T R A N S C R I P T

LEGISLATIVE ASSEMBLY LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into capturing data on family violence perpetrators in Victoria

Melbourne—Monday 12 August 2024

MEMBERS

Ella George – Chair
Annabelle Cleeland – Deputy Chair
Chris Couzens
Chris Crewther
Cindy McLeish
Meng Heang Tak
Jackson Taylor

WITNESSES

Associate Professor Andrew Carroll, Consultant Forensic Psychiatrist;

Dr Jacqueline Rakov, Consultant Forensic Psychiatrist, and

Professor Manjula O'Connor, Consultant Psychiatrist and Chair, Family Violence Psychiatry Network, Royal Australian and New Zealand College of Psychiatrists.

The CHAIR: Good afternoon. My name is Ella George, and I am the Chair of the Legislative Assembly's Legal and Social Issues Committee. We will now our resume public hearings of the Committee's Inquiry into capturing data on family violence perpetrators in Victoria.

I begin by acknowledging the traditional owners of the land on which we are meeting, the Wurundjeri Woi Wurrung people of the Kulin nation, and I pay my respects to their elders past, present and future and extend that respect to First Nations people across Victoria.

I am joined today by my colleagues Christine Couzens, the Member for Geelong; Cindy McLeish, the Member for Eildon; and Chris Crewther, the Member for Mornington.

The Committee recognises that evidence to this inquiry may be distressing, and we urge people to reach out for support. You can contact Lifeline on 13 11 14, 1800RESPECT or the Blue Knot helpline on 1300 657 380.

All evidence given today is being recorded by Hansard and broadcast live. While all evidence taken by the Committee is protected by parliamentary privilege, comments repeated outside this hearing may not be protected by this privilege.

Witnesses will be provided with a proof version of today's transcript to check, together with any questions taken on notice. Verified transcripts, responses to questions taken on notice and other documents provided during the hearing will be published on the Committee's website.

I am now pleased to welcome Associate Professor Andrew Carroll, Forensic Psychiatrist and fellow at the Royal Australian and New Zealand College of Psychiatrists; Professor Manjula O'Connor, Consultant Psychiatrist also from the Royal Australian and New Zealand College of Psychiatrists; and Dr Jacqueline Rakov, Consultant Forensic Psychiatrist from the Royal Australian and New Zealand College of Psychiatrists. I invite you to make an opening statement, and this will be followed by questions from members. Thank you.

Andrew CARROLL: I have worked as a forensic psychiatrist in Victoria since 1998. For most of that time I have worked with Forensicare, the Victorian Institute of Forensic Mental Health, but recently I left that organisation to take up the role of deputy chief psychiatrist for forensic mental health at the Department of Health. In my private role I produce assessment reports for the criminal courts in Victoria and interstate, many of which involve assessments of people who have used serious, sometimes fatal, violence against members of their own family. Over the past five years I have assessed 25 homicide offenders, of whom 12 met the definition for family violence. These have included cases of intimate partner homicides—mainly by men, sometimes by women—as well as homicides of siblings, parents and children. This is why I am so keen to speak in my role today as a member of the faculty of forensic psychiatry at the college.

Research suggests that around a quarter of domestic homicides are perpetrated by people suffering from very severe psychiatric illness at the time in the form of psychosis—that is to say loss of contact with reality—and/or in the form of severe depression. This figure immediately flags the possibility of secondary prevention. Secondary prevention in the context of serious violence by those with severe mental illness refers to assertive therapeutic interventions for that small but identifiable subgroup at clearly elevated risk of violence towards others due to symptoms of mental illness, particularly psychosis. I note here that the vast majority of people living with mental illness do not pose a heightened risk of violence and are far more likely to be victims than perpetrators.

Unfortunately, my experience of the Victorian public mental health system over the past quarter of a century indicates that we do a very poor job in this state at secondary prevention in the area of family violence perpetrated by those with severe but treatable mental illness. Our forensic mental health inpatient base only has the scope and resourcing to focus on tertiary prevention—rehabilitating some of those who have already carried out a serious crime, usually homicide. Unlike New South Wales, we do not have a spectrum of low and medium secure, long-term inpatient beds that could intervene effectively with high-risk patients by providing the extended lengths of stay and specialist forensic treatment interventions that they require. Our nearest equivalent, secure extended care units, or SECUs, are not specialist forensic services and are not adequately equipped for this challenge for a range of reasons, including inadequate funding and lack of integration with forensic services.

This lack of a coherent approach to secondary prevention may be related in part to an insufficiently data-driven approach to public policy in mental health. I would note that data in the form of the forensic analyses that forensic psychiatrists and forensic psychologists carry out for the courts and summarise in the form of court reports contain a wealth of personal and systemic factors—data on personal and systemic factors that are not currently utilised in any systematic way to inform mental health policy. I will stop there. Thanks.

The CHAIR: Thank you, Andrew.

Manjula O'CONNOR: Thank you. I would like to start by saying that the role of mental illness in theories of perpetration of family violence is just starting to be accepted, because not so long ago you were not allowed to speak about that in perpetration of family violence because the theories were all around feminist theory of power and control, which basically meant that this issue has so far been neglected and only now is getting acceptance. In fact our college—I chair the Family Violence Psychiatry Network—we made a significant submission to the Royal Commission into Family Violence around mental health, but we were not invited to give evidence at the inquiry—it was just like, 'Yeah, one of those things.' But now we know about the mental health diagnosis of those who use violence. In fact research from ANROWS shows that 58% of men who chose to take the survey of 1,000 people had admitted to using violence—that is a big number—and 72% of women. This was a study done at Melbourne University. We know that it is a big issue.

We also have data from New South Wales—a big data study where I think they looked at something like 500,000 pieces of evidence of the police, and found that 17% of the victim–perpetrator group had mental illness of some kind, of which three-quarters were a perpetrator, and that all perpetrators who undertake men's behaviour change program should have a proper assessment, mental health assessment, because we know that the MBCP outcomes are not that good and part of that is because those taking part are not getting assessed and not getting trauma therapy and not getting proper psychodynamic psychotherapy to understand the impact of their childhood on their own behaviours. They often suffer from post-traumatic stress disorder. In fact 58% in this ANROWS study had post-traumatic stress disorder. That is my first point.

My second point is around the misidentification of perpetrators, and it is such a big issue, especially amongst the migrant communities and the Aboriginal communities. In my other life I am actually the executive director of a charity called AustralAsian Centre for Human Rights and Health, and we focus specifically on South Asian migrants. We have a big issue of misidentification of perpetrators, and I am seeing them in my private practice because my expertise is around gender-based violence. And what we are seeing is how the evidence can be manipulated by the perpetrator and the police are not able to recognise the coercive control aspect of it, firstly, long term, and, secondly, how they trigger the victim into behaving aggressively, quickly video the evidence and present it to the police as evidence of this woman being the perpetrator. It is mostly women who are being misidentified and who I see in my practice, and I have to spend hours reversing that evidence that the police have collected. The Women's Legal Service thinks that is happening to one in 10 women, but I think—my personal opinion and my private practice—that it is much higher.

The third point is that on L17 forms that the police collect data on we need 'ethnicity', 'language spoken at home' and 'years in Australia if born overseas' so that we can make treatments targeted. We should know what is going on within the communities.

The fourth point is around perpetrators continuing their worst abuse after the separation by using family law courts, the breaching of intervention orders, the manipulation of children and the court report writers—and the totally misinformed information to the report writers. They exaggerate any problems that victim-survivors have, and that gets written into the reports, which then becomes the truth. So the harm to the mental health of victims by this process has been immense, and it is a system-induced trauma. I will stop here, and I will be happy to expand on all of those points.

The CHAIR: Thank you.

Jacqueline RAKOV: Thanks for the invitation. I come to you today as a general and forensic psychiatrist. I chair the Victorian committee of the college Faculty of Forensic Psychiatry. I work both in public and private practice, and I am unfortunately one of the very few practitioners in Victoria treating those in the criminal justice system on a private voluntary basis. My experience also spans Victoria's public mental health and correctional systems, working both with victims and perpetrators of crime. I am not a researcher, but a clinician

on the front lines, where I see the gaps in our understanding and data on family violence, particularly where it intersects with mental health. While I may not have all the answers for the Committee, I hope I provide no repetition, as I aim to highlight the other crucial issues necessary for understanding perpetrators of family violence, both on individual and systemic levels.

We lack data on some of the most relevant aspects that could better inform prevention, treatment and policymaking, and my view is that one of the most profound gaps is the absence of data on the prevalence of shame and stigma, which play a huge role in the lives of those affected both by family violence and major mental illness, especially men. Shame and stigma are not just abstract concepts; they are real powerful forces that can prevent individuals from seeking help, disclosing abuse or accessing mental health services. As prolific journalist Jess Hill has discussed in her work on coercive control, shame can be a corrosive element deeply embedded in the identities of those affected, particularly men. Unfortunately, the factors of shame and stigma are notoriously difficult to capture in our current data collection methods. The very nature of these emotions means that they go, often, unreported and unacknowledged, both by the individuals experiencing them and the systems designed to help. The absence of data leaves significant gaps in our understanding of the true drivers of family violence and coercive control, leading to interventions that may fail to address the root cause of these behaviours.

A further gap in our understanding of family violence is how male depression and anxiety manifest differently. Men often show anger, irritability and aggression, or anxiety-driven outbursts, rather than the classic signs of sadness or rumination. These behaviours are frequently misinterpreted as inherent aggression or coercive control, leading to under or misdiagnosis. The lack of systematic data collection on these symptoms means we are missing opportunities for early intervention and treatment, and to bridge these gaps we would need to refine data collection methods clinically and ensure mental health assessments recognise the unique ways these conditions present in men, especially in the context of family violence.

My job at Monash Health specialises in fixated threat and radicalisation, and I think it is worth noting the growing influence of online spaces, like the manosphere, where young men are exposed to toxic ideologies that glorify misogyny, encourage violence and breed mistrust of women. Involvement in these spaces can drastically shift a man's world view, often leading to harmful behaviours, particularly in the context of family violence. Unlike sexual offending where established assessment and treatment frameworks exist, psychiatrically we lack similar approaches to address the psychological impact of online radicalisation. This raises a key question: should we be focusing on closer monitoring of internet activity or should we take a proactive approach by integrating prosocial behaviours and mental health literacy into adolescent education?

My last and probably biggest bugbear point is that we have a glaring lack of data regarding individuals who have had their mental health treatment orders revoked by the mental health review tribunal and subsequently find themselves involved in the criminal justice system or tragically involved in violent incidents such as harming or even killing a carer. This absence of data represents a significant blind spot in our mental health and justice systems, one that has serious repercussions for public safety, the wellbeing of carers and the rehabilitation prospects of those individuals suffering severe mental illness. Without the robust data we are unable to fully understand the scope of this issue. We do not know how many individuals are slipping through the cracks after their treatment orders are revoked. Are these individuals receiving any form of follow-up care as voluntary clients? Are they being monitored in any meaningful way or are they simply left to deteriorate until they reappear at our emergency rooms, psychiatric facilities or jail doorsteps? The lack of accountability here is staggering. This data void means that there is no way to hold the system accountable for these outcomes. Without clear records and analyses of what happens to individuals post-order revocation there is little incentive for improvement. This not only endangers the lives of those with untreated or inadequately treated mental illness but puts their carers and broader community at risk. When we fail to track and manage these cases, we are essentially leaving it to chance whether these individuals will receive the help they need or whether they will again become entangled in a cycle of incarceration, violence and self-destruction.

As someone once advised, you cannot boil the ocean. So where do we start? To effectively address violence when linked to untreated mental illness we should reform data capture and usage. Law courts and prison psychiatric staff already hold valuable records about sentencing outcomes or mental health contact data, offering an opportunity for a more integrated system. The mental health review tribunal must maintain comprehensive records of individuals whose treatment orders are revoked, ensuring they remain traceable. We need to move beyond isolating incidents and blaming the attitudes and recognising this violence as part of a

broader systemic issue and failure. This requires integrating data systems, improving traceability and enhancing mental health support for perpetrators. It would not be just a policy need but rather an ethical imperative to protect our communities, support those who are struggling with illness and prevent further tragedy. Thank you.

The CHAIR: Thank you. Thank you all for your opening statements. I would like to just start with touching on some of the things that you raise, Jackie, around those data gaps. My question is: how do we better collect that data and what are some of the practical steps that the Victorian Government can take to start building that fulsome picture?

Jacqueline RAKOV: I think if you asked me to change something today, my first intervention would be with the mental health review tribunal. That issue came to me as a clinician working in a prison who would receive new people under the mental health unit who had been two weeks ago revoked by the tribunal, subsequently withdrawn from contact from their mental health service, withdrawn themselves from prescribed treatment, had a relapse of their major mental illness and perpetrated some violence, and there was no closing of that loop for anybody except we were just having to start again by education, potentially more assertive treatment. And I think the tribunal has a very organised calendar, roster, schedule, applications, its legal paperwork—I think that data would be easily available.

The CHAIR: So just to clarify: the Mental Health Tribunal should be able to collect that data about individual people?

Jacqueline RAKOV: Yes. When they make a decision there is a piece of paper that they sign, so it should go somewhere in terms of maybe the CMI database in Victoria or some sort of mental health contact.

The CHAIR: And getting a bit technical here, do you know if the Mental Health Tribunal are using the MARAM framework.

Jacqueline RAKOV: I do not think they do. Having sat in on countless hearings, I do not think so.

The CHAIR: Okay.

Jacqueline RAKOV: I think the main issue is that the tribunal is not using a longitudinal view of an individual who has been presented to them—talking about admissions to a hospital potentially being subject to involuntary orders, release from hospital and the cycle continuing again. Often it is junior clinicians presenting these cases in front of a tribunal, and they may not have the longitudinal oversight either to say, 'Well, three years of them not being subject to an involuntary order has been completely disruptive to their life, their autonomy, their agency, and they're in an out of hospital or jail, so what are we doing about that as the tribunal?'

The CHAIR: So when the tribunal has this information with regard to a person who has been using violence, do you know if that information can then be shared through provisions like the family violence information sharing scheme?

Jacqueline RAKOV: I am not aware of that.

The CHAIR: I am just wondering if the Mental Health Tribunal is holding this information, how is it being shared with the broader family violence sector and other service providers?

Jacqueline RAKOV: If the mental health review tribunal has that information available to them, it is only because it has been provided by the clinical team. Clinical teams embedded in area mental health services will have access to usually a family violence consultant or similar who would then, I would hope, proliferate the information needfully.

The CHAIR: And then, if that data is being collected by the Mental Health Tribunal, what is your recommendation to the Victorian Government about what to do with that data and how to use it?

Jacqueline RAKOV: I think all the data needs to be centrally available or synthesised so that if I am on call at 9 pm and someone comes in, I can see that their order was revoked two weeks ago by this other mental health service. Unfortunately, the mental health services in Victoria are geographically siloed, and we do not have access to each other's clinical records, only what is on the CMI database.

The CHAIR: Do you think it would be beneficial if those records were more readily available across services?

Jacqueline RAKOV: Undoubtedly.

The CHAIR: Is there anything in that area you would like to expand on for us about the benefits?

Jacqueline RAKOV: We lose a lot of richness in a clinical picture or a clinical formulation, which in turn becomes a risk formulation, if we do not have a fulsome view of an individual who is presenting to us. When we see someone in ED or we get a phone call in the middle of the night from a junior doctor, we only have that cross-sectional information with a little smattering of what is available at a scramble. If we had a centralised medical record or legal database, then it would make things far less based on guessing.

The CHAIR: Thank you.

Cindy McLEISH: Can I just follow that?

The CHAIR: Please.

Cindy McLEISH: With judges, where it comes to court, would they have access to that because it is through the justice system?

Jacqueline RAKOV: Access to the tribunal –

Cindy McLEISH: Or is that only if the solicitor provides it?

Jacqueline RAKOV: Again, it would have to be put before their honour.

Manjula O'CONNOR: I think I can add a little bit to that. With the family violence information sharing scheme, most of us do not come under that. I doubt if the tribunals would be because they are considered highly confidential.

Cindy McLEISH: It is the criminal system versus the health system.

Manjula O'CONNOR: Yes. It would be great to actually have not just the information about the orders from the tribunals but also whether the intervention orders are in place for these people. Often we have had cases where perpetrators are under intervention orders and we did not know that that was going on at home, and so it can interfere with the psychiatrist's assessment of what is going on.

Jacqueline RAKOV: That information is actually accessible on CMI if someone has an active order. You would have to have access to CMI.

Manjula O'CONNOR: Yes, that is right.

Cindy McLEISH: I just want to go back to one of the comments Associate Professor Andrew Carroll made earlier talking about the primary, secondary and tertiary elements. Could you expand and give us an example of each of those for clarity so that we have this recorded?

Andrew CARROLL: Primary prevention is essentially population wide, so an example might be addressing misogynistic attitudes at a population level amongst all men, perhaps starting in childhood and adolescence. So you are trying to primary-prevent any problems. Tertiary prevention in the case of homicide or serious violence is after it has already happened. The metaphor often used is the ambulance at the foot of the cliff. Most of those long-term patients at Thomas Embling Hospital, for example, or many of them, will be homicide offenders, so the death has already occurred. That is the 25 that I have seen over the past five years. Secondary prevention, to me, would be that significant group of people with severe mental illness who we know are likely to engage in family violence and probably already have engaged in family violence to some extent—may or may not have been before the courts—where the appropriate interventions are not being applied. So ideally secondary prevention with at least some of those men would involve a much longer admission to hospital than the 13-day average that you will get on a public mental health ward at the moment, a much longer admission in a secure facility informed by forensic expertise that actually addresses not just the

mental illness but also some of those problematic behaviours and problematic attitudes that overlap with the mental illness. So that secondary prevention would then make the end result of serious violence significantly less likely, but at the moment we just do not have sufficient resources or infrastructure for that.

Cindy McLEISH: And that is very much part of what we are trying to do: to look at the profiles of perpetrators to prevent the ambulance at the cliff.

Andrew CARROLL: Yes. I mean, historically people have conceptualised it in different names, but family violence more broadly, not just intimate partner violence, has always been recognised as something where severe, particularly treatment-resistant mental illness is a risk factor for that outcome, unfortunately, in a significant number—I am not saying the majority—of people with severe and enduring mental illness.

Manjula O'CONNOR: The other example would be early intervention to get in there where you suspect there is a high chance of victim- or perpetrator-hood—for example, in certain groups or communities, like the CALD communities, isolated communities, rural communities as well as specifically the men who are going through a men's behaviour change program. I think that is a great opportunity to catch those people, to treat their mental disorders at the same time as they go through an attitudinal change program. It would fall in the area of secondary prevention, to prevent further occurrence.

Cindy McLEISH: This is a broad question about whether or not you are seeing more or less presentations and how young the people you see are.

Jacqueline RAKOV: Of violence or serious mental illness?

Cindy McLEISH: The perpetrators.

Jacqueline RAKOV: In our fixated threat team we have adolescents as young as 12.

Andrew CARROLL: I think the number that I see now—I have a very low volume practice, so I do not think I can meaningfully answer that, to be honest.

Cindy McLEISH: That is okay. So 12 for –

Jacqueline RAKOV: Well, they are ones reaching the threshold of Victoria Police and fixated threat teams being alarmed. I am sure that child and adolescent mental health services could provide a more accurate picture on what they are seeing—or youth justice.

Cindy McLEISH: I have got more questions, but I will let others go first.

The CHAIR: No worries. Christine, thank you.

Chris COUZENS: Thank you for your time today. I appreciate your contribution. You spoke earlier about the shame and stigma and the difficulty of collecting data because of that. Have you got a view on how that might be addressed?

Jacqueline RAKOV: I wish I did, is the short answer.

Chris COUZENS: No, it is a hard question.

Jacqueline RAKOV: I guess it is very easy to come from a kind of coalmining perspective, where you sit one person in front of another and discuss their history, as Manjula mentioned, undertaking psychodynamic psychotherapy and exploring the themes from their formative years as to why this shame arose. I do not know if there is a screening tool that someone wants to—I suspect social work, the faculty of social work, is way more literate at this than psychiatry. I think there are researchers overseas who have done a lot of work on shame and stigma as well. I only have an 'N equals one' view of being able to assess somebody and then treat them.

Manjula O'CONNOR: It is a very common issue amongst migrant communities, especially those from collectivist communities where the pressure from the larger society is to look perfect. That sense of family violence has such a stigma and is such a shameful thing to happen and to share with the rest of the community that it leads to a number of things; one is complete silence and a barrier to help seeking. Then, at the same time,

for perpetrators that shame internalised turns into a huge sense of anger and frustration, and that is how they turn that into a need to assert themselves and to create a sense of authority and power in order to not feel that sense of shame. So a perpetrator is more likely to perpetrate more, and that shame factor is a big one, and that is interfering at the men's behaviour change programs. They do not own up, and it is so hard for a men's behaviour change program to work if people do not take ownership. And when they do get discharged, they never work through those issues and they go on to perpetrate again. It is a very powerful factor—shame and stigma.

Chris COUZENS: Do you want to contribute to that one as well, or not?

Andrew CARROLL: Look, absolutely, because there is not only the shame and stigma of the behaviour itself but also of course of admitting that you have a mental health problem. Now, it may be that there is a psychotic illness where a person just completely lacks insight—they have lost contact with reality. But I totally endorse Jackie's point about how depression presents differently in many males. So you have this kind of double whammy of the fact that the male is embarrassed about the fact that they are struggling mentally; they will often self medicate with substances, which of course makes the issue worse, and gambling often comes into the mix as well. Certainly a lot of the men I have seen after the fact kind of knew on some level that they were struggling and sometimes in a surprisingly high number. When I look back on that 25 or on that 12 of family violence homicides, a surprisingly high proportion of the men did in fact seek mental health support and were in fact seen by public or private mental health providers sometimes very shortly before the tragic event. They struggle to fully recognise what is going on, but tragically, we have this dual problem, which Jackie alluded to, that we sometimes have this overly stereotyped view of what depression looks like, that it is a person who is miserable and flat and just kinds of sits there not doing very much, whereas for many males in particular it presents quite differently, with irritability, anger and hostility. A fair number of the cases I have seen have essentially been what you would call—the language is not good—kind of failed murder-suicides where the killing has been followed by a very serious suicide attempt. This is a huge issue about male help seeking, and that really cuts across both primary and secondary prevention levels.

Jacqueline RAKOV: I think it also cuts across multiple domains that are beyond just violence. Having spoken to, say, terrorism experts and how right-wing extremism in particular is becoming very burdensome to the government, we do not know what the intervention is. Again, especially as psychiatrists, we do not have a framework like we do for sexual offending. So if we do not know how to name something, how can we capture the data on it? If people do not know how to identify something, how can they admit to experiencing that? And that is why I guess the primary prevention really needs to be even earlier in the formative adolescent stages about how to socialise and how feeling good and feeling bad are different and really paring it back. It does not have to be that sophisticated, but if you can turn the ship one degree, in two decades time you will be in a very different place.

Chris COUZENS: Okay. What opportunities are there to enhance collaboration between psychiatrists, GPs and services for people using family violence?

Manjula O'CONNOR: Currently we do not have any clear pathway. It would be useful to set up a combined taskforce, like we do have a family violence psychiatry network. That would be a great idea, to have a network of GPs and psychiatrists working together on this issue. We do work with the GPs on doing research and surveys, which we are doing currently around knowledge and attitudes among psychiatrists around family violence, and the one we did about eight years ago was showing that people are not getting more than 2 hours—most people are not getting even 2 hours of training. We are repeating that survey, and we are hoping that that has improved a lot in the last 10 years. We have worked very hard at the college to create educational programs. But to your point, that would be a great step forward to work with GPs around perpetration of violence, because GPs are the first people who will come across these men who are alcoholics, who have suddenly lost a job or who have ongoing complaints about their family life. Perpetrators often use terms like 'family conflict' and being 'nagged', and those kinds of terms really need to give the GPs alarm bells that something is happening. I was actually invited to write an expert report for a New South Wales court where the GP had seen this man over a period of time and there were clear warning signals. He was referred to a psychologist but he never took any counselling, then he became more and more paranoid, was not picked up, killed his wife, killed himself—that is the pathway which can be interrupted by working more closely with the general practitioners. I think Professor Kelsey Hegarty has done some research but not actual clinical work, and it will be a great opportunity.

Andrew CARROLL: The other potential avenue which is quite new is that the Royal College of Psychiatrists has either recently launched or is about to launch a diploma in mental health for general practitioners. I think Manjula will know more about this than me, but I would think that that has got a module or some element of training in mental health issues related to family violence. I would certainly hope that it does, but at the very least it provides an avenue for collaboration between our profession and the general practice profession.

Manjula O'CONNOR: I will definitely look at that, thanks. I was not aware.

Jacqueline RAKOV: There also might be an opportunity for a professional practice guideline to be put out by the college. We have done that before for, say, firearms risk assessments or many others. I am not in that network, but it maybe something worth addressing—that it is accessible to GPs in a language that they know of.

Manjula O'CONNOR: Definitely.

Chris COUZENS: Thank you.

The CHAIR: Thank you, Chris. Chris.

Chris CREWTHER: Thank you very much, Chair. Firstly, thank you very much, all, for your evidence and your time today. My question is for Professor Manjula O'Connor. In your submission to the Royal Commission into Victoria's Mental Health System you note that you led the public dowry abuse campaign in Australia which resulted in the inclusion of laws against dowry abuse in the Victorian *Family Violence Protection Act* in 2019. Firstly, congratulations on that; that shows what can be done when you look at the intersections of family violence and mental health. As reflected in your statement today as well, you have noted that family violence is commonly associated with mental health disorders such as PTSD, major depressive illness, anxiety disorders, suicidal behaviours and so on. Noting this, I have got a few small questions.

Firstly, generally do you think that services like Orange Door are sufficiently covering off mental health with respect to the intersection of family violence and with respect to tackling family violence? And what specifically do you think that they can improve on?

Manjula O'CONNOR: Orange Door is very much a mainstream organisation. Those intersectional aspects of family violence are supposed to be covered, but we do not believe they are being adequately covered. Those referral pathways are lacking. We only have one multicultural centre providing service for Victoria, inTouch multicultural centre. Where do these people go? They are mostly being handled by people at Orange Door. I see personally a lot of unsatisfactory responses from users of that service. Those who are coming from CALD communities do not get understood, their issues are not well—there is not a connection between the worker and the client in front of them. We do believe that Orange Door needs to be resourced a lot better than it is currently.

Chris CREWTHER: Thank you. Do you think the L17 forms need to better cover off on mental health, along with general data collection around family violence, as you have noted?

Manjula O'CONNOR: I did not quite catch that question. Are we talking about L17 forms?

Chris CREWTHER: L17 forms—do you think that they need to better cover off on mental health?

Manjula O'CONNOR: That is one of the big things. There is a rich data source sitting there, but we cannot use it for CALD communities, because we do not know how many of these people belong to which community—because multicultural communities are not the same. They are all diverse. If we want to target something for people coming from the African community, it is going to be different for something for someone from the Middle East or for someone from the South Asian community. We have no idea how many of these groups are represented in those datasets, so we really, really request you guys to please make a recommendation for the L17 to record ethnicity, language spoken at home and years in Australia.

Chris CREWTHER: That actually links in to my third question. Just now and also in your opening statement you mentioned the need to include ethnicity, language spoken at home, years in Australia and so forth. You may have been here for my question to the previous witness reflecting concerns around collecting

data on groups of perpetrators that may face further stigma versus the need to collect it, as you have noted, to potentially help with targeted interventions and knowing what the issues are. Do you have any comments on the statements of the previous witness, but also your views in that regard?

Manjula O'CONNOR: Around the stigma and shame and not getting –

Chris CREWTHER: And the risk, I guess, with public data that various groups may be stigmatised or stereotypes may be pushed or data may be misutilised. There is a bit of a concern there, versus the question I asked of the previous witness: that concern versus the opportunity, if you have that data, to actually target interventions and so on.

Manjula O'CONNOR: That is a real risk, isn't it, really? Every time you speak about these issues you collect data that can be used by people for their own purposes to attack the migrant communities. But I think if you are publishing the whole data, like, 'This is mainstream, this is this community and this is this community,' it would be very visible to everyone that family violence is occurring across the board. It is not just one community versus another. So it is a matter of presenting it in a way that does not highlight or name and shame a particular community.

But I do think that we also need data around dowry abuse and financial abuse. We know financial abuse is occurring across all aspects of family violence and it is such a powerful way to disempower a victim, through economic abuse. Then to demand more cash and gold and other stuff when they are a temporary migrant on a temporary visa, it is such an amazingly rich ground for the perpetrators to use to abuse that situation. So we do need to know all this data, actually, as to how many. Although Home Affairs does have data on people around temporary visas, it is again so confidential that nobody knows what is going on, really. The silos of data collection are making it very hard to know how much resource you should be putting in which area.

Chris CREWTHER: Do I have time for one more?

The CHAIR: You do.

Chris CREWTHER: Great. Do you think more needs to be done with the migrant absorption and education of new migrants phase, particularly where migrants have come from communities or countries where there is quite a difference in culture compared with Australia and there may be different attitudes around, say, treatment of women and so forth? Do you think a lot more needs to be done in that space, and in terms of data on entry of new migrants as well?

Manjula O'CONNOR: I think that the best place to do this is when migrants have been in the country for six months. They ought to be given all the education around the laws of the country and to know, because no migrant wants to be on the wrong side of the law. They know that this is against the law—that there are certain things that you cannot do or you can do and where to get help—and have some idea about how it can represent.

We actually have programs that my charity has created, and we have been asking the home affairs and settlement services to have a look at this but there seems to be reluctance. I do not know what it is; I have not been able to understand from home affairs why—maybe for the reasons you mentioned before, stigma and shame around the migrant communities feeling targeted. But if this was offered to every single migrant coming in—because even migrants coming in from high-income countries which are non-English speaking countries may not know the gender-based violence laws.

I think that education of migrants as they enter the country is just so important. They are being given a link to the DSS right now; nobody ever looks at it. There is no need. You know, they are getting married, they are so happy, they are going to live in Australia, they are in la-la land. You do not want to look at and think of domestic violence at that point. So we think that we need a little bit more resources and effort going into creating more knowledge and information. We already have a platform like the English classes. It is not that hard; you just go in there and do some work with the English teachers.

Chris CREWTHER: Thank you, Professor.

The CHAIR: Thank you. I have got one more question, and then I think Cindy has a few as well. What data can health practitioners share about patients' health records in regard to family violence while still complying with Victorian privacy and health records legislation?

Manjula O'CONNOR: Do you want to take that, as the deputy chief psychiatrist?

Andrew CARROLL: Look, I am very much not here in my deputy chief psychiatrist role. I am here in a college role. I think we will take that question on notice, if that is acceptable?

The CHAIR: That is fine. I do have a follow-up, which you may also like to take on notice. Does privacy and health records legislation require reviewing to provide the Victorian Government and researchers with greater access to deidentified data, with consent, for analysis?

Andrew CARROLL: Again, I think we will take that notice. That is quite detailed and obviously cuts across a few different discourses, but that is a useful question.

Manjula O'CONNOR: Andy is talking about the public system here, whereas we also have a very strong private system of which I am a member—and you are too, Jackie. In our system we do not share any information. We are not under the family violence information-sharing scheme. Private psychiatrists do not come under that.

The CHAIR: Are there different requirements under each system as to what you can and cannot share in relation to family violence?

Manjula O'CONNOR: If the lawyers ask us—they subpoena my notes all the time—I have to give it to them. And if I am asked to write a report for a patient for family law or an intervention order or something, I do provide all the information, but it is a case-by-case basis. We do not have a particular rule or law.

The CHAIR: Perhaps in your response you could also explain some of those differences between the private and the public systems when it comes to patients' health records in regard to family violence and what can and cannot be shared and some examples of when records can be shared and when they cannot be shared?

Andrew CARROLL: Yes.

The CHAIR: Thank you.

Manjula O'CONNOR: I think as far as I know, in the private system if we get permission from the patient, then we can share. But we need their permission. There is no overall ruling.

The CHAIR: Great. Thank you. Cindy.

Cindy McLEISH: I want to just touch again on the shame and stigma—about where that starts for somebody. Is it something that at primary school teachers can be quite aware of? They have got different counsellors and support staff there that start to realise that somebody is heading down that path where they feel that a kid is stigmatised or has shame about something? Is it something that schools can kind of pick up on?

Andrew CARROLL: It goes back even beyond that—not just the teachers picking up early signs. I think some of this is about discourse in the playground. I mean, that is very different now, I suspect, than it was in 1970s England, where I went to primary school. It was a form of insult that was used quite commonly on the playground, to be—choose whatever word you want implying that someone has mental health problems. It would have been the same in Australia, I am sure. That is the root of stigma and shame when it comes to mental health problems when those men are now adults and grown up. Other people would know more about how things are now. I do think there are some positive signs in society now in this regard—but still a long, long way to go. I think Jackie might have some thoughts on that as well.

Jacqueline RAKOV: I work a lot in the psychotherapy space as well. I think it does start very early, often in the experience of how people are parented, so not just the genetic predispositions to negative or antisocial attitudes. It is on public record that I treated a young man who grew up in a very homophobic environment. As a result, he felt compelled to go onto the internet to find out what was going on for him and found himself interacting with very unsavoury characters, and it led to him being involved in the criminal justice system. Had

he been in a warm and supportive environment that, I guess, encouraged curiosity and support, that could have been diverted. It really starts early. He had internalised shame that was confirmed by his father and grandfather to the point where he did not even go to social networks or the playground to discuss anything, just the dark depths of the internet—family.

Manjula O'CONNOR: It is very much a parenting skill to actually instil in your children a sense that, whoever they are, whatever they are, they are okay, they are good and they are acceptable—and to have a consistent message around that in the family so that when school is hard for kids, the kids feel safe enough to share that with their parents. That is really all about how the children are nurtured in the home to feel safe and valued. It is a very sad indictment that there was a recent study that came out, the ACE study; the children maltreatment study of Australia came out late last year, in December, run by University of Queensland. It shows that 40% of Australian children have suffered some form of abuse in their home and that these children go on to suffer all forms of significant mental illness as they grow up. There needs to be a much stronger emphasis around parenting. The interesting part about that is that the federal government has provided Triple P parenting courses free of charge to all the parents of Australia, but do you know what the uptake is?

The CHAIR: No. Next to none?

Manjula O'CONNOR: It is 10% or 15% or something.

Chris COUZENS: They probably do not even know about it.

Cindy McLEISH: Yes. And we see dreadful examples of parenting. As MPs it is something that we would all see and certainly hear about. Following on from that, do you see any patterns in the profiles of those who use family violence, and I am talking in probably a couple of different categories? This is what you mentioned earlier: you have the male–female intimate partner relationship, you have the siblings or the child on the parent, whether that is an adolescent or whether it is a 40-year-old on somebody who is a bit older. Do you see any patterns or profiles and it moving along as people move from maybe being coercive to being a little bit more physical to being more full-on physical?

Manjula O'CONNOR: That is an interesting question.

Cindy McLEISH: There is a lot in that.

Manjula O'CONNOR: It is a very interesting question: what is the journey of the perpetrator, how does it begin and how do they get to the physical violence part of it? I cannot remember any research that does a chronology of a perpetrator's life story of violence from the start, but of course it can be small things. The trouble with things like economic abuse is it is so hard to know where it becomes abuse and where it is normal. If the money is being managed by a joint account, then at what point that perpetrator makes it abusive is hard for the victim to know because she is so used to him controlling the money all the time. It is an interesting question. I can think of a million answers to it, but I cannot formulate it properly.

Andrew CARROLL: The pattern that I think is easy to miss because it is hiding in plain sight is that there are some people with psychotic illnesses that do not respond terribly well to our current treatment models who develop delusions about family members. That is nothing to do with them having a personality problem. It is nothing to do with these other things. It is actually that they have a hard-core mental illness where, for example, they might think that a family member has been replaced by an alien who is then wanting to do something harmful to them. That is a small group, but it is the type of person I see after they have done the worst thing. It is a treatable group. That is the tragic thing about these ones—that with a better service model we could actually treat those. It is just an illness that is not being treated.

Jacqueline RAKOV: I have jotted down the two patterns that I have observed, maybe not necessarily within the individual but in terms of violence: the undiagnosed neurodivergence populations—I think that is becoming a very big and under-addressed problem; we have teenagers currently incarcerated for homicides with autism diagnoses that only arose after the charge—and failures by the mental health system on individuals with serious mental illness when they are lost to follow-up. If someone disengages with treatment, you will often hear a service say, 'Oh, they're lost to follow-up—too hard to manage. We'll just revoke their order.' But really that is the time when someone should be getting more assertive treatment and more education for the

individual and the family or supports or care coordinators, because I think both groups are very amenable to intervention.

Cindy McLEISH: It is hard to measure what you prevent, isn't it?

Manjula O'CONNOR: Exactly right. There are so many levels of it. It is such a complex problem. There are a million facets to it, like wheels within wheels within wheels within wheels, that paralyse the system.

Jacqueline RAKOV: I think we have enough evidence, though, to suggest that we should continue to do that and not abandon the practice because it is hard to do. It is like cardiologists with their aspirin and cholesterol drugs. They do not wait for someone to have the heart attack; they know from, unfortunately, all the other tragedies what they should be doing.

Cindy McLEISH: One of the things I hear often too is about people with mental illness feeling quite good so they do not think they need their medication anymore, and that starts a downward spiral. Do you see that?

Manjula O'CONNOR: Yes, all the time.

Jacqueline RAKOV: Or feeling bad as a result of the unwanted effects of the medication and not wanting to discuss that with the treating clinician and then withdrawing themselves from treatment.

The CHAIR: Thank you, Associate Professor Andrew Carroll, Professor Manjula O'Connor and Dr Jacqueline Rakov, for your evidence today and the time you have taken to provide a submission to the inquiry. We are incredibly grateful for that. I also thank all the witnesses who have given evidence to the Committee today, as well as Hansard, the Committee Secretariat and the security team here.

I declare this hearing adjourned.

Committee adjourned.