



National Centre of Excellence
for Complex Trauma

Productivity Commission Draft Report - Mental Health

Dear Commissioners,

Blue Knot Foundation is sending this short response to the draft report, along with its original submission, as the information in the submission, which we believe is critical, does not appear to have informed the draft report.

In our view the draft report has omitted consideration of the often unidentified and unaddressed underlying causes of a significant proportion of mental distress and diagnosed mental illness i.e. the impacts of past and present trauma. In Blue Knot's original submission, we documented the prevalence and stakes of unresolved trauma in impacting the capacity of people to reach their potential in life, have purpose and meaning, and contribute to the lives of others.

While reform area 1 focusses on screening for social and emotional development and early intervention, the reality is that many children have a lived experience of abuse, neglect, violence or parental/caregiver unresolved trauma. This often causes ongoing mental distress and traumatic stress, the impacts of which, if left unaddressed, often continue into childhood, adolescence and adult life. Key experiences are lack of safety, shame, self-blame, low self-esteem, social isolation, relationship difficulties and poor education and work attainment. Ongoing triggers, physiological trauma responses, and attendant mental distress are often diagnosed and reach the criteria for mental health disorders. People so impacted also often present with substance misuse, suicidality and self-harm but as long as the trauma remains unresolved the 'symptoms and challenging behaviours' will continue. Much of this requires a trauma-informed response as well as trauma specific treatments, contingent upon adequate trauma screening.

Reform area 2 – closing critical gaps in health care

A critical gap in health care remains screening for past and current trauma. Through screening it can be identified as the first step towards it being appropriately addressed. If prior trauma isn't addressed the revolving door of unresolved trauma and intergenerational cycles of trauma will continue unabated with many people carrying multiple comorbid diagnoses, none of which holistically encapsulate the person's lived experience or address their traumatic stress and its mental health expressions.

As per page 6 of your report, clinical services often do overlook the traumatic determinants and antecedents of mental distress and illness and fail to address them, as do other critical support services. Many survivors of complex trauma struggle to find services commensurate with their needs, due to a lack of understanding around the aetiology of their distress, and lack of training in trauma-informed and trauma specific services. In fact, many people are retraumatised within the mental health system, because of a lack of information and understanding around their trauma, and traumatising practices e.g. seclusion, and chemical and physical restraint.

president

Dr Cathy Kezelman AM

patron

Thomas Keneally AO

ABN 49 072 260 005

ambassadors

Jane Caro

Rose Parker

Christine Foster

Detective Chief Inspector Peter Fox

blue knot helpline 1300 657 380

education & training

information & resources

advocacy & health promotion

other services

contact

T 02 8920 3611

E admin@blueknot.org.au

W blueknot.org.au

PO Box 597 Milsons Point NSW 1565

The stigma and discrimination experienced by people with mental ill-health and distress as a result of trauma is exacerbated by the stigma and discrimination of trauma survivors, including victim blaming. Trauma survivors are often reluctant to seek help due to histories of betrayal, lack of safety, shame and stigma and a failure of services to respond to their needs. Frequent retraumatisation means that many survivors experience chronic failures in treatment and supportive responses, exacerbating their mental distress, and contribution to their sense of hopelessness.

As regards the areas of focus for the Commission's recommended reforms p.7, trauma screening, identification and appropriate addressing including in intergenerational cycles is a way of intervening in cycles of mental illness and suicidality. The experiences of consumers and carers can only occur with empathy and understanding, and this means asking themselves the question 'what happened to you to have affected you so profoundly'? A system which never or rarely asks 'why' is dismissive of people with lived experience, and their carers, and exacerbates treatment failures. People with a lived experience of trauma benefit from multiple systems and services, related both to their trauma as well as its attendant mental health presentations. People will not reach their near potential unless core issues of low self-worth and shame are addressed, as well as the impacts of deprivation, poverty and compounded disadvantage.

In terms of the costs of unresolved trauma and attendant mental health impacts please see accompanying submission.

1. Early help for people

Early intervention means working with parents and prospective parents to address cycles of trauma and unresolved trauma. It is important to consider risks in the context of the realities of abuse, neglect and violence – prevention and their impacts across the life span on mental health, without the right interventions and support. One of the key risk factors is parental unresolved trauma and another is the lived experience of trauma, abuse and violence commonly experienced in the home – there is a social and emotional developmental lived reality.

A campaign which reduced stigma related to mental illness is critical – so too is one focussed on reducing stigma around abuse, neglect and violence and the double stigma for people who additionally are diagnosed with a mental illness. People with a lived experience of trauma have a substantially increased risk of suicide – suicide prevention must include steps to work with people's lived experience of adversity and address them proactively.

2. Improving people's experience of mental health care

The approach to care, skills and training are critical – and should be person-centred, trauma-informed and recovery-oriented to optimise people's experience of services. This is a workforce development and capacity issue and needs to be addressed to minimise retraumatisation and enhance mental health outcomes. Experience of mental health care depends on people receiving the right treatment at the right time and this necessitates systems change to incorporate safe compassionate mental health environments which optimise possibilities for recovery and healing. Many of the service gaps are in expertise and include the need for trauma training of GPs, allied health, psychiatrists as well as geographical access and equity issues.

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In terms of complex needs, many people are living with diagnosed mental illness which has arisen in the context of complex trauma and adversity. Complex mental and social health needs cannot be addressed in a vacuum, but must be considered, in the context of their aetiology as well.

3. Improving people's experience of services beyond the health system

Psychosocial disability is a significant issue for people with a lived experience of trauma. Healing and recovery are very dependent on a range of diverse supports. People with complex trauma histories often have complex needs which cross multiple

We are keen to meet with the Commission to discuss the issues presented in both our submission and this short response to the draft report.

I look forward to your reply,

Dr. Cathy Kezelman AM

President Blue Knot Foundation

www.blueknot.org.au

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