Domestic and Family Violence and Involuntary, Inpatient Psychiatric Treatment

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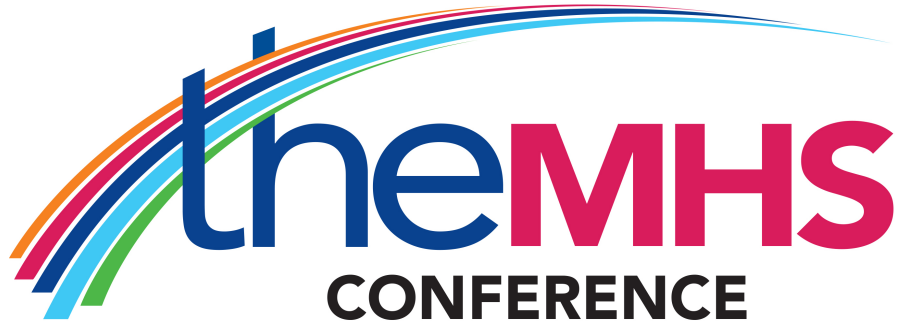

Acknowledgement of Country

Introduction: our contexts

Legal practice (Jennifer):

- Legal experience in mental health law; and
- Policy experience in system-wide domestic and family violence response.

Social work research (Emma):

- Exploring the socio-political contexts of mental distress, power relations between consumers and professionals, and the impacts of coercive mental health practices.

Gendered violence and mental distress

Several decades of feminist scholarship showing a direct link between domestic violence and mental distress (e.g. Humphreys, 2003).

Psychiatric diagnoses may be insufficient in describing mental distress occurring in the context of gendered violence (Pill et al, 2017; Tseris, 2019).

Despite this evidence, mainstream service provision operates within a paradigm of biological reductionism that usually involves the assessment of de-contextualised symptoms and provides a medication-first response (Read, 2018).

Gendered violence and mental distress

‘Psychosis’ can be understood as a form of hypervigilance in the context of violence and trauma- searching for potential threats (Read, 2018).

Violent men may use the psychiatric system as a means of control/abuse (Laing & Humphreys, 2013).

Methodology

An exploratory, practice-based approach is used to unpack key learning and identify areas for future research.

How might critical reflection open up new possibilities for responding to women's experiences at the intersections of gendered violence and involuntary mental health services?

De-identified vignettes are used to capture experiences.

Critical reflection analyses the details of practice, especially interrogating assumptions, exploring power relations, and disrupting binary thinking.

Mental Health Act 2007 (NSW) Involuntary Patient Orders

1. Mental illness, a condition that seriously, temporarily/permanently impairs, the mental functioning of a person, characterised one/more of these symptoms, s4
    - delusions;
    - hallucinations;
    - serious disorder of thought form;
    - severe disturbance of mood; and/or
    - sustained or repeated irrational behaviour indicating the above
2. Risk of serious harm, s14
3. Inpatient care is the least restrictive kind of safe and effective care, appropriate and reasonable available to the person, s12(1)(b)

Case studies – Alison

- Alison left a marriage with domestic and family violence in 2011 after 12 years.
- She has been supported by a clinical psychologist, psychiatrist and GP.
- In 2018, she was assessed by a psychiatrist, who concluded there were “no signs of acute mental illness”.
- Ongoing concerns re safety in social housing accommodation
- Collateral evidence from her son.
- Alison was scheduled under the *Mental Health Act 2007* (NSW) in 2020 on the basis that her fears were delusions and she was at risk of harm to her reputation or misadventure.

Case studies – Brianna

- Brianna was admitted reporting sexual assault at local police station.
- Did not receive rape kit in the inpatient ward for 3 days.
- Did not receive a Statement of Rights under the *Mental Health Act 2007* (NSW).
- Brianna had excluded her mother as a Designated Carer under the Act, but nursing staff proceeded to contact her mother.
- Collateral information from the psychologist confirmed historical sexual assault.

Case studies – Carol

- Carol was a mother of two young children, divorcing her partner.
- Two health professionals from the acute care team of her local hospital diagnosed her with psychosis on her doorstop and compelled medication compliance.
- No social support for babysitting while she attends the emergency department.
- Carol was concerned re impact of this diagnosis on family law proceedings.
- She was worried about the strong side effects of the antipsychotic medication.
- Carol could not access an alternative diagnosis in short timeframes.

Implications

- Complexity of relationship between domestic violence and mental health issues
- The need for a multidisciplinary response
- Integration with existing domestic violence responses
  - women experiencing violence are identified, supported and referred appropriately
  - increased training and support for staff
  - relationships between hospitals and local domestic violence support services
  - connections with broader domestic violence response systems

Implications

- What might a woman experiencing gendered violence (or its aftermath) need, and how does this compare to what is offered in a hospital admission?

- Engaging with vignettes demonstrates the complexity of lived experience…

Typical question: Does she have psychosis or is she responding to violence?

A better question: What meanings might the experiences have, and what might be helpful?

- The need for further research into the gendered dimensions of inpatient mental health admissions – please be in touch!

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