QSAN
Queensland Sexual Assault Network

Inquiry into the opportunities to improve mental health outcomes for Queenslanders

Submission to Mental Health Selection Committee

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Date: 11 February 2022

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1. Introduction

The Queensland Sexual Assault Network (QSAN)) welcomes the opportunity to provide a submission to Mental Health Select Committee in response to the '**Opportunities to improve mental health outcomes for Queenslanders'** inquiry**.**

We are concerned that sexual violence is not mentioned in the terms of reference and that our services were not part of any consultations. This is despite the evidence that many people attending community and inpatient alcohol and other drugs (AOD) and mental health services have experienced trauma; and that trauma is often in the form of Sexual Violence. Furthermore, those with a history of coexisting AOD use and mental health issues are more likely to experience repeated sexual victimisation. The linkages between abuse, mental health and AOD problems are particularly acute for women (Breckenridge et al., 2012).

In order to increase safety and reduce harm for those with AOD and Mental Health issues we must include Sexual Violence and sexual safety in the conversation.

This is a brief submission written under a significant time constraint through a grant of extension as we were not aware of the inquiry. We respectfully request to be included in any subsequent consultation on these issues.

2. Background on Queensland Sexual Assault Network (QSAN)

QSAN is a state-wide network comprised of 23 non-government specialist sexual assault services and is the peak body for Sexual Violence prevention and support organisations in Queensland.

QSAN member services are spread across the state of Queensland. Our services represent a depth and diversity of specialised knowledge and service delivery approaches. With gendered analysis and flexibility, the focus of this network has been to provide trauma-informed support for survivors of sexual violence (in particular those who are most vulnerable and at risk).

Within this breadth of service delivery is the benefit of specialised services (such as Murrigunyah, WWILD, Immigrant Women's Support Service, Zig Zag, and Living Well) and specialist programs that develop and share best practice responses to those who are:

- Aboriginal and Torres Strait Islander
- Culturally and Linguistically Diverse
- Living with cognitive or intellectual disabilities
- Women, Young Women, and Older Women
- Men and Young Men
- Children
- Children and Young People engaging in sexually harmful behaviours

3. Background on Sexual Violence

Sexual Violence is an umbrella term that covers a broad range of sexual behaviours, language or activities that are unwanted and happen without consent. These can make a person feel uncomfortable, frightened, threatened or even numb.

Sexual Violence can happen to anyone, with most sexual violence being perpetrated by someone the victim knows and trusts, for example, a partner, friend, work colleague, family member or acquaintance.

Sexual Violence is perhaps the most committed, least reported and least punished of all crimes. General statistics on sexual violence In Australia from the Australian Bureau of Statistics Personal Safety Survey (2017):

- 2.2 million women (23%) and 718,000 men (8.0%) aged 18 years and over have experienced Sexual Violence in their lifetime, including childhood sexual abuse and/or sexual assault since the age of 15
- 1 in 5 women have been sexually assaulted or threatened since the age of 15
- 98% of women who have been sexually assaulted said that the perpetrator was a male

4. The intersection and co-occurrence of Sexual Violence, Alcohol and other Drugs and Mental Health

a) In the general community

The 2007 Australian National Survey of Mental Health and Wellbeing (Slade et al., 2009) estimated that 80 percent of adults drink and that 1 in 5 Australian adults have an anxiety, mood, or substance use disorder. In addition, Australia has high rates of Sexual Violence that will also affect these populations.

The relationships between mental health, substance abuse and Sexual Violence are closely interwoven. People who have experienced Sexual Violence are more likely to abuse substances and to be diagnosed with a range of disorders such as anxiety and depression (Quadara et al., 2015). At the same time, people who have mental health issues and/or abuse substances are at a higher risk to become victims of Sexual Violence.

Therefore, when seeking help for dealing with substance abuse, mental health issues and/or Sexual Violence, it is important that there is no wrong door; all systems should be equipped to respond and treat in an integrated way that recognises the complex relationships of these intertwined components.

b) In AOD facilities

The treatment of AOD is complicated by neglecting to acknowledge the relationship to trauma and Sexual Violence. The use of substances may have preceded a sexual assault, occurred during the assault, or developed as a coping strategy in response to the trauma the victim experienced (Anderson et al., 2005).

Among women who reported one type of gender-based violence, over 23% also reported experiencing a substance use disorder. Where women had experienced more than three types of gender-based violence, 47% had also experienced a substance abuse over their lifetime (Rees et al., 2011).

If screening and assessment is not done in AOD services, the opportunity to address the trauma is missed which silences the client and ignores their experience. Research shows that disclosures of Sexual Violence increase dramatically once clients in AOD or mental health facilities are directly questioned about past abuse (Keel, 2005).

Training must be available to workers in AOD services to build knowledge and capacity around Sexual Violence and its impact, so they are confident in their practice.

c) In in-patient psychiatric units

Women admitted to psychiatric wards experience high levels of violence and sexual assaults. The Victorian Mental Illness Alliance Council (VMIAC, 2013) reported that across the nine different psychiatry hospital wards surveyed in Victoria, 85% of female inpatients felt unsafe during hospitalisation, 67% reported experiencing sexual or other forms of harassment and 45% of respondents had experienced sexual assault during an in-patient admission. The report further described that when the patients reported the incidents, 82% found the nurses to be “not at all helpful”.

It’s difficult to find data on sexual assault in psychiatric wards in Queensland however the Victorian situation is not unique. QSAN services acknowledge that similar assaults and harassment happen and that when women have reported these incidents they are not always dealt with appropriately.

Since the 1990s larger institutions have continued to be closed and psychiatric patients increasingly managed in community settings, with short stay admissions to mixed gender psychiatric wards in general hospitals when required. Admissions are reserved to treat acutely and severely unwell people who cannot be managed in the community (VMIAC, 2013).

This practice has now led to an even greater risk of physical and sexual assault, particularly against highly vulnerable female inpatients, who may already have a history of sexual abuse and domestic violence.

“Preventing Sexual Violence in psychiatric facilities has been a longstanding challenge that has received only limited attention from researchers and regulators. Numerous factors at the

patient-, staff-, facility- and health care system–level contribute to sexual assaults within these facilities and difficulties in obtaining justice for victims" (Barnett, 2020).

Because most Sexual Violence in psychiatric facilities is perpetrated against women by men a move toward gender-segregated wards must be given serious consideration.

Recommendations

1. **That Queensland Health moves to counteract the silence and invisibility of Sexual Violence by including information on this topic in all AOD and mental health public education strategies**

2. **That Queensland Health ensures that Sexual Violence information is included in all screening, assessment, and treatment material on AOD, mental health and dual diagnosis**

3. **That guidelines are developed, and workforce capacity built through professional development and sharing expertise between Sexual Violence, AOD, and Mental Health sectors**

4. **That inclusive collaborative partnerships and referral pathways are developed between Mental Health, AOD and the Sexual Violence sectors**

5. **That integrated models of care include Sexual Violence services**

6. **That further consideration is given to gender segregation in psychiatric wards to maximise the physical, sexual, and psychological safety of patients**

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