not appreciate that the violence itself was often motivated by non-illness related factors. They examined the argument that most instances of violence among people with severe mental illness are primarily symptom driven or as a result of the illness in conjunction with other non-illness based influences by developing an assessment tool and examining 72 psychiatric reports submitted to court. From the assessment tool they determined that 79.2% of the sample was primarily symptom motivated in their violence and 20.8% were considered to have other contributing influences in conjunction with the mental illness. This means that of the people that it was believed had mental health issues were causal to their violence, 20.8%, it was not enough to explain the incident. However, there would also be

other offenders for whom there were no psychiatric reports, as mental health was not considered an issue.

This is particularly important due to the high prevalence of mental health problems in men arrested for domestic violence. In research conducted by Shorey et al. (2012) on men who were arrested for domestic violence, they found that 19.9% of participants met the criteria for a probably diagnosis of depression, 26.2% meeting the PTSD criteria, 15.2% for a probable panic disorder, 26.7% for a probable social phobia and 19.5 % for a probable diagnosis of general anxiety disorder. This can be interpreted in a number of ways, firstly it is important to note that these are people whose violence was labelled as domestic violence and were found guilty of this crime. As discussed above, this therefore may not represent a sample of all people who commit family violence, but rather those who commit domestic violence that is identifiable and, subsequently, are convicted. Also, there is no information regarding whether the men in this study had been using coercive controlling behaviours and/or whether they believed that their mental health had contributed to their actions. We can infer however, this it is possible that mental health contributed to motivate the violence (for example, poor emotional regulation, extreme anxiety). Although it is also possible that for most offenders with mental health problems, it does not fully explain the violence and they remain largely responsible for their actions within the violent episode. It is this area that is of particular interest for investigation, as it offers many opportunities for intervention. Also, issues of substance addiction are a major area for investigation. In the same research paper 39.1% of perpetrators had a probable alcohol use disorder diagnosis and 21.5% met the criteria for a probable drug use disorder. Alcohol and drug addiction or abuse is generally understood to be a psychosocial disability, however there is disagreement amongst researchers as to whether this is an 'illness related factor' or a 'non-illness related factor' in motivating violence. Further complicating this relationship is the prevalence of comorbidity, where a person with a mental illness also has an alcohol or drug disorder.

In qualitative research paper by Ryan (2002) carers were interviewed on their experience of managing risk, including their experience of the person they care for being violent towards them. One carer said;

"What I would do at first would be to try and talk right softly to him, try and… I don't know, really show him I were nearly on my knees, you know. But then I learned as time went on. When I saw he were going to be violent…I'd get out of there and maybe ring a doctor or I've even gone to the hospital and told them he was at that stage again and needs help." (Ryan, 2002 pp.20).

In help-seeking experience research such as this, carers generally sought help from medical professionals and not the police. The research also noted that many carers found it difficult to balance their safety and maintain the trust of the person they cared for. They often felt that they were betraying the user they supported when alerting mental health services and sought help. This is important for mental health services and community organisations to be aware of because disclosure of violence already faces many barriers for those that experience it.

In summary, this area has significant issues regarding people identifying the violence within their caring role as a form of family violence and then once identified, disclosing and/or reporting the violence is complex. Finally, there are significant issues regarding how to determine illness related violence compared to non-illness related violence and, especially from within the family, how responsible the individual is for their actions. All these areas need further research in order for us to understand more comprehensively the extent of violence in mental health caring roles and to develop effective intervention services.

Key Recommendations

1. Undertake further research into this area including prevalence research, qualitative research into carer and consumer motivators and barriers to help-seeking in order to improve the service response to this cohort's needs.

2. Improve consumer and carer awareness of disclosure options and what will occur when they seek help.

3. Where risk is identified towards staff in hospital or community settings, an assertive approach to engage with family should be implemented.

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Chapter 2: Coercive controlling family violence within mental health caring

Carers in general (and mental health carers in particular) are an 'at risk group' for experiencing traditional family violence. There is a shortage of empirical research examining traditional family violence against mental health carers. Tentatively, this could be because violence associated with people who have a mental illness is largely explored to understand how the mental illness itself contributes to violence. In contrast this chapter shall explore the social issues surrounding mental illness, violence and carers that can mean that carers are at risk of being in a violent caring relationship.

Through a variety of mechanisms (including biologically, socially, politically, economically etc.) it has been conventional in Australian culture that, following the individual themselves, the immediate family is the principal responsible party for the ongoing care of individuals with disabilities and mental illness. For care of elderly relatives, this is generally also the norm although it has over time become less the expectation and nursing homes, retirement villages etc. are socially and politically acceptable measures, although this still differs substantially between different cultures in Australia.

However, for a parent whose child is born with a disability, a husband or wife that has or acquires a disability and/or the many variety of people who find themselves in a primary caring role for someone with a disability or mental illness, there is an expectation that they will 'fulfil their duty' of care to the loved one. This is most forcefully established by socially constructed roles that families are supposed to fill and the strong opposition to the institutionalisation of people with disabilities until nearly the end of 20th Century (Newton et al., 2001). However, it is also a politically and economically motivated decision that it would be extremely costly to have the state provide long term care for people with these ongoing needs. Thus, it is considered that the health service exists to address acute and crisis need and the community health and social services are to sustain the care within the family/community as much as practicable.

This also has benefits for most consumers, as it is highly associated with increased quality of life for those who have the social supports in place to facilitate the lower support from the

health system. However, for those without a person who can care for them and without the capability to manage their own care, outcomes can be highly negative (homelessness, entering the criminal justice system or self-medication through drug use and alcohol etc.). For the majority of carers, with the support of the health and community systems they also prefer having their loved one at home and see the community based treatment and family care dynamic as positive and rewarding. Nevertheless, mental health carers report a higher negative impact from their caring role than physical or intellectual disability carers. In Berk & Berk's article (2015) they examine some of the reasons that carers for people with mental health issues experience greater burden than other carers with similar time commitments and duties. One key aspect to their findings is the lack of other alternative care options for mental illness, with places in permanent supported accommodation rare. In research undertaken by Band-Winterstein et al. (2014) one carer commented;

"I don't want to live with him but I have no choice…he can't live alone and I make sure he doesn't sleep out in the street …there is no-one else to take care of him" (Nili, 75-year-old carer) (Band-Winterstein et al. 2014; pp. 1923).

In this comment we hear that this carer, Nili, is completely disengaged from being a carer. She is 75 years old and her son who she cares for is 50 years old and abusive towards her. However, in Nili's mind there is no other option. She believes that there is no other place for him and there is an element of fulfilling her duty that, despite the abuse, she must ensure he doesn't *'sleep out in the street'*. In this comment is a strong theme of the powerlessness that many carers experience and the belief that alternatives are inaccessible

In a coercive controlling violent relationship there is a power imbalance. Who establishes this power imbalance is not as important as who 'buys into it'. For example, the gendered nature of domestic violence is (at least substantially) due to unequal power men have had within our culture for many years, concepts such as 'head of the household', 'breadwinner' and 'home maker' are linguistic examples of how we are cued to assume certain genders play certain roles, namely males in leading empowered roles and females in subservient, disempowered roles. The males that become domestically violent in their relationships are

not 'creating' the patriarchy, but rather assume the status and power that they have interpreted is their right in a violent way. In a similar way in a caring relationship, the care recipient does not create the expectation that family members should care for each other, however the manner in which they interpret this 'social norm' and the extent of care that is demanded, can lead to power inequalities within the relationship and the potential for the care recipient to wield the power over the carer. In the same research article, a second carer was interviewed on caring for her violent son and said;

"(…) now I live in fear…I want him to be taken right now. I want to go on living but I'm afraid he will be raped in prison and then his life will be over…he also told me that he will kill himself if he goes to prison."
(Miri, 68 years old carer) (Band-Winterstein et al., 2014 pp. 1923)

> *Care recipients may seek to have power and control over the person that cares for them because, in other aspects of their life, they feel they have little power and control.*

In this statement there are a number of confusing thoughts Miri is processing. She is quite sure that she does not like to 'live in fear' and that she would prefer he did not have to live with her because of the violence in the house. However, she believes that the only way to organise that is for him to be arrested and sent to prison. In addition to her fear, she feels compelled to protect him from being imprisoned. Also her son appears aware of her desire to protect and/or the social expectation that parents must protect children and has said that if she has him sent to prison, he will commit suicide. He is therefore able to have power in this relationship because;

1) They do not know of any alternative long-term treatment and care facilities in which he can live other than prison,

2) They both assume that it is the family's role to care for a person who has a mental illness, and;

3) He demonstrates through the warning of suicide, his expectation that his wellbeing is more important to his mother than her own and that his safety will be prioritised

Care recipients may seek to have power and control over the person that cares for them because, in other aspects of their life, they feel they have little power and control. In research by Schwartz et al. (2005) they demonstrated that abusive behaviours were positively related when the perpetrator experienced a threat to their masculinity, especially related to feeling powerless due to low income. In the study conducted by Anderson and Umberson (2001) they suggest that violence can help to construct a sense of masculinity where one is weak. No research has yet examined motivations such as this in the context of a mental health care recipient. However, people with mental illness can often have very little choice, control or power within their own lives. Legally, they can be deemed unfit in regards to decisions about where they live, how they spend their money and what medications they take etc. Unlike other medical conditions, and without committing any crime, a person in the Australian Capital Territory with a mental illness can be restrained or detained for their safety and treated against their will (ACT Mental Health Act, 2015). It could be conceptualised that Mental health care recipients may, therefore, attempt to control and have power over their carer in order to assert their power and 'wellness'.

In situations such as these, without the appropriate services available, including domestic violence perpetrator intervention services that can work with people with complex behaviours and/or alcohol drug dependencies and alternative accommodation options for people with mental illness, the expectation will be that they are either in;

1. the care of their family members,
2. the short-term acute hospital system,
3. the forensic mental health system,
4. A temporary community based mental health treatment facility, or;
5. homeless.

In the mental health space, there is a strong focus on a recovery model for mental illness. This stresses the potential for people with mental illness, with the appropriate treatment and support, to live full, participatory and meaningful lives. And whilst domestic violence offender programs exist, there are no proactive early intervention services for people who

are, or could be, violent and very little to empower carers to, manage difficult behaviours, chose to live separately and maintain caring, or refuse to provide care, even with a risk of violence to themselves. The majority of services in this space focus on acute mental health intervention and the presumption is that violence will cease when the acute phase is over.

In an American survey, they attempted to assess prevalence of family members experiencing violence from a person with a psychiatric disorder (Labrum & Solomon, 2015). They surveyed 573 adults who had a relative with a psychiatric disorder and 47% of all respondents reported being the victim of violence committed by the relative since the onset of the illness. However, as stated previously, there is very little research examining the violence type, or the family member's experience of this violence. In a paper examining motivators and barriers of domestic violence disclosure in mental health services, they interviewed the service users and the professionals. The professionals reported that role boundaries, competency and confidence impeded them from enquiring about domestic violence with their clients and both groups reported that when the focus of sessions was on medical diagnosis and treatment of symptoms which acted as a barrier to disclosure of violence. The focus of this paper was on the service users being victims of domestic violence, however there are clear parallels in mental health service users being able to disclose violence towards them and to disclose their own violent behaviours. The service users reported that barriers to disclosing being a victim of domestic violence included fear of consequences and social service involvement which would also be a strong barrier for perpetrators of violence. One psychiatrist in the study said about clinician's role in enquiring about domestic violence;

"*People are hesitant because they don't feel confident, they don't feel it's their job, they think that somebody else is better equipped to do it*" (Rose et al., 2010; pp. 4).

Despite the concerns that the mental health service professionals had about asking their clients about domestic violence, in a study by Howard et al. (2010) they found that the experience of being asked, even without the established therapeutic relationship was often enough to allow women to disclose their experience. However, the article is clear to

emphasise that disclosure is only the first step, and professionals need to be confident in their knowledge of appropriate interventions available for their client and pathways available to them if they do disclose.

Key Recommendations

1. Improve staff confidence and capacity in mental health services to work with people who are at risk of being violent or have experienced violence.

2. Define clear risk and safety policies in regards to working with carers and consumers within a recovery framework whilst also mitigating risk to household members.

3. Re-examine discharge from acute in-patient settings and ensure that carers have the ability to refuse the person staying with them.

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Chapter 3: Carers experiencing family violence and related mental health effects of living with violence

Domestic violence is a prevalent and significant issue for many Australian families. The most recent available ABS data discussed rates of domestic violence in the ACT by examining the ACT Policing Intervention Team PROMIS system where details of Australian Federal Police call outs are examined against the domestic and family violence criteria within legislation in the ACT post-incident (ABS, 2013). From this system, approximately 60-70 family and domestic violence incidents occur in Canberra each week. In 2014, the number of victims of family and domestic violence-related assault *offences* as recorded by police in the ACT was 615 victims (or 159 victims per 100,000 persons). The Domestic Violence Crisis Service (DVCS) is the ACT's specialist service for all people experiencing domestic and family violence and they received 21,361 calls for help in 2015 (Carnovale, 2016).

In research conducted by Petersen et al. (2005) women were interviewed on barriers as to why people who are in violent relationships with partners or other family members will not access domestic violence supports. They analysed the interviews and women articulated a range of factors including; belief that the violence was not 'severe enough', fear of judgment, the belief that contacting such services will mean they will have to leave the relationship, fear of the perpetrator finding out, fears of police or child protection involvement and more. One interesting finding in the Petersen et al. research was that the further away from the traditional schema of powerful husband violence towards submissive wife, the less likely people were to identify their own situation as domestic violence and the less likely they thought that the services available were 'for them'. Hence, whilst this recent data into prevalence of domestic and family violence in the ACT is already troubling, there is a valid concern that the prevalence could be higher due to 'silent victims' who are not accessing services or identifying themselves to police.

Released in 2016, the Review of Domestic and Family Violence Deaths in the ACT found that in 2015, eleven family violence related deaths had occurred, resulting in 13 deaths. Of these, many of the cases reviewed there was no recorded history of physical violence and the victims had not accessed help from police or domestic violence services.

This chapter shall focus on the following issues;

1. Why carers may experience greater difficulty identifying they are experiencing domestic violence
2. Why being a carer could make it more difficult to access support services for domestic violence, and;
3. The difficulty for services to adequately support a carer in a domestically violent relationship.

This chapter shall specifically focus on people in caring roles who are being abused by someone other than the care-recipient. The chapter shall also examine the long-term impacts of managing a caring role in a violent relationship on the carers' mental health. There is a lack of research into this area and so this chapter shall engage some related domestic violence research and carer stories, however it is recommendation of this paper that this area is researched more thoroughly in the future.

Carers can find it more difficult to identify their situation as domestic violence. Carers are often primarily focused upon their caring role, and depending on the needs of the person they care for, this role can be, in many ways, all consuming. Many carers find it difficult to find time or energy for caring for their own wellbeing, to sustain paid employment, they can become socially isolated and financially dependent on welfare or on their partner's income. In the 2007 survey into national wellbeing, carers were found to be the lowest wellbeing level of any group examined and it was found they were less likely than the general population to regularly see a doctor and more likely to endure personal health problems for longer without medical intervention (Cummins et al., 2007). In the paper by Berk & Berk (2015) they found that the role of being a carer can produce an excessive amount of stress or 'carer burden'. The more difficult the caring role is as perceived by the carer, the more likely they are to neglect their own self-care (Perlick et al., 2008). In addition, they are also less likely to use coping strategies that help decrease their stress, and tend towards self-injurious coping strategies such as avoidance, excessive consumption of alcohol and other drugs, passive acceptance, collusion, coercion and wishful thinking (Perlick et al. 2008). With the majority of family and friend carers in Australia being female (in 2012 females made up the majority of carers, representing 70% of primary carers (ABS, 2013)) and the victims of

domestic violence being primarily female, it is reasonable to assume that a proportion of carers experience domestic violence. Paired with the knowledge that carers have impaired ability to prioritise their own needs and are less likely to use effective coping strategies to reduce stress – it is necessary to examine this area in greater detail.

In a paper by Petersen et al. (2005) they conducted focus groups with adult women to discuss barriers and motivators of seeking help for intimate partner violence. Participants suggested that personally identifying their experiences as IPV is often difficult to see within the abusive relationship, especially when you are already focused upon managing the abusive situation.

"*It asked about what have you done for yourself lately to boost your self-esteem. I can't get it word for word, but that was the question that really triggered it for me. And then it went on to talk about social activities: What do you like to do? [and I realised the] abusive relationship took up so much of my time [there was nothing left]*" (Petersen et al., 2006; p. 69).

In this statement from a participant, you can see that it was only when she had that reflective moment to examine her situation, that she realised that the abusive relationship had consumed all her time, in a similar manner to which carers can experience social isolation and feel they have little time for themselves. A woman who is negotiating caring responsibilities in addition to experiencing domestic violence, may be so focused on managing their present situation, that they have little time or energy to reflect on their experience and identify it as a domestically violent situation. If a carer identifies their experience as being in a domestically violent relationship, they must then make a decision in regards to seeking help.

Primary family carers can have substantially different roles and demands upon them. For some carers the duration of the caring may be limited, or the caring role may vary in its impact upon the carer. For example, family carers may be caring for an elderly relative awaiting a place in a nursing home, so they may have a large role, but for a short amount of time. For others, it could be that the person they care for only needs help infrequently, they

may need minimal supports but life-long. For some carers however, they can have long-term and high need caring roles that have a significant impact on their life. For example, a parent of a child with a high-needs disability will need to provide constant care to the child, indefinitely. It is these carers who may face the greatest barriers to leaving a relationship with domestic violence. These carers, are the ones who are more likely to leave paid employment to be a carer, may have increased costs associated with meeting medical appointments, medications or medical aids, experience social isolation and lose personal time for themselves because the caring role keeps them mainly home-bound. If the primary care-giver gives up work and becomes reliant upon another household member for financial support – this can increase their dependency and decrease their ability to leave if DV occurs.

Financial pressures could therefore be a large motivation for some carers staying in a violent relationship. In addition, the identified risk of social isolation, and therefore companionship itself, could also be a factor in the sustaining of the relationship. In the same focus group as discussed above, one participant commented;

> *Financial pressures could therefore be a large motivation for some carers staying in a violent relationship.*

"After ya'll get through fighting and fussing or whatever and then he come back and everything's alright and he start loving you again, you know, have sex and all of these things, you know. That's about the only thing that makes you feel safe because you're not going to tell somebody else" (Petersen et al. 2005; p.72)

In some ways, being a carer is seen by many as similar to being a 'parent' and for many people who parent a child with a severe disability, they see it as simply an extension of their parental responsibilities. However, the role of carer and parent do differ, parents of children that are not disabled will grow to be independent adults. The children may eventually become carers for the parents as they become frail aged. There are developmental milestones for parents to look forward to and the relationship changes over time. Carers for children with severe disability will also experience the joy of achievements and various developmental milestones will occur, however it would be very rare for a person with

profound disabilities to ever be independent of needing some form of care, whether from a carer or a service provider. It is likely that the carer will be responsible for the wellbeing of the child well into adulthood and potentially until the carer is physically unable to continue in that role.

In research into intimate partner violence, there are both stories of victims feeling having children meant that they needed to stay in the relationship and others who suggested it gave them the motivation to leave. In the sense of having a person relying on you for support and protection, caring can be seen as similar and could both impede or facilitate help-seeking for carers. In Wendt et al. (2015), Ameena spoke about feeling resentment toward her son because she felt now ''stuck'' in his father's life forever.

"I sometimes think that's it's not good to say that I made the mistake and this son I don't like him because to be honest I really sometimes I don't like it ...I just stuck here you know and this is just very hard" (Wendt et al. 2015; p.539)

In contrast, in the Petersen et al. (2005) paper the women saw it as a trigger for helping women to leave.

"So [women] leave for…their children, if they don't have the strength to leave for themselves, it's like, let me make sure my children don't suffer through with their spouses so they don't have to suffer the way I did" (Petersen et al. 2005; p.70).

In many ways the domestic violence services in Australia have adapted quite well to support women with dependent children by organising accommodation for them and their children if they choose to leave the relationship, counselling programs and financial assistance. However, carers who have a dependent person they care for, may not be aware of the services available to them or know whether they can access them, and in some cases, may not be adequately supported by them or eligible for them.

In the ACT there has been a large effort to address the needs of disabled women seeking domestic violence services and providing the necessary services to support their needs

(Women with Disabilities Australia, July 2008). However, carers for disabled children do not have the same provisions, and are likely to experience some similar difficulties in accessing the standard domestic violence support as a woman with a disability, in regards to leaving the relationship with the person they care for, and potentially greater difficulties if the person they care for is a dependent adult.

In an alternative situation, the carer who is experiencing family violence may be a young carer. As mentioned previously, young carers are often not identified by services they interact with and may face barriers of fear, especially in regards to not wanting child service involvement. In a situation of a sibling having a disability in a single parent household, and one of the children taking on a large caring role – abuse towards the young carer or the disabled child could be endured for many years to attempt to keep the family together.

It is well established that there are significant impacts on mental health of people who experience and/or witness domestic violence. These can continue long after the violence has ended. In a review conducted by Dillon et al. (2012) examining 75 international research articles from 2006-2012, found that intimate partner violence was associated with a range of mental health issues including depression, post-traumatic stress disorder, anxiety and self-harm.

"Increasing evidence suggests that the impact of IPV is not exclusively concurrent with the experience of abuse and may last long after the violence has ceased." (Dillon, et al. 2012)

As mentioned previously, carers already experience lower mental wellbeing than the general population. The increased trauma of experiencing domestic or family violence on them undertaking their role and the fears they have for the person they provide care for can have lasting impacts on their mental health and further disenfranchise the carer from being able to seek help and the level of assistance they may need in order to begin to recover. In the US-based study by Zlotnick et al. (2006) they investigated patterns of mental health recovery in women with a history of intimate partner violence followed over five years. Whilst, as expected, they found that women with an experience of IPV were significantly

more likely to experience a greater amount of depressive symptoms than women who had no experience of IPV, they also found that women who had remained in the abusive relationship for the 5-year timeframe of the research were no worse off psychosocially than women who had left those relationships. The authors concluded that the psychosocial impacts of IPV were long-term and domestic violence services and mental health services needed to address this need.

Key Recommendations

1. Improve coordination of services through well-formed procedures of recording information and communicating that with other relevant services.

2. Improve alternative care options within the community, including carer respite, permanent community supported accommodation.

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Chapter 4: Carers perpetrating family violence against their care recipients

People with a mental illness are also at risk of being abused by their carer. As discussed earlier, people with mental illness are more likely to be victims of violence than perpetrators and, in some circumstances; it is the carer who perpetrates this form of family violence. This chapter shall examine how people with a mental illness are an at risk group for being in a domestically violent relationship. It shall then go on to examine this in terms of coercive controlling violence perpetrated by their carer and also situational violence perpetrated by the carer. The chapter will also examine why carers are at risk of becoming perpetrators of violence and conclude examining the barriers that people with mental illness have in disclosing their experience of violence.

As discussed in previous chapters, traditional domestic violence involves coercive and controlling behaviours and can often be seen in relationships where there is power imbalance. In a study by Trevillion et al. (2012) they examined the directionality of the relationship between mental health and domestic violence and found they were bi-directional in causation. This means that a person with a mental illness is more likely to become involved with an abusive partner and, in addition, the experience will negatively impact their mental health. In an article by Goodman et al. (1995) it was suggested that people with schizophrenia may find it difficult to analyse information in regards to the dynamics of relationships and assess warning signs that the person is currently, or is likely to be, abusive due to the symptomology and impacts of their illness, namely; limited reality testing, impaired judgment, planning difficulties, and difficulty with social relationships. Therefore, people with some severe mental illnesses may be at an increased risk of forming a relationship with a violent partner. In this situation, the partner may take on a carer role that is characterized with attempts to control the behaviour of their partner, place

restrictions on their movement or activity and abuse them, they may also attempt to undermine their credibility with professionals, or even make them doubt their own memories. In interviews with women from a psychiatric hospital, they asked them about their experience of violence and disclosure. Many women commented that they were afraid they would not be believed;

"You're living in fear until people believe you. You're left feeling dirty and like you've been let down again by the system, cause there is a lack of support and lack of people believing you" (Rose et al., 2010; pp.2).

"I was taken to the GP, I'd initially gone to see the GP on my own and then he burst into her office and started telling her, Oh, she's taken an overdose, she's done this, she's done that" (Rose et al., 2010; pp.3).

However, the monitoring and care that mental health carers provide heavily complicate this. For example, it is quite normal for carers to be very involved in helping coordinate the services for the person with the mental illness. This can include organising doctors' appointments, managing finances and trying to ensure medication compliance. In Solomon et al. (2005) they examine how the nature of the carer/care recipient relationship can impact on violence. For example, they suggest that in an attempt to avoid undesirable behaviors carers may place limitations on the relative they care for such as 'not drinking in the house, smoking only in certain rooms or receiving spending money only if they take their prescribed medication' (Solomon et al., 2005; pp. 48). These are behavior management techniques that are also commonly used in therapeutic settings. However, the use of these techniques can lead to a combative relationship between the carer and care recipient who interprets them as coercive. Straznickas et al.'s (1993; cited in Solomon et al., 2005) study found that assaults on family caregivers frequently followed attempts to set limits.

However, the notion of carers having a role in restricting or managing behaviours in some ways can act as an impediment in identifying domestic violence, especially legally. The actions taken may be very similar, however the motivations of the actions by someone providing care versus someone who is abusive are very different. This is highly contentious in law as intention is not considered, and the 'reasonable person' comes into play. For example; is the carer restricting the care recipient's activity as a method to wield power over them or for concerns of long-term safety and wellbeing? Are the actions they take in managing behaviour and ensuring safety considered reasonable?

In these situations, it can be very difficult for people with severe mental illness to obtain help, to be believed if they do and to become independent of their carer.

People with severe mental illness are a stigmatized and often hidden population, many can become isolated and reliant on carers to support them with managing their illness, or financially etc. Depending on the relationship dynamic, a carer may have a great deal more power in the relationship and may increase the care recipient's dependence for abusive reasons. In these situations, it can be very difficult for people with severe mental illness to obtain help, to be believed if they do and to become independent of their carer.

In other circumstances, carer violence can be more akin to situational violence, with no ongoing attempt to coerce or control. To reiterate from the earlier discussion, situational violence is described as violence that occurs as a result of escalating arguments, emotions or situations and there is no intention for either party to have control over the other. Therefore, the dynamics within a caring relationship with a care recipient, including the attempt to ensure medication compliance (etc.) alongside heightened emotional responses can lead to violent arguments where a carer is violent towards a person with a mental illness. It is important to note, that despite the non-traditional nature of situational

violence, and the lack of 'intention' to wield power, this does not mean that this form of violence is reasonable, justifiable or excusable. Situational violence still results in people getting injured, children witnessing traumatic incidents and, on occasion, death. Touched on earlier in this paper has been the topic of blame, and it is definitely an important area in domestic violence, especially in regards to help seeking. If victims do not see the perpetrator as being responsible for their actions, they will often see both themselves and the perpetrators as 'victims of circumstance'. In a mental health carer and care recipient relationship, the care recipient can attempt to justify the violence and excuse the carer because the carer is stressed by the 'burden of caring' and care recipients can feel indebted to the carer's assistance.

In discussions and research on carer burden, and 'carer burnout' this is definitely a key issue, because maintaining a stressful caring role without appropriate supports can be a factor in carer violence occurring. In the mental health space, this is a particular concern if the services are not able to provide a holistic and integrated approach to supporting people with mental illness and their families appropriately.

Key Recommendations

1. Improve identification of violence through mental health services asking all carers and consumers if they have experienced violence.
2. Ensure evidence-based intervention services for victims and perpetrators of domestic violence with mental illness are readily available

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Conclusion and Future Directions

This paper has sought to tease out the complex relationship between mental illness, family carers and violence and make recommendations for improving the wellbeing and appropriate service response for this cohort. This paper is a preliminary step in evaluating the particular issues for carers and people with mental illness in identifying violence, accessing support and having the appropriate services available and makes recommendations that can fall into three broad categories, namely;

1. **Increasing our evidence base in this area through research**

   a. Undertake further research into this area including prevalence research, qualitative research into carer and consumer motivators and barriers to help-seeking in order to improve the service response to this cohort's needs.

   b. Ensure evidence-based intervention services for victims and perpetrators of domestic violence with mental illness are readily available

2. **Awareness raising and training for carers, consumers and staff in the mental health space**

   a. Improve staff confidence and capacity in mental health services to work with people who are at risk of being violent or have experienced violence.

   b. Improve consumer and carer awareness of disclosure options and what will occur when they seek help.

3. **Policy and procedure development for mental health services and related community organisations**

   a. Improve identification of violence through mental health services asking all carers and consumers if they have experienced violence.

   b. Improve coordination of services through well-formed procedures of recording information and communicating that with other relevant services.

   c. Define clear risk and safety policies in regards to working with carers and consumers within a recovery framework whilst also mitigating risk to household members.

d. Where risk is identified towards staff in hospital or community settings, an assertive approach to engage with family should be implemented.

e. Re-examine discharge from acute in-patient settings and ensure that carers have the ability to refuse the person staying with them.

f. Improve alternative care options within the community, including carer respite, permanent community supported accommodation.

Whilst many of these recommendations will call for additional funding (including research, training and increasing in the capacity of mental health services) most recommendations are in regards to improving the current mental health system and carer supports available. There is an imperative upon the sector to work together in order to handle complex clients and ensure that services are wrap-around for the individual and their family. Many of these issues could be addressed with improved integration of related services and sharing of relevant information, awareness raising within the community around the many forms of domestic violence and the possibility of recovery.