IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	Court Reference: COR 2019 005247

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Cody Morrella Watson
Date of birth:	17 August 2000
Date of death:	25 or 26 September 2019
Cause of death:	1(a) Hanging
Place of death:	13 Teresa Street, Greensborough, Victoria
Key words:	Mental health, child sexual abuse and assault, best practice, trauma informed care, suicide

INTRODUCTION

1. On 26 September 2019, Cody Morrella Watson was 19 years old when she was found in circumstances indicating she had taken her own life. At the time, Cody lived in Greensborough with her mother and stepsiblings.

2. Cody was born in Melbourne and grew up in Wonthaggi, raised by her mother. They later settled in Greensborough. Sadly, during her childhood Cody was exposed to ongoing family violence and was sexually abused by a close family member, which she did not reveal until her teenage years.

3. Cody's mother, Brigette Watson, described her daughter as a quiet and gentle child. She was a good student, had friends, and did not experience bullying at school. Despite the family moving around quite a bit, Cody adapted to her environment and did not appear to experience any issues from the dislocation.

4. Ms Watson identified a turning point in Cody's life at age 15 years. At this time, Cody disclosed the sexual abuse to her mother without going into specific details. Ms Watson stated that after moving to a new school to start afresh, Cody's mental health *"started to spiral downhill"*. Cody began using marijuana and left school after several months. She tried working part-time but her anxiety precluded ongoing employment. Cody's drug use increased, and she began using alcohol.

5. During this period, Cody was diagnosed with borderline personality disorder, anxiety, and depression. This was on top of a previous diagnosis of lupus. Her mental health history included several instances of self-harm and at least one suicide attempt.

6. In about July 2019, Cody's long-term relationship with her boyfriend ended, which further impacted her mental health.

THE CORONIAL INVESTIGATION

7. Cody's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Cody's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into Cody's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

12. On 26 September 2019, Cody Morrella Watson, born 17 August 2000, was visually identified by her mother, Brigitte Watson, who signed a formal Statement of Identification to this effect.

13. Identity is not in dispute and requires no further investigation.

Medical cause of death

14. Professor Noel Woodford, Professor of Forensic Medicine and Director of the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection of Cody's body in the mortuary on 27 September 2019 and provided a written report of his findings dated 3 October 2019.

15. The post-mortem examination revealed findings consistent with the reported circumstances.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

16. Routine toxicological analysis of post-mortem samples detected venlafaxine[2] and its metabolite at a level consistent with therapeutic use, ethanol (0.12 g/100mL),[3] and cannabis.[4]

17. Professor Woodford provided an opinion that the medical cause of death was *"1(a) Hanging"*.

18. I accept Dr Professor Woodford's opinion.

Circumstances in which the death occurred

19. On 25 September 2019, Cody had an appointment with Headspace which she attended reluctantly. Cody later told her mother that the session had been good, and they talked about strategies to help her with her recent breakup.

20. At about 10.00pm that evening, Cody chatted with her mother before going to the rear shed, which she used as a hangout. At midnight, Ms Watson sent Cody a message to say she was going to bed, but Cody did not reply.

21. At about 7.00am the next morning, 26 September 2019, Ms Watson looked for Cody but could not find her in the house. She subsequently found Cody unresponsive in the shed. Cody had used a rope to hang herself from the roof beam. Ms Watson contacted emergency services and cut Cody down.

22. Responding Ambulance Victoria paramedics attended a short time later and subsequently verified Cody's death. Responding Victoria Police members found drug paraphernalia and cannabis in the shed. They did not find a suicide note nor any evidence of Cody's intentions in her diary or mobile phone.

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[2] Venlafaxine is indicated for the treatment of depression.
[3] A blood alcohol content over 0.15 g/100mL can cause considerable depression of the central nervous system affecting cognition and capable of producing adverse behavioural changes.
[4] Delta-9-tetrahydrocannabinol is the active form of cannabis. Persons under the influence of cannabis will experience impaired cognition (reasoning and thought), poor vigilance, and impaired reaction times and coordination.

CORONERS PREVENTION UNIT

23. As noted above, Cody had exposure to family violence and was sexually abused during her childhood. As part of my investigation, I obtained advice from the Coroners Prevention Unit (**CPU**) about Cody's mental health history and the treatment she received.[5]

24. According to the medical records of Laurimar Medical Practice, in April 2016, Cody consulted with her general practitioner (**GP**), Dr Sachin Patel, and reported she had been raped outside Crown Casino. She was concerned about pregnancy and sexually transmitted diseases but when encouraged by Dr Patel to report the rape to police she said the perpetrator was a gang member and she did not feel safe to do so. All appropriate investigations and treatments were completed, and Dr Patel asked Cody to return for review which she did not. When repeated attempts by the practice to get Cody to return failed, and they posted her information about sexual violence services. Cody appears to have experienced an increase in severity of anxiety and further deterioration in functioning from this time.

25. Cody subsequently saw her GP and a general practice mental health plan (**GPMHCP**) was developed for her which included the services of a psychologist in Banyule. Cody found school very difficult at this time, describing crippling anxiety affecting her ability to sleep, eat, and function.

26. Cody often saw the GPs with her mother, and in April 2017, she asked for an antidepressant which was prescribed for her with extensive education about its use.

27. By June 2018, following what was a temporary relationship breakdown with her boyfriend, Cody disclosed to her GP that she had increased anxiety and decreased mood, did not take the antidepressant, and was self-medicating with cannabis. She was advised to restart the antidepressant, see her psychologist, and to return for review.

28. When Cody returned in July 2018, she was still experiencing a lowered mood and said she had stopped the antidepressant after two weeks. Again, she was advised to restart it, continue to take it and return for review.

29. In February 2019 Cody told her GP she was living with her boyfriend in a shared flat which she found stressful and that she had again only taken the antidepressant for a short time. Cody

[5] The Coroners Prevention Unit is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

was given further education about the need to continue taking an antidepressant to achieve a therapeutic effect.

30. Cody was engaged with Headspace in Greensborough and saw Headspace clinician Georgia Einfield. She had several presentations to the Austin Health emergency department under section 351 of *Mental Health Act 2014* (Vic) following episodes of aggression and verbal abuse toward her family and boyfriend, including contingent threats to self-harm whilst intoxicated. This coincided with an intervention order specifying Cody could remain at home if not drug affected, violent, or physically threatening. Cody had some episodes of cutting and two significant suicide attempts, jumping from her mother's car in October 2017, and an overdose 2018, in the context of intoxication.[6] Her last presentation to Austin Hospital was August 2019.[7]

31. A referral was made to the Austin Health Youth Engagement Treatment Team Initiative (**YETTI**) because Cody presented with psychological issues that did not require tertiary mental health services but required a greater response than was usual in the primary care setting, as is Headspace.

32. Following a Headspace/YETTI assessment, Cody engaged with YETTI clinician Kristina Seifertova on 5 July 2019 and attended some appointments. When clinician Seifertova took leave Cody was transferred to clinician Sarah Franke. Cody had a good relationship with clinician Franke and asked her to continue as her case worker. The focus of treatment was mitigation of risk, strategies for managing her symptoms, safety planning, and engagement with addiction services. Referral had been made to Youth Support and Advocacy Service (**YSAS**) addiction services, and a planned appointment made with clinician Fiona McLeod-Watson. Both YETTI clinicians had regular and extensive contact with Cody's mother and completed regular team clinical reviews with consultant psychiatrist Dr Lee Allen.

33. On 16 August 2019 Cody was reviewed by Dr Lee. She reported a six-month history of decreased mood, increased panic, feelings of guilt, regret, worthlessness, negative self-image, and that she felt she was a burden. She admitted to drinking a bottle of wine a day to help her sleep as it helped stop her nightly ruminations. Cody said that the antidepressant venlafaxine (sustained release 75mgs) a day was helpful after she had been compliant for about four

[6] Austin Health medical records page 109 and Laurimar Medical Practice records.
[7] Austin Health medical records page 119, 142.

months.[8] Cody did not report having any current suicidal thinking and the plan was for her continued engagement with YETTI and YSAS.

34. On 23 August 2019 Cody told clinicians that she and her boyfriend had taken a break, but her plan was to get better and live with him again. However, she reported an increase in feelings of guilt, anger, and panic. She was ambivalent about the relationship saying it was better at home because he was not there, with less fighting and arguments.[9]

35. According to the medical records, Cody reported she was at risk of (or actually) homeless on and off throughout 2018 to 2019, that she mostly couch-surfed, lived with her father in Kinglake[10] for a brief time, and that more recently she and her boyfriend had been living in the lounge room of the family home.[11] During this time Cody reported alcohol dependence and abuse, and the use of up to 1.0 gram of cannabis daily. In August 2019, she reported that she was going to be kicked out of home because of her drug use and associated behaviours. The services offered to assist Cody to secure accommodation, but she resisted, preferring when able to stay with her family when possible.

36. On 18 September 2019, Cody told GP Dr Wengtak Poon that she had been compliant with the antidepressant and her mood had improved. Cody stated she was doing a course in the city, was seeing Headspace but continued to have trouble sleeping.

37. The formal handover from clinician Seifertova to clinician Franke occurred on 25 September 2019. The medical records entry is retrospective and noted:

> *"Monitor mental state and risk on a weekly basis Crisis safety plan. Daily routine work. Distress tolerance. Anxiety, motivation and mood coping mechanisms. Social skills due to difficulty speaking to new people. Exploration of sense of self and other. Organise tour of Fitzroy Resi, Gertrude st, detox admission. Ongoing contact with mother Brigitte. Ongoing contact with Fiona AOD worker. Explore willingness to engage with NCASA*."[12]

38. Clinician Franke noted Cody reported *"something bad happened"* at her dealer's house a few days prior but she did not want to discuss it. Cody was confused and distressed by her recent contact with her former boyfriend who told her he was not her friend the previous evening.

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[8] It is unclear which medical practitioner changed her antidepressant from fluoxetine to venlafaxine.
[9] Austin Health medical records page 107.
[10] Austin Health medical record page 11.
[11] Austin Health medical records page 117, 213.
[12] Austin Health medical records page 99.

Strategies were discussed about how best to manage what appeared to be ongoing and frequent contact with him. Cody was rated as low risk for self-harm but at chronic risk of suicide.

Support provided by Laurimar Medical Practice, Austin Health, and Headspace

39. The CPU noted that Cody consulted with several GPs at Laurimar Medical Practice and concluded that there appears to have been good communication between them, a continuum of treatment, and good engagement with Cody's mother.

40. Similarly, the CPU advised that the care provided by Austin Health YETTI and Headspace support that management was appropriate in the context of the focus of treatment. As noted by clinicians Seifertova and Franke, treatment was primarily focused on containment of risk, safety planning, exploration of coping strategies, and linking Cody with addictions services. Cody was contacted at least weekly and, if she responded, was seen face to face at least weekly. There was also good engagement with and support of Cody's mother who was contacted by practitioners and supported when Cody did not attend appointments or did not respond to attempts to contact her. There was evidence of regular multidisciplinary team and psychiatrist reviews.

41. The CPU concluded by noting that it would have been reasonable for increased communication with the Laurimar Medical Practice by YETTI and Headspace given Cody's frequent contact but there is no suggestion that this would not have prevented her death.

The impact of Childhood Sexual Abuse

42. According to Ms Watson, Cody had been exposed to repeated family violence from a young age and was sexually abused by a family member. When Cody was 15 years old and during a sex education class at school, she became very distressed by memories of what had happened and disclosed to her mother. Further incidents reported by Cody were a rape in 2016 and an incident involving her dealer a couple of weeks before her death about which she would not elaborate.

43. Cody's descriptions of her symptoms as recorded by practitioners are reflective of the symptoms listed by sexual assault and trauma services, including low self-worth, passive suicidal ideation, low mood, shame, guilt, tearfulness, daily panic attacks, negative rumination, flashbacks, nightmares, sleep disturbance, anger management difficulties, poor emotional regulation, anxiety, being in 'crisis mode', interpersonal and relationship difficulties, feeling emotionally numb, chronic feelings of isolation and despair, re-

experiencing abusive patterns in adult relationships, and intense shame and fear of speaking about the sexual assault because it may impact on important relationships.

44. Contemporary mental health practitioners work within the trauma informed principles, but this did not appear to result in any willingness to address the actual trauma experienced by Cody. The medical records and statements do not include exploration of Cody's trauma experience from her childhood experience of family violence, childhood, and adolescent sexual assault as Cody found it difficult to open up and talk about it all and was fearful of exploring the issue.

Identified themes in similar coronial investigations

45. The CPU advised that there is a repeated theme across the deaths of a cohort of teenage and adolescent women who had been achieving at school, had substantial friendship circles with recreational and social activities, and usually supportive family networks who, after disclosing child sexual abuse (**CSA**), develop increased risk behaviours, commence substance use, and experience irreparable breakdown in social and friendship groups.

46. This cohort have a higher likelihood of homelessness, coexisting mental health and substance use disorders within a few years of disclosure, with most attracting diagnoses of complex trauma and eventually a borderline personality disorder. They are seen by many primary health services, progressing to specialist or tertiary mental health services, eventually having presentations to emergency departments in the context of intoxication and crises. They are usually referred to private psychology services and families encouraged to provide support. Their treatments are most often with an antidepressant, low dose antipsychotics, and a focus on containment of risk, safety planning, and learning coping strategies. Addressing the trauma itself is rarely a treatment offered.

47. Families are often overwhelmed and affected by the risk behaviours including abuse and aggression, usually when the person is substance affected, and are burdened by the ongoing difficulty of trying to rescue their family member, while also protecting themselves.

48. Cody's history reflects this experience. Her timeline of disengagement with school, conflict with her family, loss of friendship groups, onset of intense anxiety, increase in risky behaviours, and use of substances occurred at the age of 15 after she disclosed the sexual abuse to her mother. Thereafter, Cody became increasingly vulnerable because of her risky behaviours and the experience of being re-traumatised. After the rape disclosed in 2016, Cody

experienced further decompensation and escalation in her behaviours and substance use, and again after the incident involving her dealer proximate to her death.

49. The containment of risk, teaching coping strategies, safety planning, and prescribing of an antidepressant for a diagnosed mood disorder is appropriate. However, it does not address what was likely the nexus of Cody's experience of trauma and associated distress and emotional dysregulation.

50. Specialist services such as a Centre Against Sexual Assault (**CASA**) provide services that accommodate the recognised difficulties for survivors in articulating their experience in the context of the trauma this is likely to generate, are sensitive to a survivor's window of tolerance, and offer safer non-verbal therapies such as art therapy and physiotherapy body work. These therapies are expensive to run, as is longer term cognitive behaviour therapy which a GPMHCP will not provide enough sessions and will usually attract a gap payment these women cannot afford.

51. In addition, for this cohort of young women there are the added issues associated with adolescence, perceptions of peer pressure, fear of loss, and a more likely response of self-recrimination. For example, many survivors find such interventions as mindfulness, breathing, or yoga as triggering because all require a focus on the body yet according to medical records, it is frequently what private practitioners encourage a survivor to do. CASAs have limited funding and prioritises survivors with recent experiences of sexual assault and there is a waitlist for assessment.

52. It is unclear if it is reasonable to expect a primary care and/or tertiary mental health service to provide therapies within a trauma informed framework. For this reason, and to assist my understanding of Cody's experience and what best practice treatment would have looked like, what are appropriate evidence-based therapies, and whether these are accessible in treatment primary care, private psychologists, and tertiary services:

    (a) I invited the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) Victorian Branch to provide a submission; and

    (b) I obtained an expert report from Dr Helen Kambouridis, Counselling Psychologist, Gatehouse Centre, The Royal Children's Hospital.

53. I asked both Dr Kambouridis and the RANZCP specific questions about the delivery of care to young adults who recently disclosed childhood sexual abuse. These included best practice,

specialist training requirements, risks associated with providing therapy, the timing of therapy, risks in delay of access to therapy, the service system for delivery of therapies including barriers and gaps, and how access can be improved.

54. Both submissions provided evidence of discipline alignment including psychology and psychiatry. This is reflected in the terminology used and the focus of the details of possible system changes.

Best practice in providing therapies and care

55. Dr Kambouridis and the RANZCP identified trauma focused and informed practice[13] and therapies.[14] This includes Trauma Focused Cognitive Behavioural Therapy (**TF-CBT**), which according to Dr Kambouridis is one of the more robust evidence-based treatments for CSA,[15] and trauma-informed care and practice (**TICP**). RANZCP described this as an approach which recognises and acknowledges trauma and its prevalence, alongside awareness and sensitivity to its dynamics, in all aspects of service delivery, with emerging evidence TICP can help to decrease psychiatric symptoms and substance abuse and improve daily functioning.[16]

56. Dr Kambouridis noted the importance of the engagement and involvement of family and carers to support the client/patient through treatment.[17] Engagement assists families and carers to understand the experience of their child and in the support of such treatment has also been found to increase the likelihood of positive outcomes from treatment.[18] In addition, the evidence suggests that Family Therapy can reduce the risk of further related psychopathology.[19]

57. RANZCP focused on psychotherapy,[20] and noted best practice in psychotherapeutic treatments to include careful diagnostic assessment reaching an understanding of the impact

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[13] The 10 Principles of trauma informed practice included in Dr Kambouridis's submission are: provide a safe place for the client; ensure client empowerment and collaboration; communicate and sustain hope and respect; facilitate disclosure without overwhelming the client; be familiar with a number of different therapeutic tools and models; view symptoms as adaptations; have a broad knowledge of trauma theory and provide the client with psycho-education; teach clients adaptive coping strategies; teach clients to monitor their thoughts and responses and teach clients interpersonal and assertiveness skills.
[14] Trauma Focused Cognitive Behavioural Therapy (TF-CBT); Trauma-informed care and practice (TICP).
[15] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 2.
[16] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 3.
[17] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 2.
[18] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 2.
[19] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 2.
[20] A psychotherapeutic approach to best practice psychiatry involves the psychiatrist engaging with the patient, meeting them where they are emotionally and psychologically, in developing an understanding together of what has brought the patient to seek help. Psychotherapy is the healing of a patient by establishing a therapeutic relationship with a clinician who can guide them through understanding patterns of responding (thoughts, feelings, behaviours) in their lives leading to helpful changes in thoughts, feelings, attitudes, behaviours, relationships and / or personality. Faculty of Psychotherapy

of adverse childhood experiences on the emotional and personality development of the patient concerned is essential. This understanding needs to be reached before definitive discussion about a recommended treatment approach can occur. A supportive, empathic attitude, validating distress, is needed throughout the process in all cases.[21]

58. In addition, the RANZCP stated best practice includes a careful history of trauma, current risks and safety, and awareness that recent disclosure of CSA can increase risk of self-harm, including suicidal behaviour, when a patient has been threatened with punishment, and that interventions for current risks is always necessary.[22]

59. The RANZCP noted that CSA and developmental trauma may need different psychotherapies across a lifespan, including different modalities of psychotherapy and in keeping with their capacities and needs at those times,[23] and noted that psychiatric diagnoses including borderline personality disorder and complex post-traumatic stress disorder are often present in patients referred to psychiatrists for treatments relating to CSA and development traumas, usually have greater risks,[24] and require specialised and validated treatments.[25]

60. Dr Kambouridis also identified group therapy (useful for adolescents); Eye Movement Desensitisation and Reprocessing therapy (**EMDR**); Child and Family Traumatic Stress Intervention (**CFTSI**), Play Therapy,[26] Animal Assisted Therapy, and the emerging awareness of third wave therapies including body-based therapies and somatic psychotherapies, and creative arts therapies.

61. Dr Kambouridis and the RANZCP submissions included the need for therapies to be adaptive and be the most appropriate to the individual's needs at the time of presentation, that evidence supports treatments specific to CSA and any symptoms have positive and longer-term

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(Victoria) Submission to the Royal Commission into Victoria's Mental Health System 2019. Psychotherapy is a cost-effective intervention with longer term and more intensive psychotherapeutic intervention demonstrating ongoing improvements post treatment cessation. Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 2.

[21] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 2.

[22] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 3.

[23] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 2.

[24] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 2.

[25] Dialectical Behaviour Therapy (DBT), Mentalization-Based Treatment (MBT; Transference-focused Therapy; Scheme-focused Therapy, Cognitive Behavioural Therapy, and Supportive Psychotherapy.

[26] Play Therapy with children who have experienced CSA can lead to significant reductions in distress, anxiety, and post-traumatic symptoms. Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 2.

outcomes,[27] and that interventions that are heavily talk centred or cognitive in nature have greater impact as cognitive abilities increase with age.[28]

62. Dr Kambouridis highlighted that not all survivors of CSA develop post-traumatic stress disorder and studies suggest some children and young people remain asymptomatic. The more comprehensively evidence-based interventions including TF-CBT, EMDR, CFTSI are predominantly focused on reducing and recovering from post-traumatic stress disorder.[29] The benefits of interventions for survivors without post-traumatic stress disorder or symptoms can come from the provision of psychoeducation about the impact of such trauma and the exploration of meaning making from their experience,[30] and that specific treatment modalities may not be of value.

Specialist training

63. Dr Kambouridis and the RANZCP submissions were consistent about the need for specialist training, with the RANZCP being specific to the discipline of psychiatry, and both acknowledged that various credentialled discipline specific practitioners can provide psychotherapies.[31] The RANZCP-trained psychiatrists are trained in the foundations of psychotherapy as part of psychiatry training and this also includes the impacts of trauma on people and its relationship to mental illness, the assessment and management of mental illness and risk.[32] Dr Kambouridis acknowledged that most specialist training programs are focused on adults, with limited information about working with children:

> *"Not only is specialised training required to provide particular therapies, but further training in delivering trauma informed practices, and working with children and young people are also valuable*."[33]

64. Dr Kambouridis noted the common factors of interventions including a therapeutic relationship and the principles of trauma informed practice. She specified that the techniques for delivering interventions such as TF-CBT, EMDR, CFTSI, and family and group therapies, requires specific training. Dr Kambouridis also identified the need for specialist training in

[27] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 2.
[28] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 2.
[29] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 3.
[30] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 4.
[31] Psychologists; occupational therapists; metal health nurses; social workers and specialist general practitioners.
[32] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 4.
[33] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 3.

trauma-informed therapies in the context of a growing acknowledgment and understanding of trauma and its impact.

65. In addition to the RANZCP training program's core skills, including in supportive common-factors and trauma informed practice, psychiatrists are also able to undertake further specialist training. psychotherapy in general psychiatry is standard[34] and requires education about the factors included and their implementation, as are RANZCP Certificates of Advanced Psychiatry, which also enables accredited membership of RANZCP Faculties.[35] The RANZCP Certificates of Advanced Psychiatry include Child and Adolescent Psychiatry and Psychotherapies.

66. The evidence for specialised training needs was further reinforced by the RANZCP:

> *"It is generally understood that patients bring to their treatment, aspects of their developmental and family dynamics (patterns of relating and interacting) to be worked with and through. If mental health professionals do not have adequate understanding of how these developmental dynamics play out, later in life, in therapeutic relationships, this can lead to risks of enactment of trauma, difficulties containing risk, maintaining professional boundaries and the therapeutic frame*."[36]

67. Similarly, Dr Kambourdis advocated for specialist training:

> *Involving young people in decision-making throughout the therapeutic process, being clear and transparent about the process and tailoring communication to their age and developmental stage, any disabilities or neurodivergence with which they may present is critical. It is in this way that clinicians can begin to understand what has happened to their clients and ground their work in trauma informed practice*.[37]
>
> *… Finally, it must be remembered that the chance to reconstruct or reinterpret their trauma is critical for victim/survivors ... and that the power of respectfully witnessing a young person's trauma and their struggle to make sense of that experience, should never be underestimated …*[38]

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[34] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 4.
[35] RANZCP Faculties promote the highest standards in the relevant academic and clinical areas and provide ongoing learning and support for members. Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 4. RANZCP provided additional information including the Fellowship Competency Statements, Guide to psychotherapy training, training requirements for Child and adolescent Psychiatry and Psychotherapies.
[36] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 5.
[37] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, pages 6-7.
[38] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 7.

68. The importance of practitioner supervision (especially during training programs) and/or peer review was repeatedly raised in both submissions.

Risks associated with accessing and providing therapy

69. The submissions from Dr Kambouridis and the RANZCP acknowledged and identified the risks associated with therapies; identified the need for the management of risks and maintenance of a survivor's safety; noted that this will be different for each patient.

70. Dr Kambouridis referred to the findings of the Royal Commission into Institutional Abuse which identified the negative impacts of delayed responses to CSA including that those who delayed telling someone about being sexually abused were more likely to experience mental distress and the deleterious impacts of CSA on mental and physical health, behaviour and relationships.[39] In addition, this may increase without timely intervention. Dr Kambouridis noted that delays in treatment may potentially be perceived by the survivor as evidence that they are not worthy of interventions and support, and which can invalidate survivor experiences.[40] Other complications can arise from delay in accessing treatments,[41] and can result in survivors being stuck in unhelpful patterns of behaviour and relationships.[42]

71. Dr Kambouridis stated that for young adults who experienced CSA when children:

> "*… the extent of confusion they may feel about their experience can remain high as not only did they not understand what was happening at the time, but how to make sense of their experience is likely to change as their brains and bodies mature …*[43]
>
> *Those working with young people/young adults should ideally also understand developmental processes and system dynamics that typically impact young people. Some knowledge of these evidence-based therapies (not necessarily all) would also be reasonable, but as noted above, the often complex and nuanced presentation of young people who have experienced CSA requires a more subtle planning and execution of treatment that may include, but not be wholly restricted to the use of these evidence-based therapies*."[44]

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[39] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 4.
[40] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 5.
[41] Avoidance, dissociative behaviours; social withdrawal; increased maladaptive coping strategies that can be intrenched as the time since the abuse increases.
[42] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 4.
[43] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 3.
[44] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 5.

72. According to Dr Kambouridis the risks associated with therapy that is not trauma informed include a risk of re-traumatisation, escalation of symptoms and the compounding of a survivor's trauma. At the very least survivors may experience shame, blame and judgement, even where the therapist is completely well intentioned.[45]

73. Dr Kambouridis acknowledged the risks for a survivor who engages in therapy specific to CSA, as it can be particularly confronting and frightening; memories can be triggered that activate feelings and reactions so strong that it is as if the abuse is happening all over again.[46] Making assumptions about a survivor's experiences, their meaning-making and the type and course of treatment (even in the application of evidence-based treatments) is something to be avoided.[47]

74. Dr Kambouridis supported collaborative exploring and trauma-informed practice as crucial, the careful pacing of therapy, for a practitioner to meet the patient where they are at, and to interweave psychoeducation that assists them to make sense of their reactions and responses into the process and to build adaptive coping and regulation skills to assist them in managing inevitable ups and downs in their treatment.[48]

75. Both submissions supported that effective treatment benefits outweigh the risks, when supported by a skilled therapeutic approach that includes ongoing monitoring and the management of risk during therapy. The RANZCP noted that research shows that the side effects/adverse treatment reactions are limited, with the efficacy of psychotherapy as a treatment modality outweighing any potential risks.[49] Similarly, Dr Kambouridis noted that there is a general consensus across the treatment review literature that in general, treatment outcomes of CSA is effective with children and young people showing significant symptom reduction following treatment as compared to pre-treatment scores or control groups.[50]

Barriers and gaps in providing best evidence-based therapy

76. The submissions from Dr Kambouridis and RANZCP acknowledged and identified gaps and barriers to survivors accessing effective therapies.

[45] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 4.
[46] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 3.
[47] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 3.
[48] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 3.
[49] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 5.
[50] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 3.

77. Dr Kambouridis identified gaps in knowledge about best-practice in providing services to marginalised groups, including access,[51] and reiterated the importance of family/adult supports for children and young people in accessing and in ongoing therapy:

> *"While therapeutic intervention may be of value, the ongoing support of parents/carers/family for young people cannot be underestimated and nor should be the potential barrier when family support is not available, or even more concerning, when family dynamics interfere with the therapeutic process*."[52]

78. The Royal Commission into Victorian Mental Health Services noted that mental health services needed to be more trauma informed and that services may have themselves been traumatising.[53]

79. Dr Kambouridis recognises that specialist services such as CASA are more well-grounded in trauma informed practice, however, there is evidence that attitudinal and resource barriers exist that interfere with providing evidence-based therapy.[54] [55] Moreover, that although trauma informed practice is becoming more widely available, it is not well established in general mental health services. Dr Kambourdis noted that *warm referrals*[56] to appropriate treatment services for CSA can be made by other professionals and services.[57]

80. According to the RANZCP, an effective response to CSA requires protective, legal, and therapeutic systems to coordinate, and a failure to coordinate may in fact, result in further harm.

81. As already noted, both submissions identified the training and competency of health care practitioners to deliver trauma-informed care is limited, including across public mental health services, and that the demand on public mental health services to provide care in circumstances of CSA disclosure, whether disclosure is delayed or not, presents difficulties.[58]

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[51] Culturally and Linguistically Diverse communities; First Nations communities; LGBTQI+ communities; and refugee and asylum seeker communities.

[52] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 6.

[53] Royal Commission into Victorian Mental Health Services. Recommendation 23: Establish a new Statewide Trauma Service. According to the Mental Health and Wellbeing reform website, the call for consortium funding submissions end date 19 August 2022. A phased codesign is forecast for 2022 – 2024 to design and develop the Statewide Trauma Service's key functions and full service model. Recommendation 24: A new approach to addressing trauma.

[54] Dr Kambouridis refers to information from the Phoenix Australia Centre for Posttraumatic Mental Health

[55] Phoenix Australia Centre for Posttraumatic Mental Health noted that best practice interventions for PTSD are not always used by clinicians, even in CASAs. Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 5.

[56] When the worker discusses the services the other organisation provides with the client, gains client consent to contact the other organisation and makes an appointment for the client.

[57] General practitioners, nurses, Child and Maternal Health Nurses.

[58] The lack of focus on psychotherapy within the public system limits exposure of trainees to the theory and practice of psychotherapy. Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 6.

According to the RANZCP, the physical health needs of patients with complex trauma is often higher and requires a holistic approach and that tertiary level services continued to be ill-equipped in many instances to manage this complexity.[59] Also, mental health services provide opportunities for psychotherapy, but there is little provision of psychotherapy within the public mental health system, with a lack of availability, accessibility and integration of longer courses of psychotherapy modalities that are integrated with attention to the individual's needs. [60]

Suggested improvements

82. According to the RANZCP, the early involvement of child and adolescent psychiatrists in services working with children with trauma[61] is warranted, rather than involvement only when problems are severe, and the child/adolescent is in crisis. More child and adolescent psychiatrists need to be trained to meet the demand for early and more frequent involvement in CSA.

83. An understanding of trauma informed practice should be the minimum expectation of any professional providing therapy to survivors of CSA whether a specialist sexual abuse treatment practitioner and/or Australian Health Practitioner Regulation Agency registered provider of services through Medicare.

84. Currently, access to the Medicare funded psychology services requires a mental health diagnosis and Dr Kambouridis suggested that this could be removed for victim/survivors, reinforcing the perception survivors are worthy of accessing support and suggests this would decrease the stigma associated with seeking treatment.[62]

85. The RANZCP highlighted that training is needed to respond appropriately to community need and that there is also a need for consideration of competencies required in adult psychiatry, child and adolescent psychiatry, and other providers of mental health services.[63] The

[59] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 5. Some services noted to be exceptions, including Spectrum; there is lack of focus on psychotherapy within the public system for trainee psychiatrists that may impact on the skills of the next generation of psychiatrists. Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 6.
[60] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 5. Mental health services are responsible for providing opportunities for psychiatrist and trainees to practice in their field of psychotherapy.
[61] State child protection services, community child and adolescent mental health.
[62] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 6. This was previously raised as an issue for direct family members and caregivers of adult and child survivors.
[63] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 6.

RANZCP noted that because of the expertise of psychiatrists, they should be involved in both training and treatments.[64]

Royal Commission into Victoria's Mental Health Services

86. The need for specialist training is supported by the recommendations of the Royal Commission into Victoria's Mental Health Services:

    (a) Recommendation 23: Establish a new Statewide Trauma Service; and

    (b) Recommendation 24: A new approach to addressing trauma.

87. The following are the aspects of the recommendations that focus on the training of public mental health services for trauma informed care and specialist advice:

    (a) Recommendation 23(2)(b): develop and deliver education and training that supports Victoria's mental health and wellbeing workforce to deliver trauma-informed care;

    (b) Recommendation 23(2)(d): coordinate and facilitate access to specialist trauma expertise, including secondary consultation for mental health practitioners and peer workers across Victoria's mental health and wellbeing system;

    (c) Recommendation 24(1)(b): contribute to the ongoing learning and professional development of the mental health and wellbeing workforce through supervision, consultation and shared clinical care.[65]

88. According to the Mental Health and Wellbeing reform website, a consortium of service providers has been announced to design and deliver the Mental Health Statewide Trauma Service. Each of the 13 providers brings expertise relevant to trauma informed care and support for Victorians. The Department of Health is working with the consortium to develop the foundations of the service, including a workplan to co-design the research, capability uplift, and service delivery functions of the new service.[66]

[64] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 6.
[65] Royal Commission into Victoria's Mental Health System Final Report.
[66] Department of Health, Mental Health Statewide Trauma Service, https://www.health.vic.gov.au/mental-health-wellbeing-reform/mental-health-statewide-trauma-service (viewed 19 January 2023).

89. There is no information about the progress of Recommendation 24 which appears reasonable given the role of the Statewide Trauma Service is to develop and deliver the training to the mental health and wellbeing workforce.[67]

Discussion

90. The thoughtful and comprehensive submissions identified many issues, including the lack of appropriate services offered by much of the public mental health sector specific to trauma informed services or longer-term therapies including psychotherapies.

91. Longer term counselling and treatments are mainly provided in the private or non-government organisation sectors and there is currently no system for ensuring competency outside of the specialist training courses for specific therapies. Nonetheless, the Court's experience suggests this does not always mean the practitioner is relevantly competent or that the training was evidence-based. Practitioner insight into their own capabilities and limitations to provide contemporary evidence-based care relies on a combination of the reflective nature of required clinical/peer supervision, and/or increased knowledge from engaging in continuous professional development for maintaining practitioner registration with the Australian Health Practitioner Regulation Agency. This does not apply to counsellors, social workers, and other psychotherapists although many voluntary professional membership organisations expect and promote engagement in such activities.[68] The need for specialist trauma informed skills when working with victim/survivors of CSA, in particular children, adolescents and young adults is not explicitly articulated across all disciplines, practitioners, and providers. Many workforce roles require supervision and mandatory training as part of employment.

92. Psychotherapy or specialised trauma-informed care relevant to CSA is not frequently or routinely offered in the public mental health sector, and outside of case management there are few examples of longer-term options and/or non-pharmacological therapies. This situation creates a delay which, according to the submissions, can be deleterious and it creates an inequity of access to specialist therapies for CSA for victim/survivors who are of such high risk that therapies cannot be safely delivered in the private/primary care sectors, which appears to have been the case with Cody.

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[67] Department of Health, Recommendation 24 A new approach to addressing trauma, https://www.health.vic.gov.au/mental-health-reform/recommendation-24 (viewed 19 January 2023).
[68] Psychotherapy and Counselling Federation of Australia Register; Australian Association of Social Workers; Australian Counselling Association.

93. There is a lack of specialist care options within public mental health services, and access is most often through referrals to CASAs, fee for service providers,[69] and the Better Access to Mental Health Care Scheme[70] through the Medicare Benefits Schedule through a general practitioner. Most of these options present the victim/survivor with delays in finding appointments and accessing longer-term care as they are currently restricted to 10 sessions a year with a further 10 if required under the COVID-19 response.[71] There is no specific approach such as that provided by Medicare for Eating Disorders.[72] In addition, in circumstances where a gap payment cannot be afforded the likelihood of engagement is reduced.

94. Access to the specialist public mental health services, such as Spectrum, require a diagnosis of a borderline personality disorder and/or complex trauma. This is not appropriate in the early stages of disclosure of CSA and as noted by Dr Kambouridis:

> *"A carefully, nuanced assessment of a survivor's presentation is also important, with consideration given to potential earlier traumas, especially relational/attachment traumas that may be impacting current presentation. If such assessment is not undertaken, a history of confused diagnoses can ensue, leaving survivors feeling damaged and unable to be "fixed", while decisions made about treatment can be misinformed.*"[73]

95. According to Dr Kambouridis, while over the longer term many children, adolescents, and young adults who are or have been managed in the public mental health sector, can then be safely and appropriately access care in the private sector, all would benefit from appropriate engagement for CSA trauma informed assessment and evidence-based therapies or psychotherapy early on, access to which is currently uncertain. Moreover, when working with anyone who has been sexually abused it is important to take a client-centred approach, to consider their strengths, the supports they have around them and to work collaboratively with them no matter their age to develop a plan of intervention tailored to their needs.[74]

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[69] Private treatment programs may be partially covered if with private health insurance. Mental health services can be accessed via private hospitals and private treatment programs and/or a private psychiatrist.

[70] Medicare rebates are available to clients for selected mental health services provided by general practitioners, psychiatrists, psychologists (clinical and registered), eligible social workers, and occupational therapists.

[71] Better Access Initiative – supporting mental health care. www.servicesaustralia.gov.au/better-access-initiative-supporting-mental-health-care. The additional ten COVID-19 sessions ceased on 21 December 2022.

[72] Medicare Eating Disorder Plan is an evidence-based, best practice model of treatment. The plan can include up to 20 Medicare-subsidised sessions with a dietitian and 40 sessions with a mental health clinician over a 12-month period.

[73] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 4.

[74] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 6.

96. While not expecting public mental health services to be the providers of CSA specific care, the experience of this Court is that many victim/survivors who disclose CSA as adolescents and young adults present in crisis to public mental health services with high risks. As characterised by the RANZCP, the care they receive in those circumstances tends to have a focus on episodic, acute, crisis driven interventions, which does not allow for adequate assessment or continuity and integration of care.[75]

97. The focus of treatment by the public mental health services in the months proximate to Cody's death was on mitigation of risk, strategies for managing her symptoms, safety planning, and engagement with addiction services. Although appropriate to her identified needs, treatment options did not include access to evidence-based CSA/trauma informed assessments and therapies.

98. The Royal Commission into Victoria's Mental Health Services identified many issues, gaps, and resourcing deficits with public mental health services which the 65 recommendations are designed to address.[76] Specifically, Recommendation 58: Workforce abilities and professional development includes definition of the knowledge and skills of the mental health and wellbeing workforce. This is an opportunity to review what trauma informed skills and competencies are required of the child and adolescent and young adult services workforce, including working with CSA victim/survivors. There is also an opportunity to review the skills and competencies of the emergency department mental health workforce, psychiatric triage and access team workforces who provide much of the response to crisis contacts and presentations such as Cody's. This includes a response that is safe and appropriate to the needs of a victim/survivor in such circumstances regardless of narrative or age, that aims to involve specialist clinicians including age-appropriate teams and/or psychiatrists, as early as reasonable during the contact(s).

Conclusion

99. The submissions were clear in their agreement that in CSA early intervention has the best outcome; treatment/intervention is effective for children and young people; trauma informed practice is essential; a nuanced and developmental assessment is critical to inform intervention; specialist training is needed for working with children, adolescents, and young

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[75] Statement of Royal Australian and New Zealand College of Psychiatrists dated 6 October 2020, page 6.
[76] Royal Commission into Victoria's Mental Health System Final Report.

adults; and an evidence-based system would include early access to specialist knowledge and skills.

100. Dr Kambouridis noted that:

> *The dynamics that typically create a context in which child sexual abuse can occur – including secrecy, isolation, invalidation, disconnection, manipulation, grooming, minimising, shaming and blaming – should be kept in mind and considered when planning interventions. These dynamics can be countered through development of a therapeutic relationship that privileges openness, transparency, connection, validation, acceptance and understanding and which remains curious, non-judgemental and affirming.*[77]

101. It is unknown if Cody's experience of care was trauma informed or that if specific CSA therapies were offered that Cody would have engaged in them or would have prevented her death. Nonetheless, the review of Cody's death, and especially the expert opinion from Dr Kambouridis and submission from the RANZCP, make it clear there are opportunities to change the services provided to CSA victim/survivors who, for whatever reason and at whichever point of care, engage with public mental health services.

102. The response to the Royal Commission into Victoria's Mental Health Services Recommendations 23 and 24 provide opportunities for this to be considered.

FINDINGS AND CONCLUSION

103. Pursuant to section 67(1) of the Act I make the following findings:

    (a) The identity of the deceased was Cody Morrella Watson, born 17 August 2000.

    (b) The death occurred on 25 or 26 September 2019 at 13 Teresa Street, Greensborough, Victoria.

    (c) The cause of Cody's death was hanging.

    (d) The death occurred in the circumstances described above.

    (e) Having considered all of the evidence, including Cody's mental health history and the lethality of means, I am satisfied that Cody intentionally took her own life;

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[77] Expert opinion of Dr Helen Kambouridis, dated 25 June 2022, page 7.

(f) The support and care provided by Cody's GPs and Austin Health YETTI and Headspace was appropriate and reasonable with treatment primarily focused on containment of risk, safety planning, exploration of coping strategies, and linking Cody with addictions services.

(g) Nevertheless, the available evidence supports a finding that best practice treatment for CSA victims and survivors is CSA trauma informed assessments and therapies, the availability of which is severely limited.

(h) There is clearly a need for expansion of the availability of CSA trauma informed assessments and therapies, which could be addressed by the State government's responses to the recommendations of the Royal Commission into Victoria's Mental Health Services.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

To the **Secretary of the Victorian Department of Health** I recommend:

1. That the consortium of service providers designing and delivering the Mental Health Statewide Trauma Service consider the specific needs of child sexual abuse victim survivors who are receiving care from public mental health services.

2. As part of its planned initiatives responding to recommendations of Royal Commission into Victoria's Mental Health Services, that the Department provides the following development and capabilities to mental health and wellbeing professionals:

   (a) trauma-informed skills and competency;

   (b) education that is specific to the needs of clinicians working with children and adolescents and young adults who have experienced or been exposed to child sexual abuse; and

   (c) education that is specific to the workforce providing the first response (including emergency departments, psychiatric triaged and access teams) to victim/survivors who are in crisis following disclosure or in the context of already disclosed child sexual abuse/trauma.

I convey my sincere condolences to Cody's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Brigitte Watson, senior next of kin

Anthony Morrell, senior next of kin

Laurimar Medical Practice

Headspace, Greensborough

Austin Hospital c/o Austin Health

Professor Euan Wallace, Secretary of the Department of Health

Austin Health

Senior Constable Benjamin Owen, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 23 January 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.