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*to Reduce Violence against Women & their Children*

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Women's Input into a Trauma-informed systems  
model of care in Health settings (the WITH Study):  
*Final report*



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### **Acknowledgement of Country**

ANROWS acknowledges the traditional owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander elders past, present, and future, and we value Aboriginal and Torres Strait Islander history, culture, and knowledge.

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## Women’s Input into a Trauma-informed systems model of care in Health settings (the WITH Study): *Final report*

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# Definitions

## Deliberative dialogue

Deliberative dialogue is a style of facilitated workshop. Through deliberative dialogue, participants explore areas of common ground from which alternatives can develop and action can form. It is a way for people to be able to work their way through different options, weigh pros and cons, explore trade-offs, and perhaps together find new solutions or, at least, common ground for action (Boyko et al., 2014).

## Digital storytelling

A personal story told through digital media, including narrative, images, music, and sounds. Digital stories are typically created in a workshop setting by participants with no professional media training.

## Empowerment counselling

A style of mental health counselling that focuses on empowering patients to take control of their own recovery.

## Extrinsic and intrinsic mechanisms

Internal and external factors that interact with each other.

## Mental health problems

For this project, we used a broad definition of mental health problems, including issues such as anxiety, depression, and post-traumatic stress disorder, as well as serious mental illnesses such as schizophrenia.

## Practitioner-centred service

A service that listens to, and takes into account, the needs of practitioners and is supportive.

## Recovery

Recovery is broadly defined as a state of wellbeing, where a person's humanity is emphasised over their identity as a patient or victim (Ralph, 2000).

## Sexual violence

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, and including but not limited to home and work (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 149).

## Systems model of care

A systems model of care encompasses all levels of an organisation or system.

## Trauma

Trauma occurs when an individual experiences an event (or repeated events) such as sexual assault, physical injury, or the threat of death that they are unable to prevent, stop, or psychologically process (Meszaros, 2010; Reeves, 2015).

## Trauma-informed care

Trauma-informed care seeks to create safety for patients by understanding the effects of trauma, and its close links to health and behaviour (Quadara, 2015).

## Women-centred care

A feminist model of care that has women's individual needs as its central focus.

# Acronyms

ABS	Australian Bureau of Statistics ANROWS
ANROWS	Australia's National Research Organisation for Women's Safety
ACMI	Australian Centre for the Moving Image
CAG	Community advisory group
CASA	Centres Against Sexual Assault
CBPR	Community-based participatory research
CBT	Cognitive behaviour therapy
CMH	Centre for mental health
DHB	District health board
FV	Family violence
MH	Mental health
NAMHS	Northern Area Mental Health Service
NHMRC	National Health and Medical Research Council
NPT	Normalisation process theory
PAR	Participatory action research
PVAW	Preventing violence against women
RWH	Royal Women's Hospital
SV	Sexual violence
SHRFV	Strengthening Hospital Responses to Family Violence
TIC	Trauma-informed care
VCASA	Victorian Centres Against Sexual Assault

VIP	Violence intervention program
WHO	World Health Organization
WITH	Women's Input into a Trauma-informed systems model of care in Health settings (the WITH Study)

# Executive summary

Women commonly experience sexual violence and there is a strong relationship between sexual violence and poor mental health (Quadara, 2015). The relationship is extremely complex, often involving a past history of multiple traumas, requiring collaboration between mental health, sexual violence, and other sectors to provide effective care. Mental health and sexual violence services often see the same women, however there may be a lack of communication and cross-referrals between services (Quadara, 2015).

There are several guidelines to assist organisations to deliver trauma-informed care (Bateman, Henderson, & Kezelman, 2013). Trauma-informed care seeks to create safety for patients by understanding the effects of trauma (including violence) and its close links to health and behaviour (Quadara, 2015). However, there is no current organisational model outlining how services can optimally implement trauma-informed care when both mental health problems and sexual violence are present. Furthermore, there may be particular barriers that prevent these specific services from working effectively together.

The ANROWS Landscapes state of knowledge paper by the Australian Institute of Family Studies (Quadara, 2015) on this topic found that while academic and grey literature shows consistent themes about the principles of trauma-informed care, there is little evaluative evidence to inform organisational and systems change. This Horizons report outlines the Women's Input into a Trauma-informed systems model of care in Health settings (the WITH Study) commissioned by Australia's National Research Organisation for Women's Safety (ANROWS) to understand how to promote and embed a systems model of trauma-informed care in health settings responsive to women's and practitioners' needs in the area of mental health and sexual violence. It was led by The University of Melbourne in collaboration with the University of New South Wales and the Domestic Violence Resource Centre Victoria, and in partnership with the Royal Women's Hospital, Centres Against Sexual Assault (CASA House), the Northern Area Mental Health Service and Northern Centres Against Sexual Assault in Victoria, and Royal Prince Alfred Hospital Sexual Violence Service, New South Wales.

## Project aim

The WITH Study aimed to understand how to promote and embed a trauma-informed systems model of care, responsive to women and practitioners, into the complex system of mental health and sexual violence services. Our research (see Figure 1) was divided into:

- A separate state of knowledge published report (Quadara, 2015);
- Women's voices (Part A) and Health systems change (Part B), reported here;
- A knowledge translation exhibition (Part C) which will form a separate linked ANROWS report later in 2017. The exhibition will aim to explore and explain the challenges and impact of trauma-informed care by presenting the voices of women (as digital stories, quotes) who have experienced mental health problems and sexual violence, alongside those of staff and practitioners (as images, quotes) working in services that cater to these needs. In doing so, the exhibition will articulate how new interventions, strategies, or work practices have the potential to change systems and processes, leading to better outcomes and holistic care for women who have experienced both mental health problems and sexual violence.

## Part A: Women's voices

Through qualitative interviews with women who have experienced mental health problems and sexual violence, and development of digital stories by women, we explored:

1. What are the socially constructed extrinsic contextual factors and intersecting intrinsic factors that increase the likelihood that women who experience sexual violence develop later mental health problems and, secondly, that women with mental health problems experience sexual violence?
2. What are the pathways to safety and care for women experiencing mental health problems and sexual violence?
3. How does the process of digital storytelling affect women's mental health and wellbeing?

## Part B: Health systems change

Drawing on consultation with staff from services, health systems change theory and literature, and the voices of women from Part A, we asked:

4. What factors influence the design and implementation of an integrated systems model of care for women experiencing mental health problems and sexual violence?

## Methods

The WITH Study was based on participatory action research and feminist research principles; therefore we intentionally focused on the voices and lived experiences of women (Part A). The experiences of women were then used to inform the work about health systems change (Part B), with two survivors working as research assistants to co-facilitate staff workshops.

### Part A: Women's voices

- **Thirty in-depth timeline interviews** with women recruited from a New South Wales sexual assault service exploring their experiences of mental health problems and sexual violence over their lifetime;
- **Thirty-three in-depth interviews** with women recruited from a Victorian hospital, a clinical mental health service, or a sexual violence service exploring their pathways to care for mental health problems and sexual violence;
- **Five women who participated in a digital storytelling workshop** at the Australian Centre for the Moving Image, enabling them to make their own multimedia stories about their experiences of mental health problems and sexual violence;
- **Four semi-structured interviews** with women exploring how undertaking the digital storytelling workshop affected their mental health and wellbeing.

All of the above findings, with health and sexual assault services, informed Part B.

### Part B: Health systems change

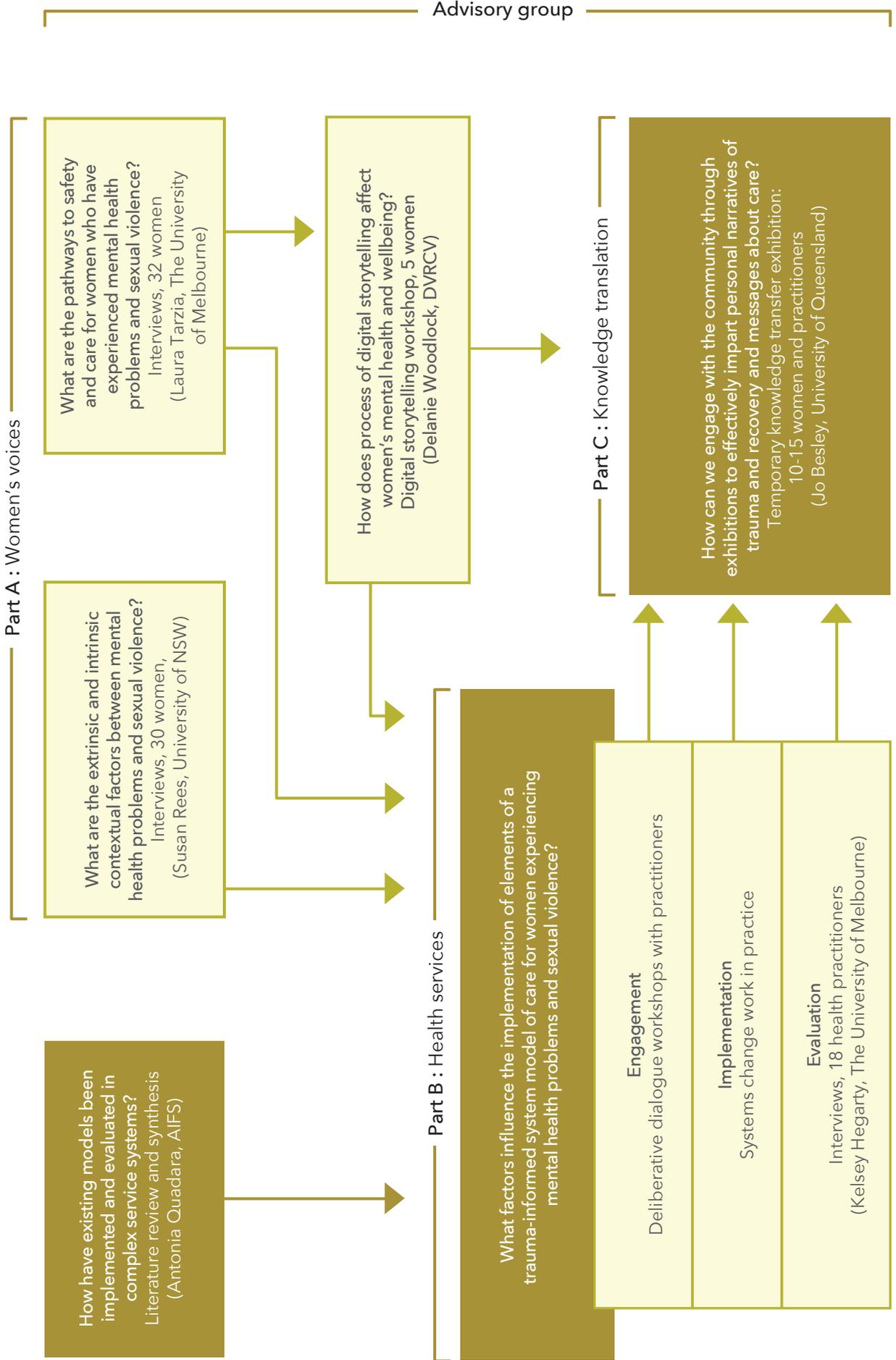
- **Four deliberative dialogue staff consultation workshops** with 33 staff from services (a tertiary public hospital, two sexual assault centres, and a clinical mental health service) using women's voices from interviews and digital stories; health system change theory and evidence; and exploring what can be changed in the health system to further support delivery of trauma-informed care so that women can be supported on their pathway to safety and care, no matter which service they access first;

- **Use of the digital stories in six presentations in health settings;**
- **Twenty consultations** with management teams at the sites who, during the WITH Study time, were also enacting new strategies and systems as a result of other projects and recommendations from the Royal Commission into Family Violence in Victoria;
- **Development and implementation of new policies, tools, and training at health settings:**
  - new draft flowchart guideline for family violence (with sexual violence included);
  - trial of a family violence identification tool in the emergency department of the hospital;
  - co-delivery of training by mental health and sexual assault services around vicarious trauma for the emergency department staff at the hospital; and
  - training by sexual assault services to staff at the clinical mental health service.
- **Nineteen semi-structured interviews** with staff from a tertiary public hospital exploring their experiences delivering trauma-informed or sensitive care for women experiencing mental health and sexual violence issues, any ongoing barriers and facilitators to delivering sensitive care, and their views on any systems-change activities being undertaken.

We then developed a **Health Systems Implementation Model** synthesising the findings from the literature review, Part A and Part B, and a theory of organisational change.

**Figure 1** Overview of WITH Study

How can we promote and embed a trauma-informed systems model of care, responsive to women and practitioners into the complex system of mental health and sexual violence services?



## Key findings: Part A

### Complex interrelationship of mental health and sexual violence experiences

From timeline interview analyses conducted by the University of New South Wales research team, several patterns (models) were evident over women's lifetimes.

The first model involved the **absence of a trusted other to disclose sexual violence**, placing women at risk of mental health problems through either isolation due to fear and anticipation of future abuse or absence of an alternative voice to self-blame, leading to anxiety and then to self-harm and suicidal ideation.

The second model involved **disclosure of sexual violence being minimised or ignored** by an extra-familial individual or agency, placing women at risk of depression symptoms and suicidal ideation through self-blame, inability to communicate feelings, and loss of trust in services.

The third model indicated that **early childhood sexual abuse** (intra or extra-familial) or parental neglect heightens the risk of sexual violence later in life, in combination with anxiety symptoms and alcohol and drug use. Women described a loss of self-esteem and self-worth, and feeling insecure in an adult relationship with a reduced capacity to discern the risk of future abuse in a relationship, undermining the psychological capacity to avoid or exit the relationship. Isolation from significant others increased the risk of being "targeted" by potentially abusive men. This model was strongly related to sexual or drug-related risk-taking behaviour, both of which combined to increase vulnerability for further abuse.

The fourth model involved **disclosure of sexual abuse being ignored or blamed on the child or young woman** by a family member. It was the most closely associated with the onset of all forms of common mental disorder, including suicidal ideation. It was evident that self-worth and personal value and meaning were substantially undermined following the invalidated disclosure to a family member. Women were also able to articulate a recovery model, which is integrated below into the findings from the Victorian interviews.

### Recovery and pathways to care

Integrating data from all the studies in Part A suggests that, from women's perspectives, in recovering from sexual violence and mental health problems they had found the following:

- Supportive counselling was essential, including feeling as if experiences of sexual violence were being genuinely heard, believed, and validated by the practitioner.
- Healing was enhanced by, or relied on holistic services that understood their individual experiences and responded accordingly to empower women.
- The healing process was supported by being connected to services and services that were connected with each other.
- There was a need to support both "surviving" and "thriving", including practical help that facilitated a positive recovery process.
- Digital storytelling was a process that could assist women in this transformation to thriving, although required attention to supporting women if they become distressed as they remembered their experiences.
- Women needed to understand the concept of male power and how it is associated with violence, and realise that many other women do experience sexual violence.
- There was a benefit if women moved away from a reliance on alcohol and drugs, proactively avoided people who were violent, and, at times, were able to use medication to alleviate depressive and anxiety symptoms and enabled engagement in therapeutic social activities.

Some women felt that a holistic service model was lacking, particularly when dealing with the complex needs of many women who experience life at the intersection of sexual violence and structural forms of oppression and marginalisation. In particular, participants identified challenges for services supporting women with multiple compounding factors, such as family violence, alcohol and drug problems, and being from Aboriginal and Torres Strait Islander or culturally and linguistically diverse backgrounds. Women emphasised the importance of being able to easily access appropriate ongoing trauma-informed services that share information, provide referrals, and support women in accessing help for their complex issues at all times, not only during crises. It was important that the whole organisation from the environment to the reception staff be trauma-informed.

## Key findings: Part B

### Factors influencing implementation of a health systems model of care

There are many barriers and facilitators to change in health systems across the service settings. The main factors emerging from the deliberative dialogues with staff and consultations with stakeholders were the following:

- a need for relationship building between teams;
- a shared understanding of roles and language;
- integrated care and coordination of referrals;
- training of staff;
- more workforce support;
- leadership and governance; and
- information systems for monitoring and evaluation.

#### Box 1

Trauma and violence-informed care (TVIC) expands the concept of trauma-informed care to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person's life. This brings into focus historical and ongoing violence and their traumatic impacts so that problems are not seen as residing only in a psychological state, but also in social circumstances.

(Varcoe, Wathen, Ford-Gilboe, Smye, & Browne, 2016)

From interviews with practitioners, similar themes arose about the importance of space and places, the need to work together internally and externally, the challenge of balancing competing needs, the idea that training should be tailored, and a need to support workers and create sensitive practice from the ground up.

### Implications for women, practitioners, and health systems

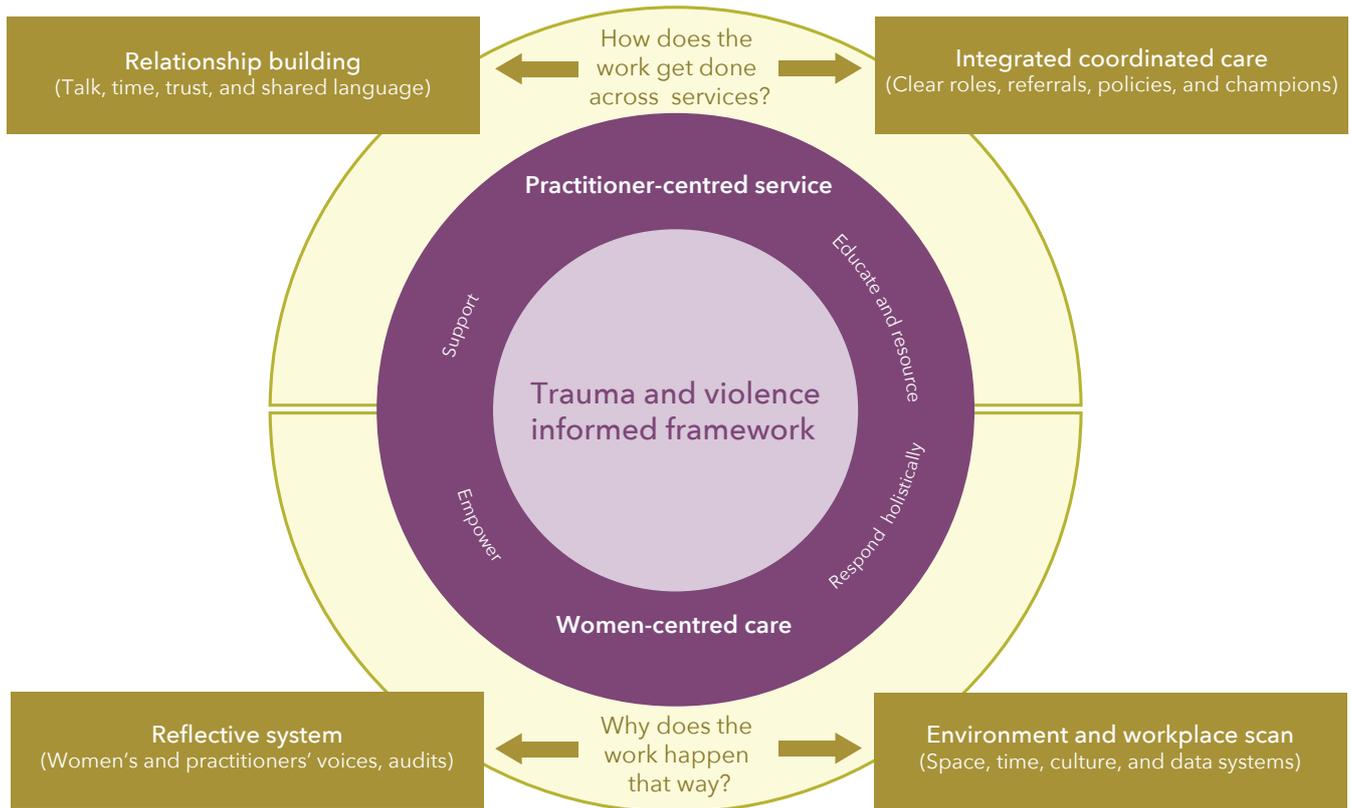
The importance of trauma-informed care and empowerment approaches to women was clearly articulated by those who had experienced mental health problems and sexual violence and in the voice of the staff and practitioners. In particular, the importance of responding to the needs of diverse women and multiple associated issues (family violence, child abuse, alcohol and drug issues) was highlighted.

There are many terms used for this type of care and these approaches but we feel that adoption of a trauma and violence informed framework encompasses the requirement for a holistic response to women experiencing mental health problems and sexual violence (see definition Box 1). Figure 2 outlines how this TIVC framework underpins a **women-centred care** approach (empowerment and a holistic response) (Garcia-Moreno et al., 2014) and a **practitioner or staff-centred service** (focusing on supporting practitioner needs and providing education and resources). These approaches are needed for women and practitioners to feel they are entering a safe and supportive health setting.

There are several health systems models for violence against women in operation globally (Garcia-Moreno et al., 2015). When applying the lens and context of mental health and sexual violence services from the WITH Study, we have integrated our findings and the literature to focus on **four main building blocks** that enact change or implement features of the above women and practitioner-centred approaches. These building blocks, based on evidence of what works most effectively to implement change in health systems, are outlined below. They are based on normalisation process theory; this aims to clarify the processes by which interventions, new behaviours, or ways of doing things become embedded into everyday practice (May et al., 2009). This theory helps understand implementation in relation to the work that people do. It focuses on the meanings people attribute to the work, their capacity to carry it out, the ways the work is actually enacted in an organisation, and how people feel retrospectively about the work they have done.

Key to health systems change is to ask two questions from this theory: *How does the work get done across services?* and *Why does the work happen that way?*

Figure 2 Health Systems Implementation Model



**How does the work get done across services? (Collective action)**

**Relationship building** was a very strong theme across both the studies involving women and staff participants to enable improvement within the health system. They said that teams within services and different services needed to be connected through opportunities to talk together and develop **trust** over **time** and a **shared understanding** of their different frameworks and roles (Wathen, Sibbald, Jack, & MacMillan, 2011).

**Integrated co-ordinated care** was seen to be a requirement for enactment of a trauma-informed framework and care. This involves very **clear roles** described for staff and **referral pathways** mapped internally and externally. In addition, policies supporting the trauma-informed work and staff **“champions”** within the service to drive the work are needed.

**Why does the work happen that way? (Reflexive monitoring)**

A reflective system was highlighted by staff participants as needed to enable improvement in delivery of trauma-informed care. These included hearing more from women about what they would like to change in the system as well as to provide feedback to practitioners. Staff input and feedback to management into changes in strategy, policies, and resources was also essential. Audit of how women flow through the system on their pathway to safety and wellbeing and what practitioners are enacting would allow quality improvement to be monitored.

An environment and workplace scan on a regular basis would allow improvements in areas that practitioners and women described as requiring attention. These included:

- better spaces to have private and confidential discussions;
- review of workflow patterns to allow sufficient time (length of a session and continuity of care) to engage with women on these sensitive topics;
- assessment of **culture**, values, and beliefs that are occurring within a workplace that can impact any change process; and
- monitoring and evaluation, which also requires better **data systems** to be developed.

The model is proposed to be complementary to existing health systems models in the area of violence against women to assist workplaces to implement changes. The building blocks are areas of focus for an organisation to pay attention to.

## Strengths and limitations of the WITH Study

The WITH Study integrated the voices of women and staff from a hospital, two sexual assault centres, and a clinical mental health service. The strength of the WITH study is in the inclusion of innovative methods and analyses of women's voices in Part A, as there has been limited research in the area of mental health problems and sexual violence that involves women with lived experience. However, the inclusion of only English-speaking women limits our findings, as does the fact that the majority of participants came from only three sites. In addition, in Part B there was limited consultation across the services, and the staff and practitioner voice is not necessarily representative of the settings. However, integration of all themes across the studies in Part A and B, combined with the use of theory and evidence, provides stronger support for the Health Systems Implementation Model than basing it on an individual project.

## Implications for research

There is a need for more qualitative and quantitative work about women's experiences of mental health problems and sexual violence and the care they access on their pathway to recovery. Similarly, more work needs to be undertaken in greater detail about what practitioners understand the enablers are to delivering trauma-informed care. Testing and further validation of the Health Systems Implementation Trauma and Violence-Informed Model is needed in health settings.

# Introduction

This report outlines the findings of the WITH Study (Women's Input into a Trauma-informed systems model of care in Health settings). The study aimed to explore the ways that trauma-informed care is delivered at a systems or organisational level for women who have experienced both mental health problems and sexual violence. Its overarching research question was:

*How can we promote and embed a trauma-informed systems model of care, responsive to women and practitioners, into the complex system of mental health and sexual violence services?*

The WITH Study was conducted in health settings across Victoria and New South Wales, and draws on qualitative work with women, stakeholders, and practitioners, as well as digital storytelling, and engages with evidence and current theory around systems change in health settings. The findings provide guidance for future improvements to the health care system when responding to women with mental health problems and sexual violence, and other co-existing conditions that lead to trauma.

## The problem

Sexual violence is defined by the World Health Organization as:

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 149)

Sexual violence is globally prevalent (World Health Organization, 2013a). In Australia, one in five women have experienced sexual violence, mostly perpetrated by someone they know, including an intimate partner (Australian Bureau of Statistics, 2013). Mental illness is also very common (Australian Bureau of Statistics, 2008) with research showing a strong relationship between mental health problems and sexual violence (Rees et al., 2011); however, the directionality of this relationship is unclear (Trevillion, Oram, Feder, & Howard, 2012). Around one in three women attending inpatient or outpatient mental health care have experienced some form of domestic violence (which includes sexual violence) (Oram, Trevillion, Feder, & Howard, 2013).

Survivors of sexual violence can experience a range of trauma-related mental health problems, including anxiety, depression, post-traumatic stress disorder (PTSD), and suicidal ideation (Campbell, Dworkin, & Cabral, 2009). On the other hand, a national study by Rees et al. (2011) suggested that pre-existing mental illness can also increase women's vulnerability to sexual violence. Women with mental illness, particularly if acutely unwell, may be poor, living in inadequate housing or homeless, or be an inpatient of a psychiatric unit, all of which increase their level of risk (Oram et al., 2013). They may have trouble accessing appropriate support services, exacerbating their existing trauma symptoms (Diemer, 2012).

Complicating the problem further, both mental health problems and sexual violence are often linked with drug and alcohol abuse and family violence (Braaf & Meyering, 2013; El-Bassel, Gilbert, Wu, Go, & Hill, 2005; Rees et al., 2011). The relationship between mental health problems and sexual violence can therefore be understood as complex, multi-faceted, and multi-directional, requiring an interdisciplinary response from services. Little is known, however, about the mechanisms and contextual factors informing the relationship between sexual violence, mental health problems, and women's access to services.

Ideally, women experiencing mental health problems and sexual violence would have a pathway to safety and care no matter which service they approach first—that is, “no wrong door” (Whitten, 2004). The World Health Organization (WHO) has developed guidelines for health professionals when responding to gender-based violence (World Health Organization, 2013b). Nationally and at various state levels, there are policies or guidelines around trauma-informed care and practice (Bateman et al., 2013; Kezelman & Stavropoulos, 2012), gender sensitivity (Victoria. Department of Health, 2011a), connection of services (Victoria. Department of Human Services, 2013), and family violence sector reform (National Council to Reduce Violence Against Women and their Children, 2009; State of Victoria, 2016). Yet despite this innovative work and the fact that mental health and sexual violence services often have a shared client group (Diemer, 2012), it does not appear to be very common for services to communicate with each other, provide cross-referrals, or address issues outside their scope of expertise (Diemer, 2012; Quadara, 2015; Victoria. Royal Commission into Family Violence, 2016). Although sector-specific trauma-informed guidelines have been implemented to varying degrees by

both sexual violence and mental health services, there is no systems model or organisational framework outlining how services can implement trauma-informed care to work more effectively when both issues are present. Suggestions have been made in regards to the need and benefits of such collaboration, but there is a lack of detail around how this might happen (Bateman et al., 2013; Victoria. Department of Human Services, 2006) and extremely limited evaluations of implementations in this area (Quadara, 2015).

There are a number of reasons why effective interagency collaboration between the sectors has not yet occurred (Quadara, 2015; Victoria. Department of Human Services, 2006). These include structural issues such as funding and bureaucratic alignment and practical impediments such as lack of knowledge and training and organisational stress. Furthermore, different paradigms traditionally inform the sectors. Whilst these may vary from state to state, sexual violence services primarily follow a feminist-oriented trauma perspective (Victorian Centres Against Sexual Assault, 2014), with the clinical mental health sector mostly operating from a medical model—and some moving towards a recovery model—and community mental health services taking a psychosocial recovery framework (Victoria. Department of Health, 2011a). Additionally, there is a growing recognition that consumers of mental health services have sexual violence histories characterised by early onset in childhood, chronic victimisation over the life course, and abuse perpetrated by adults in care and trust relationships (Rees et al., 2011). These often sit alongside broader issues in the family and social environment such as: child abuse or other family violence, intergenerational experiences of trauma, and lack of social connectedness (Herman, 1992). Thus, a “systems model” also needs to include other services, such as social work and drug and alcohol and family violence services.

The WITH Study state of knowledge report (Quadara, 2015) examined the available literature on trauma-informed frameworks and models that guide organisations to improve service provision to survivors of sexual violence with mental health problems. It found that while academic and grey literature shows consistent themes about the principles of trauma-informed care, there is little evaluative evidence to inform organisational and systemic change. The review recommends that future research should examine how trauma-informed care is meeting the needs of women who have experienced both mental health problems and sexual violence, and how trauma-informed care can be enacted in practice and successfully implemented at an organisational level within complex health systems. Similarly, a recent

literature synthesis on trauma-informed care supported the assertion that more empirical work with women and health professionals is needed to explore their experiences of, and suggestions for, trauma-informed care across health settings (Reeves, 2015).

Thus the WITH Study sought to promote, embed, and understand a “systems model” of trauma-informed care in health settings, responsive to women’s and practitioners’ needs. The intent was to create new ways for sexual violence and mental health services to work together to deliver trauma-informed care for women. Women’s voices as well as those of practitioners were central to this work, alongside the research evidence and theories about effective organisational change in health settings (Garcia-Moreno et al., 2015; May et al., 2009). This health systems model change work is very sensitive to context and there was a large amount of change happening in health services during the time of the WITH Study, which will be outlined later in this report. We worked in Victoria and New South Wales with a public hospital, three sexual assault services, and one clinical mental health service.

## Structure of the report

This report is divided into three main sections. The first two sections, Part A and Part B, describe the findings of the WITH Study, and the third section presents a discussion of the findings and implications for practice. Each section contains a number of stages (see Figure 1). Part A foregrounds women’s voices, using qualitative work to examine the directionality of sexual violence and mental health problems, women’s pathways to safety and care, and the use of digital storytelling as a way of communicating some of the challenges associated with care delivery. Part B of the report focuses on Health Systems Change in the context of mental health and sexual violence services. The final stage of Part B integrates the findings and describes a new Health Systems Implementation Model that requires further testing and validation. Implications for health system policy and practice and for further research are also outlined.

# Part A: Women's voices

## Introduction

In the last decade, the importance of women's voices in research about violence against women has gained recognition (Tarzia, Humphreys, & Hegarty, 2016). There has also been a greater momentum within health care sectors nationally and internationally in response to consumer activism to include consumer voices to help shape the development of their programs (Black, 2014; Joss, Cooklin, & Oldenburg, 2016).

Academic research is strengthening its strategic inclusion of people with lived experience into reference groups or lived experience panels, which are mostly utilised within community-based participatory research (Drahota et al., 2016; Joss et al., 2016; Wallerstein & Duran, 2003), participatory action research (Drahota et al., 2016; Kidd & Kral, 2005), and within community-academic partnerships (Drahota et al., 2016). A number of benefits have been identified, in that the inclusion of community perspectives is considered to hold instrumental value and exemplify ethical research practice, as it is through this practice that the voices of consumers are heard and respected and experiences are validated (Chené et al., 2005; Isler et al., 2015). This is especially important for groups that have a history of marginalisation (Isler et al., 2015), since historically their voices have not been listened to.

Moreover, consumers have the ability to bring to researchers' attention ideas and concerns that they might not have considered (Chené et al., 2005). Through constructive criticism and feedback, consumers can identify new research priorities and questions, and help to develop existing research projects, thereby refining research interventions, their applicability, and quality (Isler et al., 2015; Ramsay et al., 2012; Silvestre, Quinn, & Rinaldo, 2010). Specifically, consumers have improved research processes in the areas of informed consent and ethical protocol design (Chené et al., 2005; Isler et al., 2015; Pratt et al., 2015; Ramsay et al., 2012).

Studies suggest that being involved in research can empower women who have experienced violence (Valpied, Cini, O'Doherty, Taket, & Hegarty, 2014; World Health Organization, 2001). The WITH Study involved women who had experienced mental health problems and sexual violence as interview participants, as developers of digital stories, and as co-facilitators of practitioner workshops.

This part of the report will outline three stages of qualitative work with women who had experienced both mental health problems and sexual violence. The first stage involves an interview study using an innovative timeline method with 30 women recruited from a sexual violence service.

Through the use of vignettes, this stage focuses on understanding the relationship between mental health problems and sexual violence. It presents a series of models to help make sense of this relationship and explore women's recovery from sexual violence.

The second stage uses in-depth narrative interviews with 33 women with lived experience about their pathways to safety and care. Women were recruited from a major public hospital, a sexual violence service, and a clinical mental health service. Women's experiences accessing services are highlighted, as well as their views about how the health sector can improve its delivery of trauma-informed care for women who have experienced both mental health problems and sexual violence.

The final stage explores five women's experiences participating in a digital storytelling workshop by presenting data from reflective diaries and follow-up semi-structured interviews. Part A concludes by outlining some of the ethical issues involved in this sensitive work.

## Understanding the directionality of mental health problems and sexual violence

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### Background and aims

Mental health problems may occur in response to sexual violence, including rape, and conversely having mental health problems may place women at risk of sexual violence (Rees, 2014). Research suggests that both mental health and social risk factors interact to place women at increased risk of sexual violence. Past victimisation, young age, and a diagnosis of active post-traumatic stress disorder (PTSD) have been found to increase women's risk of being raped (Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999). These factors also intersect with intrinsic factors, including agency, survival-focused coping, dissociation, and disinhibition.

Understanding the mechanisms that increase risk or offer protection to women is a prerequisite to creating a trauma-informed model. To better develop trauma-informed care we identified the manifest extrinsic and intrinsic mechanisms between sexual violence and mental health problems, and mental health problems and sexual violence.

### Methods

Participants were recruited from the Royal Prince Alfred Hospital Sexual Violence Service, Sydney. Women who were not currently in crisis and were over 18 years of age were invited to participate.

The mixed methods study applied a purposive sampling strategy (Guba & Lincoln, 1982). Pre-existing qualitative and quantitative data was applied to construct a sampling frame for recruitment. The inclusion criteria included:

- Women who were not in current crisis. This was determined by sexual violence counsellors, although it was usually 2 months post-trauma.
- Women who had been diagnosed with or had self-diagnosed common mental health problems. Women with psychosis were excluded.
- Women who were amenable to sharing their experiences without distress.
- Women whose current treatment or counselling intervention would not be affected by the interview process. This was determined by counsellors.

Participants were identified by the counsellors employed at the Royal Prince Alfred (RAPH) Sexual Violence Service to

be appropriate for the study based on the above wellbeing-focused inclusion criteria. We sought to gather data of sufficient breadth and depth to increase the possibility that our findings may be generalised to other populations of women affected by sexual violence. Interviews and data analysis were undertaken iteratively, with sampling ceasing when further interviews produced a high level of informational redundancy (Sandelowski, 1995). At 30 interviews, we deemed that we had obtained sufficient rich, case-oriented data to deductively answer our research questions.

### Procedure

The study was informed by critical and feminist theory (Amaro, Raj, & Reed, 2001). The qualitative interviews were designed and pre-tested. Interviews were informed by existing evidence of extrinsic and intrinsic factors. We applied a feedback process whereby new data was analysed iteratively during the period of data collection to inform further interviews.

Time—a retrospective analysis of events over the lifespan—is a crucial dimension within a qualitative research framework designed to examine the mechanisms between the factors of interest. The study employed a timeline method to allow women to reflect on the temporal dimensions of their past and present lives. Timelines were used to elicit biographical data, starting from birth and early childhood and up to their current age, indicating the most important events and changes that had happened in their lives. The experience of mental health problems or sexual violence was explored during this process, with an emphasis on events that initiated recovery, traumatic growth, or perceived strength. Events that occurred in the broader context that were significant to each participant, or which she might remember in connection with a traumatic, growth, or health-related event, were documented and explored. This method enabled researchers to connect the individual psychological dimension of the participant's lives with the macro level of systematic or contextual social factors, and allowed for an in-depth exploration of how each factor influenced or impacted other events (Bagnoli, 2009).

On a large sheet of paper placed between interviewers and participants, a horizontal line was drawn to represent time, from childhood to the present day. After provision of consent, providing participants the opportunity to ask questions about the study and orientation to the timeline, a standard script was used by researchers to initiate the interview:

I'm going to plot a timeline and we will look at the most difficult experiences of your life, such as the experience that you are seeing this service about. You might also have had other traumatic experiences in your life,

and we will also look at those experiences. Let's start with the thing that brought you to this service, or if you prefer, we can begin the timeline from your early childhood and work from there.

Interviewers noted events and participants' age at which events occurred on the timeline, as well as making notes describing events and emotional reactions to them. Unless volunteered, details of the abusive event were not asked about. Interviewers also took separate written notes to record quotes and other more detailed information to complement the timeline. These notes were not shared with participants unless requested. Guiding questions asked to elicit further information from participants with regards to specific events included: "What were your reactions to that?" and "In what other ways did the trauma affect you?"

Because a primary focus of the study was the temporal relationships between sexual violence and symptoms of psychopathology, specific questions could be asked to clarify these relationships. In the case of a single-event trauma, participants could be asked: "Had you ever had any of these (symptoms/reactions) prior to this traumatic event?" In the case where participants had experienced such symptoms prior to the experience of sexual trauma, this was further explored: "What was happening for you at the time of experiencing this symptom?"; "Did that symptom resolve? Did it get worse?"; "Were you ever diagnosed with any mental health disorder? (If so, when?)" Timeframes of events were continually clarified and questioned throughout the interview, particularly when talking about childhood experiences. Guiding questions included: "When did these things happen? (At what age)"; "What was the worst part of that?"; "How did you respond?" To explore time leading to and immediately prior to experience of sexual violence, interviewers asked: "How were things for you before this happened?"

Another focus of the study was on exploring factors that may have either ameliorated or exacerbated negative outcomes following experiences of sexual violence trauma. During interviews, this was asked about directly: "What things helped you through this experience?"; "What support or treatment did you have and was this helpful?"; "Were there things that you think were unhelpful along the way or made things harder?" This information was also gleaned in the analysis stage, where experiences of different participants could be compared to identify trends that may be associated with improved or poorer outcomes in ways that may not be apparent or recognisable by individuals themselves. Participants were also asked to reflect on what support or experiences they felt could have

helped them along the way, by being asked "With hindsight, is there anything you think might have helped you through this experience?"

A key strength of the timeline approach is that it provides participants with the opportunity to actively participate in the reporting of their life history. It also visually organises complex information as the interview progresses, aiding clarity of recollection and allowing participants ownership of the interview situation. In the data analysis phase, timeline data allows for chronological analysis of life history and events and linguistic analysis of narratives, as well as sequential analysis of biographical data.

We sought to gather data of sufficient breadth and depth to increase the possibility that our findings may be generalised to other populations of women affected by sexual assault. Interviews and data analysis were undertaken iteratively, with sampling ceasing when further interviews produced a high level of informational redundancy (i.e. data saturation). At that point we deemed that we had obtained sufficient data to answer deductively our research questions.

### Analysis

The thematic analysis of data was undertaken with the assistance of NVivo software. Analysis of timeline material, identification of themes, and analysis of the connection between themes were conducted by two independent analysts. Discrepancies between coders were minimal; however, these were systematically reconciled externally by a third rater in discussion with the analysts.

### Ethics

Ethics approval was granted by the Liverpool Hospital human research ethics committees. Approval was granted on 14 April 2015 (ethics approval number 15/041).

### Personnel, training, and supervision

The team was comprised of academics, a psychologist, a social worker, and professional staff from the sexual violence service. Female research assistants had clinical expertise in counselling women affected by sexual violence. Research assistants also demonstrated the capacity to reach a high level of technical proficiency and reliability in collecting data and a willingness and capacity to adhere to strict ethical standards. Research assistants completed a one-day training course on the study research methods.

Associate Professor Rees supervised staff, monitored the quality of interviews, managed logistic and data issues, and

maintained close engagement and communication with the research team and the broader sexual violence service.

The team worked to ensure that the study procedure provided an affirming and positive experience for participants. Referrals to counselling or other services and supports were made if the need was identified during the research interview. This occurred in most respects through the sexual violence service or its network of other health and welfare services.

Participation was voluntary and confidential. Women could choose to participate or withdraw from the study at any time. It was made clear that the study was separate from the sexual violence service and that treatment at the hospital or the service was not dependent on or influenced by the choice to participate or not in the study. The management of data complied with NHMRC guidelines.

## Key findings

### Sample characteristics

The sample is not representative of the general population of women, or of women affected by rape and sexual assault. Participants self-selected from a clinic population seeking assistance from rape and sexual assault-related problems. The mean age of participants was 36 years. Eleven were in a current married or de facto relationship. Twelve were in paid employment and ten had a bachelor's degree or higher. The sample included experiences of rape and other forms of sexual violence, with co-occurring forms of abuse being almost universal (and therefore not differentiated in the analysis). Almost half (14) had experienced either intra-familial or extra-familial abuse during childhood. Of the 14 participants who reported sexual abuse as a child, 10 reported further incidents of sexual violence as adults. Fifteen women experienced rape and sexual violence from strangers, with seven having experienced a one-off incident of abuse from a stranger.

### Self-reported incidence of psychiatric disorders

#### Suicidality

Suicidality is strongly associated with sexual violence and rape, and is commonly co-morbid with mental health problems, including post-traumatic stress disorder and depression (Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012; Cogle, Resnick, & Kilpatrick, 2009; Devries et al., 2011; Panagioti, Gooding, & Tarrrier, 2012; Pico-Alfonso et al., 2006; Rees, 2014).

In our study:

- Over half of all participants reported suicidal ideation.
- Almost all women with suicidal thoughts reported that these occurred for the first time following the occurrence of any sexual abuse.
- Nine women (almost one third of the sample) disclosed that they had attempted suicide.
- Other features of depressive disorder and trauma symptoms were commonly described in the context of the suicidal ideation.

#### Depression

Depression is the leading cause of disability worldwide, including in Australia (Sunderland, Slade, Stewart, & Andrews, 2011). Depression and anxiety commonly co-occur. Depression is strongly associated with gender-based violence, including rape and sexual violence (Kessler, 2003; Rees et al., 2011; Rees et al., 2016; Saunders, 1999). Diagnosis of clinical depression or the description of any depressive symptoms occurred in 30 of the participants at some time following sexual violence. Eleven of those participants also described depressive symptoms prior to the sexual violence. Co-morbid symptoms of panic disorder and anxiety symptoms were frequently described.

#### Post-traumatic stress disorder (PTSD)

PTSD is strongly associated with rape. Research indicates that the risk factors for PTSD following rape include a history of depression, alcohol abuse, or injury experienced during the rape (Acierno et al., 1999). Five participants reported being diagnosed with PTSD following the sexual violence or rape. All participants with PTSD had comorbid depressive symptoms. Four out of the five participants with PTSD reported significant sleeping problems, such as sleep disturbances, hyper-vigilance, and insomnia, as the most disabling features of the disorder. An additional four participants described PTSD symptomology.

#### Vignettes

For optimal insight into the mechanisms between sexual violence and mental health problems, the qualitative findings are reported as brief case vignettes rather than as a series of qualitative quotes. These vignettes have been de-identified and all identifying information has been changed. The vignettes give voice to the dominant themes identified in the findings. A description of the significant extrinsic

and intrinsic factors is included in the text preceding each vignette. Models that reflect the mechanisms described in the thematically interconnected vignettes are provided to enable the reader to visually examine the pathways.

**Participant A** described mental distress and trauma-related symptoms, including insomnia and hyper-vigilance. The association between her exposure to sexual violence, traumatic symptoms, and suicidal ideation is illustrated. The participant explained the absence of a trusted person as a factor related to her mental state and her attempted suicide.

This recollection follows the third incident of sexual abuse, all perpetrated by her brother. She recalls that she really “hated being at home”. She felt unsafe and locked herself in her room at night. She remembers experiencing insomnia, finding it hard to sleep at night. She described being hyper-vigilant and always very alert to the risk of harm. These feelings of heightened risk of harm occurred in the presence of others as well as her brother. She felt that she could not trust anyone with her experience of abuse or how she was feeling. She would wake easily, often thinking that someone was in her room. These experiences of abuse and anxious anticipation of future abuse were associated with suicidal ideation. The participant remembered that she often “wished I was dead and hated my life”. (Aged 13/14 years at the time of this recollection)

**Participant B** described the significance of not being able to disclose the rape to a trusted person, feeling self-disgust and self-blame, and the association of these combined social and psychological experiences with disempowerment, impaired capacity, self-harm, and attempted suicide.

She had started to communicate with a man online. She met up with him and was raped on the first meeting with him. She felt that she could not tell anyone and particularly recalls fearing her parents and not being able to disclose what occurred to them: “I felt so fearful of my parents. I couldn’t tell them anything.” With no one to counter her feelings of self-blame, she remembers feeling a strong sense of self-disgust: “I felt disgusting and dirty. I stood in the shower for hours trying to get clean.” Then she tried to kill herself. It was the night following the rape. She stole the key to the medicine cupboard and swallowed all of the tablets she could find. She became extremely sick. She remembers having several days off school, and telling her parents that she was ill. (Aged 14 at the time of event)

**Participant C** described the significance of not being believed or taken seriously by authorities (the police), and being blamed for the abuse and rape by her boyfriend. Factors related to the absence of acknowledgement of the harm and the sexual violence are described as related to her experience

of depression and wanting to kill herself.

She was drunk after an office party and was vomiting outside in an alleyway near her office when she was attacked and raped by a co-worker. She was taken to hospital. The police called and she said that they did not take what occurred seriously and “were not helpful”. She later told her boyfriend, who immediately blamed her because she was drunk. He called her a “slut”. The lack of acknowledgement of the violation she suffered—from the police and then her boyfriend—led to her “feeling very depressed”. She remembers really wanting comfort from her boyfriend, but instead he was verbally abusive. She lost confidence in herself and the world around her and she lost trust in “others who were meant to be supportive”. She became so depressed that she wanted to kill herself. (Aged 22 at the time of the event)

**Participant D** described the impact of the lack of acknowledgement, support, or assistance from police following a gang rape. The connection between the police response and the participant’s decision not to speak out about the abuse is associated with drug and alcohol abuse, suicidal thoughts, and an attempted suicide.

She was gang-raped. The men held her captive in an old warehouse. She eventually escaped and ran to a neighbouring house. The police were called. She was interested in pursuing legal action, however, after some time the police told her that there was nothing that they could do because it was “my word against theirs”. She said that “the police have never been really very helpful to me”. After that experience she said that she decided that she “would never talk to anyone anymore and keep my mouth shut”. She thought she would “just have to try and forget the whole experience”. To do this, she started smoking marijuana regularly and continued to drink alcohol to excess to cope with her feelings. She felt depressed and had frequent thoughts of wanting to die. Not long after the gang rape she tried to kill herself. She said that she was treated in hospital. The nurse who attended to her said nothing to her about how she was feeling or why she attempted suicide. (Aged 16/17 at the time of the event)

**Participant E** described experiencing two often interrelated themes: parental neglect and early childhood sexual abuse. Both these extrinsic factors were associated with increased risk of sexual violence and rape (Nishith, Mechanic, & Resick, 2000; Saunders, 1999). Witnessing violence and abuse of siblings was also described. She described the connection of these early forms of abuse and neglect with later experiences of sexual violence and rape. The association between the neglect,

abuse, and alcohol and drug use is explored. An association between loss of self-esteem and behaviour that increased risk of further abuse was identified.

She described an overall lack of parental nurturance from the age of 4 or 5. Her parents were very strict and controlling and she was made to feel “responsible for things” as a child. When she was 14 years old, the participant witnessed her father physically assault her sister. She also witnessed her father physically assault her brother at age 15: “He king-hit him and he lost consciousness”. She was first sexually assaulted at age 14 by an older boy in his twenties. She was later raped by a man with whom she communicated online. She tried to kill herself on the night following the rape. She remembers that she did not tell anyone about what happened to her or that she attempted suicide. She became withdrawn from her peers and started to self-harm until the age of 18. She recalls that she started to “sleep around with boys” several months after the rape because “I didn’t care”. She ran away from home at age 16 to live with her boyfriend, who was much older than her. He was abusive and controlling.

Participants commonly used drugs and alcohol as a coping mechanism following sexual violence and rape. The use of drugs and alcohol were in turn associated with vulnerability and the risk of further abuse. The following examples from the interviews illustrate this point.

**Participant F** said that her low self-esteem following childhood abuse has been “hugely dominant” in increasing her risk of further abuse. Disempowerment and low self-esteem were connected with her reliance on alcohol to help her cope throughout adulthood. She describes feeling “extremely vulnerable and insecure” in her first adult relationship. The relationship ended following him sexually abusing her. When she was drunk, she said, “I was more willing to put myself into risky situations which predisposed me towards acts of violence”. She also identified that taking drugs and alcohol undermined her capacity and agency and rendered her more vulnerable to abuse: “...I was less able to speak up for myself” (aged 22 at the time of the interview).

**Participant G** experienced early sexual abuse and emotional neglect in the home by her adoptive father. She was aged 5 to 7 years at the time. Her adoptive mother’s son then started molesting her at night in bed. She started bedwetting as a protective mechanism, to keep him away. She remembers that her mother was “closed off” and unavailable and therefore no source of support and could not protect her. She was sexually abused by young boys who made her perform sex acts between the age of 12 and 14. Her first boyfriend was a

25-year-old man when she was 14 years old. He made her watch pornography to introduce the idea of sex and to encourage her to participate in sexual activity. Her virginity was important to her; however, her boyfriend eventually date-raped her. There was physical abuse throughout the relationship until the age of 24. She was raped again by her best friend’s boyfriend at age 26. She started sex work at age 24 because she could then use the thing that had hurt her as a form of power. She would also drink to the point of blacking out to “numb the pain”: “I used sex as power against men”; “The one thing I knew how to do was have sex. It was the only thing I was any good at.”

### **Contextual protective factors, agency and empowerment**

Participants most often identified supportive counselling as most helpful for them following sexual assault. In particular, specialised sexual violence services or women’s health services were viewed as the most effective. Empowerment approaches were commonly described as the most helpful. Participants reported that counselling and support factors that were subsequently associated with an improved mental health status included when a counsellor believed their story, took their story seriously, and assured them that the sexual violence was not their fault. Self-referred counselling was most effective. Examples of unhelpful counselling included that provided by a school counsellor who invited the involvement of abusive and blaming family members.

Group therapy was positively associated with mental wellbeing and recovery. The experience of meeting other women and not feeling alone with negative feelings such as depression, anxiety, and self-harm were identified as benefits of group therapy. Participants said that current psychosocial problems could be shared and identified in the group as outcomes of abuse. Moving away from the location of the sexual violence, or from where there was a lack of support and understanding, were strongly associated with recovery from mental distress. Moving away from the location of sexual violence signalled a shift to a life that offered increased protection from further abuse. However, moving from the abusive childhood home at a young age was also associated with additional risks, including financial problems and vulnerable situations that increased dependency on others, including on men who subsequently became emotionally, sexually, or physically abusive.

Empowerment counselling and moving away from the location of the sexual violence was associated with the capacity to live independently and to enjoy time alone, to develop supportive friendships, and to start a new career. Furthermore, higher socio-economic status increased recovery options. Factors that improved mental health status following sexual violence for women with higher socio-economic status included: taking

holidays, finding meaning through a new career, volunteering and community work, writing as therapy, and exercise and meditation.

Medication, particularly antidepressants, was described as helpful for coping, to enable engagement in self-help activities, and to be able to get good sleep. Alcohol abuse relapse was associated with exposure to rape and sexual violence. Alcohol, in turn, was associated with vulnerability to self-harm and to further abuse. Women described being less able to protect themselves when they were drunk and conversely more able to anticipate risk of sexual abuse when they were not drunk. Age, and the capacity to determine and avoid risk, was another factor associated with protection from violence. Getting treatment for alcohol abuse was strongly associated with improved mental health and reduced exposure to violence.

After a long history of abuse, including child sexual abuse, **Participant H** found an “early intervention team” which she described as both helpful and supportive. She described feeling “less isolated” and a sudden and empowering realisation that she was not to blame as a result of the intervention. She found leaving the family home at age 27 was a “positive step”, in which she started her own life and was no longer in contact with abusive family members. She was prescribed an antidepressant that helped her to manage her feelings, which she said in turn helped her to engage with the intervention and to develop supportive friendships that aided her recovery. She said that as a result of the medication she felt “less overwhelmed” and therefore more able to cope. She joined a group for women who had been raped and began to feel less alone: “It wasn’t until the group that I realised how similar I was to the others.” She started seeing a counsellor who specialised in sexual abuse and as a result she no longer felt the need to drink excessive amounts of alcohol. She felt stronger and she ended the abusive relationship because she could “see it was not healthy for her”.

The participant said:

Without counselling I’d be really in trouble. It helped me to understand, to think and reason it out before I act. It’s helped me to put guys in their place. Now I stand up for myself. Before I felt afraid to say anything. I think that people used to think that I was easy.

This participant went on to study at university again and this experience further strengthened her confidence, reduced symptoms of mental distress, and allowed her to determine a safer future.

## Models

The models are intended to provide a clear and uncomplicated visual representation of the findings.

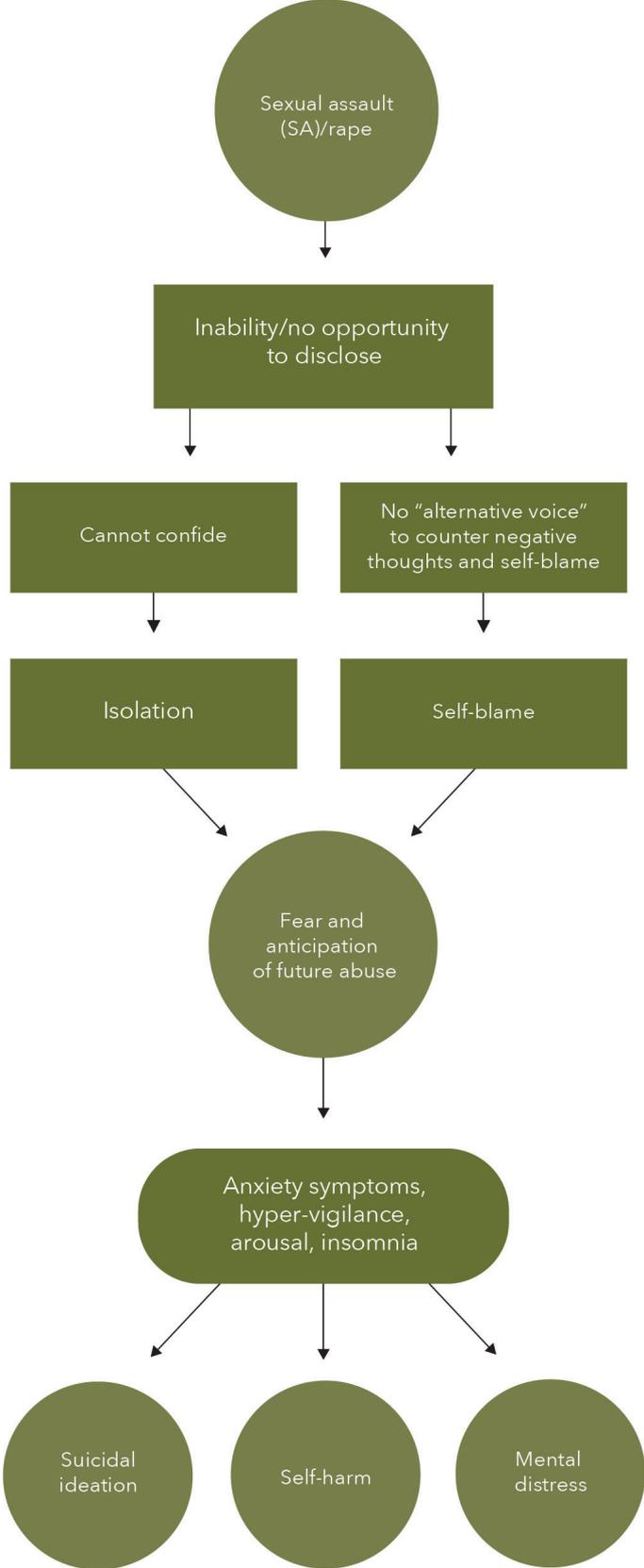
The models depict the pathways highlighting the factors that were most strongly associated in the data. Models are used to show where factors were associated in the data. They are not intended to imply that other factors might not also be associated, just that these were highlighted most strongly in our analysis of the data.

The models are intended to be read in the context of the vignettes, and as such aim to be instructive of some women’s experiences.

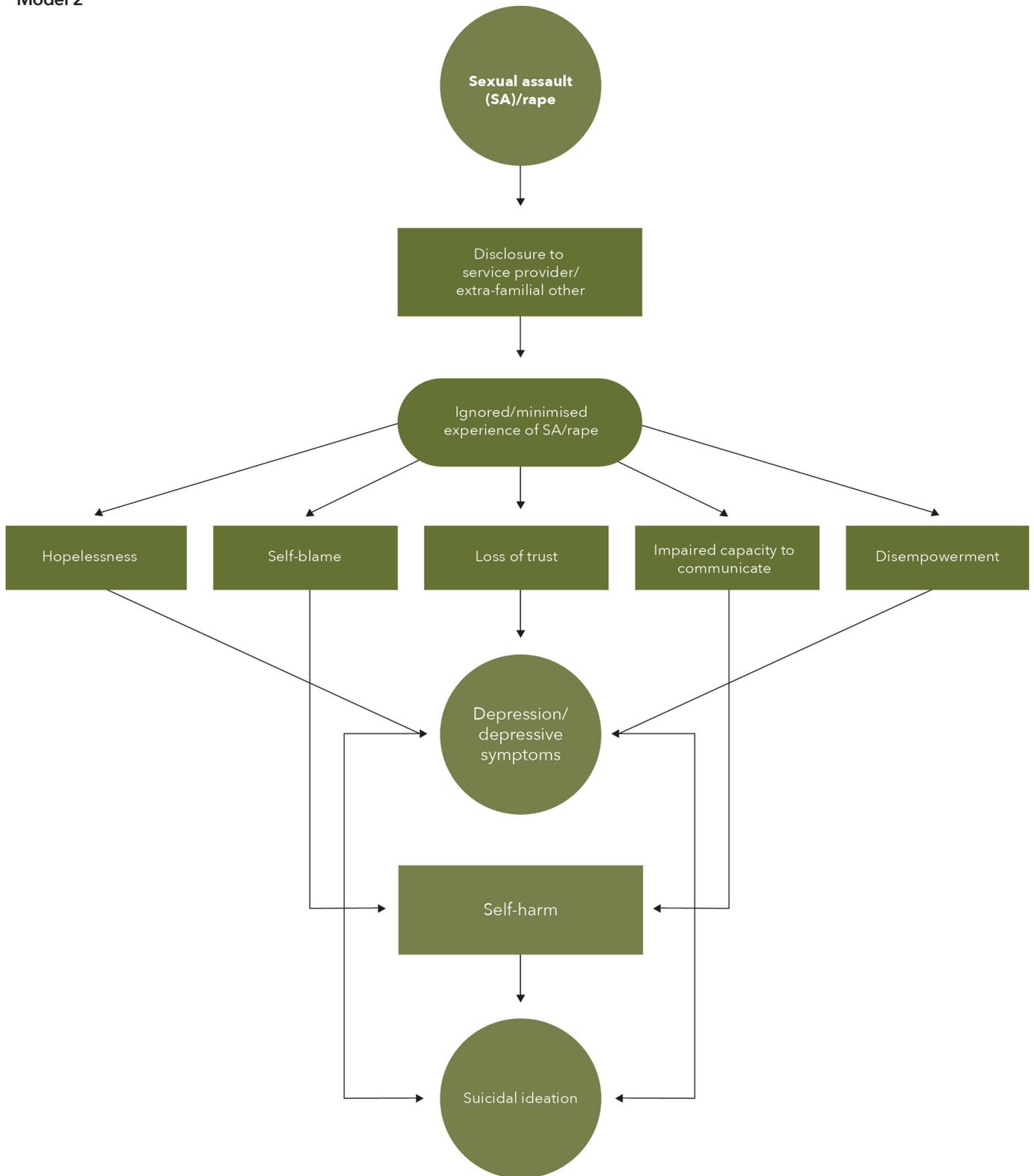
The first model reveals two pathways following the inability to disclose. Isolation following sexual assault was associated with profound fear accompanied by anticipation of further abuse. This dominant scenario led to anxiety symptoms and then to mental distress, self-harm, and suicidal ideation. In the second pathway, the inability to disclose was inherently associated with the absence of an alternative voice to counter self-blame. This scenario was associated with the anticipation of future abuse, anxiety symptoms, and then mental distress, self-harm, and suicidal ideation.

Clinical response: Incorporate an understanding of the identified pathways, particularly risks of isolation and the absence of an alternative voice to counter self-blame. Self-blame cannot be countered if there is no dissenting voice, or someone to refocus responsibility and culpability on the perpetrator. Anticipatory trauma, which is linked to isolation, fear, and an increased risk of suicidality, should not be ignored as a precursor for mental health problems and as a form of ongoing mental distress.

Model 1



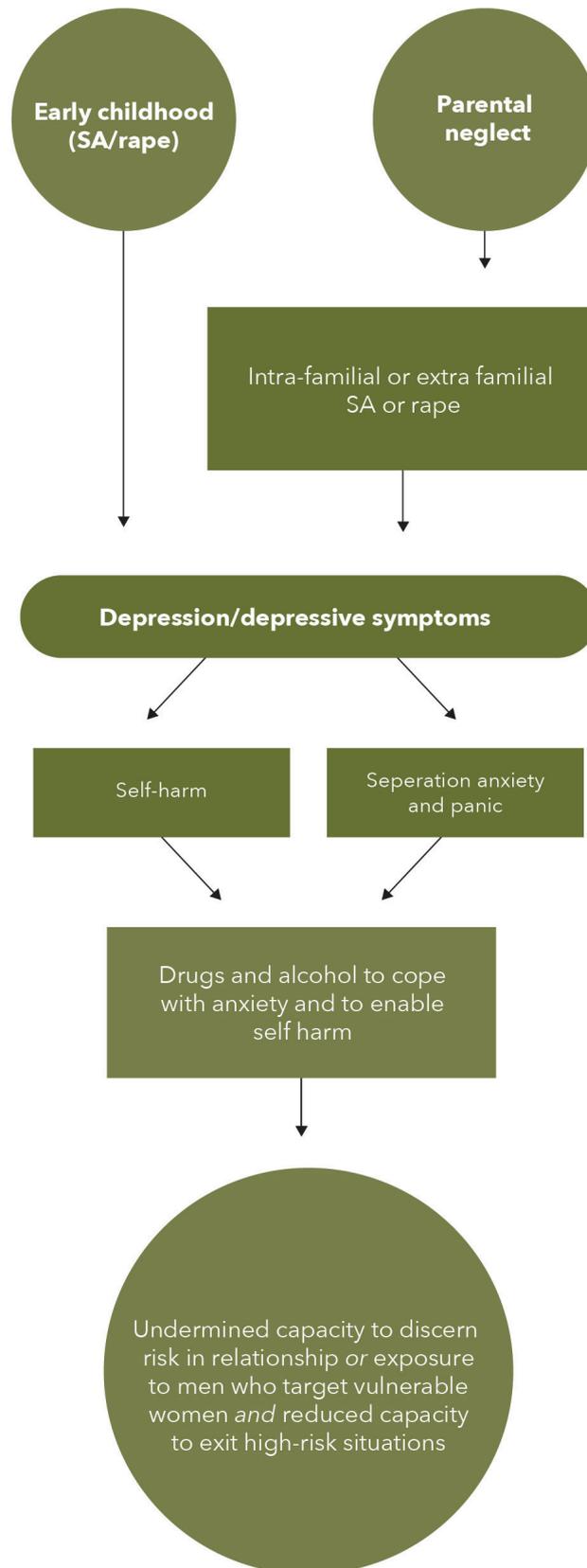
Model 2



The second model reflects the experience of denied or minimised disclosure of sexual assault by an extra-familial individual or agency. The experience of denial places women at risk of symptoms of depression and, subsequently, suicidal ideation. A dominant pathway following the inability to disclose shows self-blame and inability to communicate feelings leading to self-harm. Self-harm was in many cases associated with suicidal ideation. Loss of trust in service providers led to disempowerment.

Clinical and prevention response: Advocate for an increase in education, training, and monitoring of police and other agencies that may hold beliefs that undermine women's experiences of sexual violence or rape, and the seriousness of them as criminal offences (Heath, Lynch, Fritch, & Wong, 2013; Lonsway & Fitzgerald, 1994; Stanko & Newburn, 1994). There should be a greater focus on empowerment and women-centred approaches in clinical support for women (Dombo & Bass, 2014; Hayes, Lorenz, & Bell, 2013; Richmond, Geiger, & Reed, 2013). Services should also directly address the social and contextual factors that place women at risk of experiencing sexual violence and rape, as well as negative responses to the disclosure of sexual violence and rape. The criminal nature of sexual violence and rape needs to be fully explained to women, along with legal options for redress. The options for legal redress should be understood by the service provider and these should be shared with victims. Integrated services may be the best option to ensure that legal services are involved in the network of support available to women.

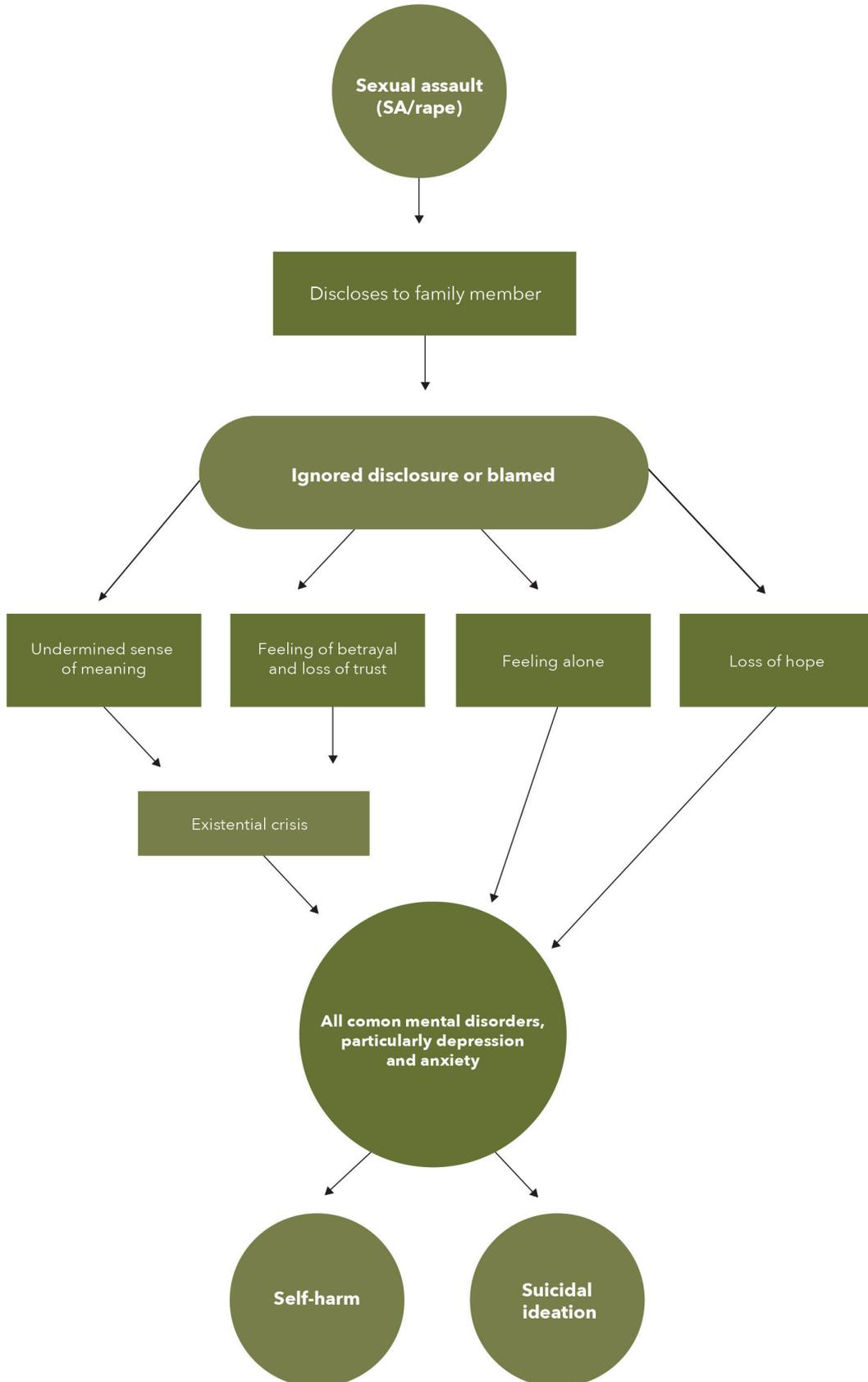
Model 3



The third model identifies that early childhood sexual abuse (intra or extra-familial) or parental neglect can heighten the risk of future experiences of sexual violence. These were associated with anxiety symptoms and alcohol and drug use in later life. Mechanisms included a loss of self-esteem and self-worth, and feeling both insecure and powerless in an adult relationship. This combination of factors was associated with a reduced capacity to discern future risk of abuse. Isolation from significant and supportive others increased the risk of being targeted by potentially abusive men. This model was strongly related to sexual or drug-related risk-taking behaviour, both of which combined to increase vulnerability for further abuse.

Clinical and prevention response: There is an urgent need to reduce the risk of child sexual abuse and child neglect in families and communities (Livny & Katz, 2016; Smallbone, Marshall, & Wortley, 2008). Clinicians and counsellors need to be aware that anxiety disorders may be associated with adult rape in combination with distress related to early childhood abuse. History of abuse needs to be routinely explored by counsellors with women. Identification of a social network or support person is important when considering factors for recovery. Alcohol and drugs were associated with emotional numbing to escape memories of abuse and self-blame. Self-medication was directly associated with managing anxiety symptoms. Alternative treatments for anxiety need to be used to replace alcohol and illicit drug use. Alcohol and drug use may increase the risk of women being targeted for sexual violence. This knowledge should in no way imply that women engaging in drug or alcohol use are to blame for sexual assault, including rape. It is also important to recognise that women may require medical support and monitoring when withdrawing from long-term use of legal and illegal drugs, as well as during alcohol withdrawal.

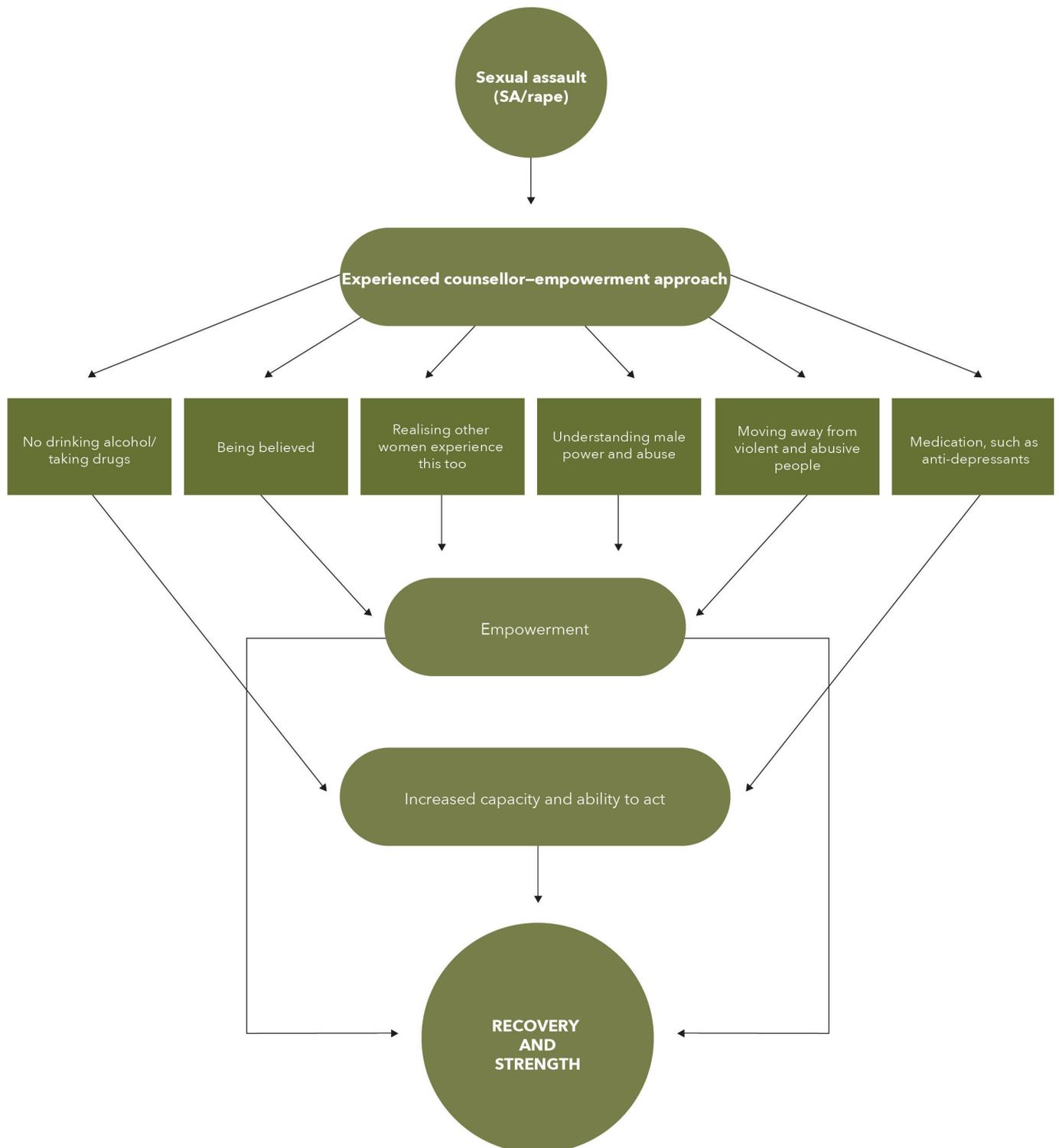
Model 4



The fourth model concerns the disclosure of sexual abuse being ignored or blamed on the child or young woman by a family member. This is revealed as the most potent form of psychological harm and was the most closely associated with the onset of all forms of common mental disorders, including suicidal ideation. It was evident that self-worth and the woman's entire meaning would become substantially undermined following the invalidated disclosure to a family member.

Clinical and prevention response: More extensive community level and particularly parental education is required regarding sexual abuse and how to respond. It is important to be aware that a longer time period between rape and sexual abuse and disclosure amongst women is associated with poorer mental health outcomes (Boeschen, Koss, Figueredo, & Coan, 2001; Ruggiero et al., 2004). Clinicians and counsellors should explore exposure to sexual violence with women and address the residual emotional impact of invalidated disclosures. Disclosure may evolve and occur over a lengthy period of time (Reitsema & Grietens, 2016). An early disclosure with a negative (not affirming) response can undermine the process to recovery. A positive response from a trusted person is identified as more important than what children actually say when they disclose (Reitsema & Grietens, 2016). Providers should locate inadequate family responses within a critical framework that assists women affected by rape and sexual violence to understanding unconstructive or negative familial responses.

Model 5



The fifth model illustrates the contextual factors that increased empowerment, reduced mental distress, and facilitated a safer life with a reduced risk of sexual violence.

## **Conclusion**

The study is the first to examine extrinsic and intrinsic factors related to the onset of mental health problems following exposure to a sexual violence or rape. The direction leading from a mental health problem to sexual violence was found only where there had been initial, pre-disorder exposure to early childhood sexual abuse. The identified direction was first from childhood abuse, followed by a mental health problem, and then subsequent sexual abuse later in life. The in-depth explorative interviews, employing a timeline method, provided the optimal approach for meeting the study objectives. The limitations included a small, qualitative, and purposive sample from a clinic population, which can make it difficult to generalise findings to other populations. The size of the study limited the capacity to distinguish between differences in forms of sexual violence or rape, and the differences between intra-familial and extra-familial abuse.

## Women's pathways to safety and care after experiencing mental health problems and sexual violence

Laura Tarzia, Kitty Novy, Kirsty Forsdike, Kelsey Hegarty

### Background and aims

For women experiencing mental health problems and sexual violence, navigating health services can be challenging (Lievore, 2003; Ullman, 2007). Both issues are typically stigmatised (Corrigan, 2000; Wall & Quadara, 2014), and in the case of sexual violence, not often disclosed to health professionals (Cox, 2015; Mouzos & Makkai, 2004; Ullman, 2007; Wall & Quadara, 2014), despite an increased use of services (World Health Organization, 2013b). When other co-morbidities and complex trauma are also present, these challenges are exacerbated further (Ullman, 2007), as services may find it difficult to respond to multiple interrelated issues (Morrison, 2009; Stathopoulos & Jenkinson, 2016; Whitten, 2004).

Historically, the health sector has been slow to provide community-based coordinated care to women experiencing violence (Thurston & Eisener, 2006). Despite the strong relationship between mental health problems and sexual violence (Campbell, Dworkin, et al., 2009; Rees et al., 2011), services provided to women continue to be fragmented. Mental health services often do not identify or discuss sexual violence (Howard et al., 2010; Rose et al., 2011) and disclosure does not always result in referrals to violence services (McLindon & Harms, 2011). Meanwhile, women with mental health problems may be inadequately assisted by sexual violence service providers who are under-resourced and unable to provide clinical care.

To date, these problems have mostly been explored from a policy perspective, and little is known about how the lack of a coordinated "systems response" to mental health problems and sexual violence might affect women. There are no studies exploring women's experiences navigating the healthcare system when experiencing both mental health problems and sexual violence, and, thus, there is poor understanding around what women want from services and how the healthcare system at an organisational level could deliver trauma-informed care in a way that meets their needs.

The aim of this stage of the WITH Study was to address this gap in the literature using qualitative methods, foregrounding women's voices and exploring their experiences accessing services for mental health problems or sexual violence, as well as barriers or facilitators to help-seeking.

### Methods

Narrative, unstructured interviews were conducted with 33 women who self-identified as having experienced mental health problems and "unwanted sexual contact". As we recruited women from a range of services (see below), including those unrelated to sexual violence, the term "unwanted sexual contact" was used so that women who did not identify with terms such as "rape" or "sexual assault" would not be put off from participating. Ethics approval for this stage of the study was received from The Royal Women's Hospital Human Research Ethics Committee (Project 15/05 approved 8 April 2015) and Melbourne Health Human Research Ethics Committee (Project 2015.201 approved 30 September 2015).

Women were recruited through the sites listed below by placing flyers and cards at the services advertising for women who had experienced unwanted sexual encounters and mental health problems. Interested women contacted the researchers directly and a mutually agreeable time was arranged to conduct an interview. Adult women of any age were eligible to participate, regardless of whether sexual violence or mental health problems had occurred first, or which services they had accessed.

1. The Women's Hospital: The Women's is a major public hospital located in inner metropolitan Melbourne. It specialises in pregnancy, childbirth, and women's cancers. Advertisements and cards were placed in the waiting rooms of key clinics, including the Centre for Women's Mental Health, gynaecology, and pregnancy.
2. Centres Against Sexual Assault (CASA House): CASA House is affiliated with the Women's Hospital, but is located off-site in the Melbourne Central Business District. CASA House deals exclusively with sexual assault and offers both crisis support and ongoing treatment.
3. Northern Area Mental Health Service (NAMHS): A clinical mental health service located in the Northern Metropolitan region. NAMHS services a catchment area in the northern suburbs and provides treatment and care for people with mental health problems.

Although women were recruited from these sites, most had experience with a range of different services, both private and public. Therefore the quotes and findings outlined below do not only apply to the services listed above. In particular, it should be noted that the Centre for Women's Mental Health is a liaison service for the hospital and is not an acute mental health service.

As mentioned earlier, an unstructured, narrative approach was taken to answer the research question, “What are women’s pathways to safety and care when they have experienced both mental health problems and sexual violence?” Unstructured interviews are commonly used when the research question involves “highly conflicting emotions, where different individuals or groups involved in the same activity have complicated, multiple perspectives” (J. Johnson & Rowlands, 2012, p. 101). Unlike the structured or semi-structured interview, where a detailed interview guide is followed to a greater or lesser extent, the unstructured in-depth interview aims to create a conversation-like atmosphere that facilitates sharing between researcher and participant. This approach may help to alleviate some of the power dynamics that can occur within the constructs of a research interview, and consequently it is particularly popular when doing feminist research (Burgess-Proctor, 2015). Interviews for this stage simply asked: “Can you tell me about your experiences accessing health services and what was good or bad about that experience?”

The focus of the interviews was on women’s pathways to safety and care, although inevitably the interviews also touched on experiences of mental health problems and sexual violence. Distress protocols were put in place to ensure that participants were supported, and women were provided with resource cards on completion of the interview.

The majority of the interviews were conducted face-to-face at The University of Melbourne; however, six of the participants preferred to conduct the interview over the telephone. A single researcher conducted all of the interviews to ensure consistency. Interviews lasted between 30 minutes and 2 hours, and were audio-recorded and transcribed verbatim. The data were analysed using thematic analysis, with cross-coding between members of the research team being used to ensure rigour.

Participants ranged from age 20 to age 60, with a median age of 40.6 years. The majority were employed, tertiary-educated, and identified as Australian. Fifteen of the women were currently in a relationship. Sixteen women were recruited from the Women’s Hospital, three from Northern Area Mental Health Service, and 13 from CASA House. One participant found a card for the study on the ground and telephoned the research team.

## Key findings

Below are the three key themes that emerged from the thematic analysis of the interview data.

### “Connect me”

Women emphasised the importance of being able to easily access appropriate trauma-informed services, and for those services to subsequently share information, provide referrals, and support women in accessing help for the complex issues they often faced. Women wanted to feel part of a supportive network of services along their pathway to safety and care, and women wanted the service to provide ongoing support, not just cut contact once treatment was complete. They identified funding as a significant barrier to this occurring, as well as a lack of information about what services were available.

Women stated that it was important to be made aware of any trauma-informed services rather than having to identify them themselves. They mentioned that such services ought to be advertised or promoted more effectively so that they could be more easily accessed:

All of the services I’ve ever accessed, I’ve had to seek them out myself. (Participant 9)

Letting people know that they’re out there [is important]... I don’t even know where CASA is in Melbourne. (Participant 15)

Services could be more publicly visible. Because I suppose unless you went to your GP and they said, “Oh there is this service available”, people might not know about it. (Participant 3)

Women also wanted to be referred on to other services when appropriate, particularly when they had co-occurring or complex needs:

I’ve got a great psychologist. Then she referred me on to CoHealth, because I had back problems. (Participant 6)

It would make much more sense for them to go, “Actually, we know a really great therapist who has worked a lot in this field and we recommend this person”. (Participant 22)

It was perceived as critical that services for sexual violence and mental health be better integrated. Women had strong views about how this should be done, including sharing information about past trauma between services (with women’s permission) and co-locating practitioners within each other’s services:

It would be my dream to have sexual assault workers in mental health facilities who are accessible when women need them. (Participant 1)

Ideally, every single person who enters the mental health system would be screened for trauma in a really sensitive way...“Have you ever experienced sexual harassment, sexual assault? Is that impacting you now on how you're feeling? Are you feeling safe? How can we help you to feel safe, during this admission?” Every hospital should have sex-segregated areas. Every hospital should give anyone who identifies as having experienced trauma access to counselling like what CASA offers...every day during their inpatient stay. (Participant 40)

A number of factors were identified by the participants as being barriers to the effective delivery of collaborative trauma-informed care. A lack of funding was commonly cited as a reason why care delivery sometimes fell short of their expectations, and many felt that this created a “hierarchy” of needs:

My other dream would be that CASA would have the funding. [At the moment] you could be waiting for 6 months for an initial appointment. (Participant 20)

Most services, they're really understaffed and in high demand and there's not nearly enough people to deal with the influx. (Participant 3)

In mental health...They don't have the resources. They have to take the people who are the most acute end of the spectrum. (Participant 7)

The inflexibility of the service system was problematic for many women. Services that were not able to provide care in an individualised way were perceived as unhelpful:

Obviously if someone really doesn't have any money, then giving them a whole big list of private therapists that they could contact if they could afford it might be a bit insulting. (Participant 22)

Because I was working I couldn't access—they said, we can help you straight away if you come to the eastern suburbs during—like Tuesday, 10.00 am or something like this. (Participant 11)

Women also felt that, at times, services failed to follow up or provide any ongoing support beyond a time of acute need:

I saw them and it was, “Oh, here's a list of psychiatrists or psychologists you'll have to ring. It's not a current list, but this is the best we have.” You know, you've got your

psychologists and stuff, keep going, that's it. (Participant 6)

It's kind of like, they deal with you and then they don't have to worry about you anymore. (Participant 12)

### “Hear me”

Women often tried multiple services before finding one that was suitable. When accessing services, women wanted to be heard and have their experiences validated. It was important that the whole organisation, from the environment to the reception staff, be trauma-informed.

Being believed and heard was of vital importance:

It helps build your self-esteem, having people believe in you. (Participant 16)

She [counsellor] handed me a piece of paper with all these symptoms of post-traumatic stress and behavioural stuff with what happens with abuse victims. I ticked every box...Instantly I felt understood. (Participant 21)

[Being validated] helped me name [the trauma] in a way that made it “more than”, when I had tried to make it “less than”. (Participant 5)

Connecting with the “right” person was also important. Women acknowledged that sometimes the first person they saw within a service was not the right “fit”, and that it was wise to keep trying different practitioners until rapport was established. Several women mentioned being overwhelmed with the number of different specialists, not knowing which type of therapy would be the most helpful:

Sometimes the first person you speak to or the first person you see might not be the right person and that's okay. (Participant 1)

Yeah, I wouldn't talk to a man about it. Even if they are trained. (Participant 19)

I could see a psychiatrist for 2 years, go on medication, and really reveal some pretty full-on stuff to her—but still not be ready to access those memories, with her... Maybe I knew, deep down, that perhaps she wasn't the right person to do that with, because she wasn't equipped for it. (Participant 20)

I had no idea how to approach the myriad of mental health professionals. Do you see an analyst? Do you see someone who does CBT? (Participant 23)

Building up a trusting relationship with a service was seen as key to trauma-informed care and a factor that facilitated a pathway to safety and care:

I have huge issues with the fact that they're [clinicians/counsellors] not allowed to share anything about [themselves] in counselling, in mental health, in sexual assault services, whatever. [Participant 7]

That element of trust—trusting that the person is listening to you and really gets what you're talking about, understands it and has the right response—especially in those initial first few months. Oh my God, that's just so important. (Participant 20)

Basically every fight or flight response is going off. Your head is just full of alarm bells and you're sussing this person out and—can I trust you? Can I trust you with the worst thing that I could possibly tell someone else? (Participant 20)

On the other hand, some women felt that they were not listened to by service providers. This left them feeling frustrated and often re-traumatised:

I feel like a record going around in circles and I just don't think that it's fair. I feel like...they wasted my life. I feel like I've been on an island shipwrecked. (Participant 15)

Instead of taking you and talking to you, what they do is they pump you up with medication. They don't listen. They haven't got an ear. (Participant 13)

They've got to let the person tell them and they've got to hear. To be heard is the most lacking thing in the mental health you could ever want. [But] they're not interested. They've been trained, they [think they] know what they're doing. (Participant 13)

So I went [to the counsellor]—and I think she just—like, she hadn't refreshed herself...because she was sitting there going, “Now, so what have we been talking about?” It's like, oh no! Please don't do this to me. Don't do this to me. [Participant 12]

Similarly, after accessing a number of different services and being constantly referred elsewhere, women felt a sense of despair about the ability of the health system to help:

I've been to like 100 [services] in my whole life. I would say over 100, and they just refer you on and on and on because no one wants to deal with complex issues or confront them. (Participant 7)

Certain people can't be seen because of their drug use and certain people can't be seen because of this and that. (Participant 1)

I'll go through all of my needs and what I feel I require, and they'll then say, “Oh, we're not the right service for you”. They'll even do that when you've exhausted all your other options, like there's no other service who will see you. (Participant 7)

Outside of specialist services, a lack of training specific to the context of sexual violence was identified as another key barrier to being heard and understood:

They [mental health services] don't understand sexual abuse...how can you treat something you don't know? (Participant 13)

If one in three women are coming to your service because of that, then one in three of your workers in that service should be experienced in that area, because that's the reality. (Participant 20)

#### “Heal me holistically”

Beyond being heard, women actually wanted services to understand their individual experiences and respond accordingly. Although they appreciated that many services were set up primarily to deal with crisis situations, they emphasised the distinction between “surviving” and “thriving” and wanted to be supported in both scenarios, including practical help.

Women stated that being treated as an individual was critical. Some felt that this was lacking, particularly when dealing with complex needs or the intersection of sexual violence and mental health with other vulnerabilities such as being from Indigenous or culturally and linguistically diverse backgrounds:

[Services should] connect with you rather than you being a name on a piece of paper or an appointment, a date. (Participant 15)

The sexual assault services, they would just get me to yarn and yarn and yarn and—some of them would expect me to unpack all this trauma. Other [services] won't even want to deal with it. There's never a balance. There's never, “What do you want to work on?” They never ask me. (Participant 7)

I don't think the services should just be white...how can you talk to someone who isn't willing to learn from you? (Participant 7)

The distinction between surviving and thriving, and how different services approach this, was highlighted by the women. As women moved along the pathway to safety and care, the emphasis for them shifted from surviving to thriving. If this shift was also reflected in the ways in which services engaged with them, women found this helpful:

There's a huge difference between surviving and thriving. So their [services] job is to help you to survive but it's got nothing to do with how to thrive—how to actually get your life back. (Participant 22)

A psychiatrist is just checking up that you're okay and whether your medication needs higher or lower levels. (Participant 16)

Beyond providing emotional support, many of the women emphasised the importance of practical help. Concrete actions that could be carried out were perceived as helpful, and created a sense that recovery was achievable. Furthermore, to some women, endless talking about their trauma became exhausting, and they preferred to be helped to develop strategies for coping and resilience:

I think I expected a bit more “Let's talk about how you're feeling” and “This isn't your fault” and blah blah blah, which I was just so over. I just wanted to put it in the past. I wanted to close that door. So her really practical approach was helpful. (Participant 3)

She was very clinical but in the same way she was very caring. She immediately put things into action. She faxed things for me. She followed up. (Participant 6)

A lot of the funding in organisations goes to the workers and it should be more spread out so that...more resources [are] going to brokerage funding and actual supports that are real, that can actually help people on a level that's real. (Participant 7)

I was utterly destroyed and I was just like, so how the hell am I going to survive this? She [counsellor] was kind of flailing and she just kind of said to me, “Well we normally recommend people try yoga and meditation”. I was just like, oh well gee, that's really not very helpful. (Participant 22)

Women's pathways to safety and care were sometimes impeded by the different paradigms that often inform services for mental health and sexual violence. Women found this was particularly the case when there was a lack of openness to other models of care and the benefits they could offer:

Sometimes working in a particular model might kind of preclude an openness to other models or even collaborating in some ways. (Participant 24)

Yeah, I felt like the people in mental health, they would never understand anything to do with my histories of childhood sexual abuse or my histories of being repeatedly sexually assaulted...They will just write everything off as being psychosis, whereas for me, it's a lot more complicated than that. (Participant 7)

## Conclusion

The findings from these in-depth narrative interviews highlight the challenges women face when trying to access services in the context of mental health problems and sexual violence. The women in this stage of the study had long and often complex relationships with health services, and many had accessed a range of services before finding one that suited their needs. It is critical to note the emphasis placed on individualised care that encompassed women's holistic needs, and care that was delivered in ways that made women feel heard, connected, and supported on their pathway to safety and care. The next section will explore the use of digital storytelling as a mechanism for women to communicate around trauma and have their voices heard.

## Digital storytelling in the context of mental health problems and sexual violence

*Delanie Woodlock, Laura Tarzia, Kelsey Hegarty*

### Background and aims

Digital storytelling is a participatory visual and digital method of research. The technique was first developed in 1993 in California by the Center for Digital Storytelling (now known as StoryCenter). The process takes place in a workshop environment where people with no professional media experience are guided through an autobiographical writing method, then use photos, video, and other images to create short, first-person multimedia projects called “digital stories” (Alrutz, 2015; Lambert, 2013).

The origins of digital storytelling are rooted in the area of critical theatre, where the main objective is to create awareness around social justice issues for marginalised people (Lambert, 2013). It has been used in healthcare settings (Clarke & Adam, 2012), educational settings (Benmayor, 2008; Robin, 2008), and for engaging community action (Beeson & Miskelly, 2005; Rossiter & Garcia, 2010). Its use in the context of violence against women and trauma is limited, despite its obvious potential as a form of narrative therapy (Morgan, 2000). One example is the Silence Speaks project, which includes women's stories about their experiences of male violence as a way of “promoting gender equality, health, and human rights” (StoryCenter, n.d.). Participants described digital storytelling as a powerful therapeutic and healing tool (Hill, 2008), and highlighted the process itself as being equally as important as the finished product (Juppi, 2015).

Digital storytelling in the WITH Study had two main functions. First, it was a vehicle for women to tell their stories about their mental health problems and experiences of sexual violence in a creative way. Through the workshop and subsequent reflective diaries and interviews with the participants, we aimed to answer the research question, “How does the process of digital storytelling affect women's mental health and wellbeing?” Secondly, the stories were used (with the women's permission) to create awareness and promote understanding among health professionals in the areas of mental health and sexual violence.

### Methods

Five women were involved in the digital storytelling workshop: Jelena, Haru, Anne, Christina, and Heather (all pseudonyms). Two of the women had participated in a previous stage of the WITH Study and expressed an interest in further involvement. Another responded to a targeted advertisement at CASA House, and two more were recruited through another project addressing unwanted sexual contact. Ethics approval for this stage of the study was received from The University of Melbourne Human Research Ethics Committee (Project 1545139, approved 7 October 2015).

The workshop was held over 2 days in October 2015 at the Australian Centre for the Moving Image (ACMI), where the women were guided through the scripting process and assisted with how to construct a digital story. Participants were also taught about storyboarding, digitising story elements, editing systems, and the production of their digital story. Experienced facilitators from ACMI, as well as two researchers from the WITH Study, were present to support the women.

After the workshop, participants were asked to write down their answers to a series of reflection questions. The same questions were asked several months later, during February and March 2016, in an interview to examine if their feelings had changed after a period of time and what the impact had been on their longer term mental health and wellbeing. The questions explored participants' motivation for being involved, their understanding of digital storytelling, their hopes for the workshop, what they felt challenging, and if they thought this method would be useful for others who had also experienced trauma.

### Key findings

Women's responses to the digital storytelling workshop and its impacts can be summarised under the headings below. Although we have integrated women's views from the reflective diaries (immediately after the workshop) and the interviews (4-5 month later), we have indicated throughout which time point each comment was from.

#### Why women wanted to be involved

The women said they felt motivated to be involved in the digital storytelling workshop for two main reasons: to share their story so that it may help others (including other victims/survivors of sexual assault and professionals in the areas of mental health and sexual assault); and to learn a new way to express themselves. Jelena wrote in her reflection:

I wanted to be part of the project because I wanted to obviously partake in it as part of my healing process, but also to encourage other men or women who might have been in a similar position to me to speak out and promote awareness. For too long, abuse, whether it's sexual, emotional, or physical, has been swept under the rug or been kept secret. I wanted to encourage people to not feel ashamed... I also felt it necessary to be part of the project to give some understanding to health professionals from a firsthand perspective.

Similarly, Haru stated in her reflection that she hoped her story “could help other women experiencing similar issues and also clinicians/health professionals for their work”. Heather hoped that being involved in the project would “give some understanding to health professionals from a first-hand perspective” (Interview).

Learning new skills and different ways to express themselves also motivated participants to be involved, with Anne stating in her reflection: “It was a great chance to tell my story in a different way and for a particular purpose. It was also good to learn a bit about video editing software.” Similarly, Christina wrote in her reflection that the workshop was “a good opportunity to be involved in something interesting and creative”.

### Benefits of digital storytelling

Overall, both in their immediate reflections and in the interviews several months later, participants stated that being involved in the digital storytelling was a positive experience. Several of the women felt that the process was cathartic and that it provided some closure on painful experiences. Participants also found the particular form of expressing themselves through digital storytelling a unique and powerful process. The use of a group setting to create the stories was also mentioned as inspiring, and they found it meaningful to be with other women and share their stories. The participants felt that their voices were valued and heard, and that their story was important.

### A cathartic experience

Two of the women wrote in their reflections that they hoped being involved in the project would be a cathartic experience and that they would be able to use the workshop as a part of their healing process. Jelena wrote that she “hoped to feel somewhat cathartic as a result”. Christina stated that she “tentatively hoped that it would be a cathartic experience, but [before doing the workshop] I was doubtful”. Christina reflected later, in her interview, that telling her story in a creative way did turn out to be cathartic for her:

I was really in two minds about doing the digital storytelling workshop because I wasn't really sure how it was going to go, and how I would feel about it, and whether I really wanted to unpack a lot of those sorts of feelings again, and delve into them when they were pretty well tucked away and I didn't have to think about them. So many things that I thought and felt I had just put away—I don't want this to be part of my everyday life. I don't want to think about it or identify with that. I'll just put it away. So when all those thoughts and feelings were quite distant,

they're really easy to...I don't know, I suppose think of them as someone else's rather than being a part of my life. So going into all of that—it was a very strange process. It was cathartic, too.

Jelena also stated in her reflection that the workshop formed a “significant part in my own healing process”. For Haru and Heather, the workshop signified a shift in how they viewed themselves and that they were able to move forward in their lives differently as a result of the digital storytelling. Heather wrote in her reflection:

I found the process of storytelling extremely useful. It helped me to shed the mantle of an abused woman. I was for 28 years—but now I'm not. I have been an abused woman, but I am not now.

Similarly, Haru stated in her reflection: “After finishing the workshop I felt as if I had sealed my past and moved on a new life.” In the follow-up interview, Haru explained in more depth the impact the workshop had on her recovery journey:

I finally was able to move on. I went to CASA House at the end of last session and I knew I don't need to go there anymore. I didn't know when the time was that I could stop with the sessions, because they don't tell me I don't need to come. I was the person who needed to tell. But this story, I felt everything was clear myself. And I was able to move on and be so much happier. I knew the flashback wouldn't come back anymore because I did this digital storytelling workshop. It was sort of my final expression of all that pain.

### Powerful and creative form of expression

Two of the women found that using digital storytelling was a powerful way to express themselves and that the creative process was therapeutic. Anne wrote in her reflection, “Overall I think the digital storytelling workshop is a powerful tool to use in this type of work and I was very pleased and grateful to have the chance to be involved.” Anne also felt that the actual process of sharing stories was powerful in itself: “It was wonderful to meet the other women in the workshop and although their stories were painful to hear, there is a lot of power in sharing them”, she said in her reflection. Haru felt that “it was a powerful process emotionally and very therapeutic for me, and the group process reduces feelings of humiliation, stigma, and other negative feelings” (Reflection).

Anne noted that the creative process of making a digital story provided her with a different way to think about her trauma, and this was transformative for her. Initially, she wrote in her reflection:

Being able to talk about or express trauma in a creative, more "abstract" way gave me a great opportunity to think about it differently...The process of making the films and then sharing them is a way of transforming them and giving them a positive purpose.

In her interview, Anne expanded on this:

There is something about telling your story in not just words, like, "Oh, yeah, I was abused and this is how I felt". I keep coming back to the word *transform*. That's the real centre of it: that you're transforming the pain into something else.

### Sharing with other women

Four of the participants said that being in a group with other women was one of the highlights of the experience for them; the experience was enhanced by being able to share it with a group of supportive and understanding women. Heather wrote immediately after the workshop: "I met other people who have been through similar experiences and I felt safe sharing my story." Haru also wrote: "It was a very positive experience that we all have the same goals to complete our digital storytelling by encouraging and supporting each other."

Jelena wrote that she valued being a part of the project because she was able to form friendships with other women and the workshop had a significant impact on her because she was "surrounded by incredibly strong women, all who each had a very hard but powerful story to tell" (Reflection).

Anne wrote in her reflection:

I found this weekend very moving and inspiring. It reminds me how strong and resilient people can be in the face of terrible situations. I think we were all proud of the short films we made.

### Feeling listened to and valued

The participants said that being able to tell their stories made them feel valued and heard. Jelena said in her reflection that she was made to "feel really important and as though my story was a necessary story to tell" and that:

...even though the women who ran the workshop weren't there to divulge into their own personal lives, they made me feel incredibly comfortable with opening up and really digging deep into my story.

Haru wrote:

It was a very positive feeling that we shared our stories and received feedback and we applauded each other before finishing the workshop. I always felt very safe and protected

by very caring staff during the workshop.

Christina felt that "the staff were wonderful and supportive and understanding" (Reflection).

### Challenges of digital storytelling

While the participants found the digital storytelling workshops a positive experience, they also found the process challenging. They mentioned that, before doing the workshop, they were fearful of being re-traumatised, both in telling their story and hearing other women's stories. Several women were distressed during the workshop and it was confronting for them to tell their stories in such detail. The participants also were concerned that, by telling their story in a public way, they might be identifiable, and they felt quite vulnerable with their story being visible. It should be noted that the research team provided participants with a choice around how public they wished their story to be, with the options being: 1) keep the story for their own private use; 2) allow the story to be used for teaching or training purposes only; or 3) allow the story to be published publicly on the ANROWS website. All the women chose the last option to make their stories publicly available.

### Feeling distressed

Haru wrote in her reflection that she had a flashback during the workshop. In her follow-up interview, she explained that it occurred when looking at images with one of the ACMI staff. Haru said:

Yes, she showed me the articles on the computer and when I saw them, it reminded me of my incident and got a flashback. She didn't know my situation. So when she showed this, I was very uncomfortable and I couldn't be rude to her. I was very scared. I couldn't tell her. I just said I'm sorry, I need a break. I was very, very uncomfortable and scared.

Haru did not have any more flashbacks and was not distressed after the workshop finished. Jelena found the process quite overwhelming, as she had to examine her experiences in detail:

Reflecting on the graphic details of my story was very confronting and editing such a huge story into a nutshell was difficult because I had so many significant details.(Reflection)

Anne and Christina said they felt distressed after the workshop. Anne wrote in her reflection: "I felt a bit fragile over the weekend and for a day or two afterwards, as I thought I might be, but overall I was fine and very happy to be part of it."

Christina was surprised by the impact the workshop had on her. She wrote in her reflection:

Whilst sharing my story was cathartic, it made me realise that I had put away a lot of feelings and thoughts about it and had consequently thought I was “fine” and over everything. However the workshop definitely made me access a lot of feelings I had forgotten I had. It wasn’t “re-traumatising”, but it was more distressing than I expected it to be.

Anne felt upset with not only telling her story, but also by hearing other women’s stories:

Sharing your story is always confronting and a bit upsetting. And also to hear what happened to the other women. Each story has its own particular horror. It is always distressing to hear it, but the fact that we were all there together doing the workshop gives you a sense that they’ll be okay. (Interview)

### Being exposed

Heather and Christina said they were concerned about potentially being identified through their stories. Heather said in her reflection:

My only concern about doing the workshop was having a name on it. Obviously our names aren’t on them. Or making it and people—whoever they were—recognising that I had made that. Someone identifying that I made that.

For Christina it was more than just being identified. It was also the feeling of having her story “out there”. She said in her interview:

It’s incredibly personal. And to make something tangible that other people can see and access. And even though I know that no one is going to know that’s me, just knowing that it’s out there is kind of scary.

Knowing that others would see the story made Christina feel uncomfortable and hold back in expressing herself. She said:

I think I would have felt really much more comfortable with it if it was a process just for me. I’m more than happy for it to be used in the research, because that was the whole point. But if someone was saying it’s a really therapeutic thing for you to do to explore your feelings, and no-one’s going to see it and it’s not going to go anywhere. And just to get it out might be really helpful, I might have—not put a lot more into it, but I would have felt like I could express myself a lot more if no one else is going to see it.

### Long-term impacts

The participants’ answers to the reflection questions immediately after the workshop and their responses several months later were very similar. The women still felt that, overall, the process had a positive impact on their mental health and wellbeing. As the interviews were conducted sometime after the workshops, the participants had an opportunity to reflect on the way the project had an impact on them in a more long-term way.

### Conclusion

Overall, the women who participated in the digital storytelling workshop found the experience positive. For some, it was transformative. It was a cathartic process, one that enabled them to express their painful experiences in a different and creative way. This led to several of the women feeling that they could move on in a significant way from their past traumatic experiences. Feeling valued and listened to made the women feel that their stories mattered, and that they had an important contribution to make. Through the process of creating their digital stories, the women were, in Anne’s words, “transforming the pain into something else”.

However, at varying levels, the workshop caused distress for all five women, and some lingering anxiety in the longer term for one of them. Digital storytelling is a powerful tool to enable women to work through their traumatic experiences, and, because of this, it may unsettle some women beyond the workshop. It is critical, therefore, that appropriate support from experienced staff be available to women who have experienced trauma such as sexual violence, both during and for some time after a digital storytelling workshop.

## Ethical considerations: working with women

Working with women in this sensitive area can be challenging (Ellsberg & Heise, 2002; Ellsberg, Heise, Pena, Agurto, & Winkvist, 2001). In general, when researching trauma or violence, it is important for researchers to develop a strong ethical framework to avoid re-traumatising or otherwise overly distressing women who consent to participate (Bender, 2016). At all times, participant safety and wellbeing should be paramount. On the other hand, the inclusion of survivor voices is essential to doing good research in the area of violence against women. Consequently, the sensitivity of topics such as trauma and sexual violence should not cause researchers to avoid doing this important research.

As part of the WITH Study, a number of ethical considerations were taken into account. These included:

- Interviewer sensitivity: Campbell and colleagues (Campbell, Adams, Wasco, Ahrens, & Sefl, 2009) have outlined key recommendations for interviewing rape survivors for research. These include being non-judgemental, knowing when to normalise participants' experiences, active listening, and empathy.
- Language: not all women identify their experiences of sexual violence, sexual assault, or rape using this language. Consequently, recruitment materials referred to "unwanted sexual contact" rather than "sexual assault" or "sexual violence" when recruiting from services not related to sexual assault specifically. On the other hand, where women were recruited from a sexual assault service (e.g. in the stage of the study conducted in NSW), it was assumed that this language would be acceptable.
- Giving control back to the participant: although most of the interviews delved into some level of detail regarding women's trauma histories, how much or how little to reveal was left up to the participant.
- Option to withdraw: all participants were provided with the option to withdraw from the project at any time. None chose to do so.
- Managing participant distress: a number of participants became distressed when relating their experiences either in the interviews or during the digital story telling workshop. When this occurred, the interview or workshop process was paused and the participant was offered a cup of tea, glass of water, or tissues. She was then given a choice whether to continue or halt the interview or development of the workshop. On completion of the interview or workshop (regardless of whether distress was evident), participants were encouraged to sit and chat with the interviewer or facilitator informally before leaving the venue.

The following section of the report focuses on health systems change, drawing on the voices of women from Part A.

# Part B: Health systems change

## Introduction

Part B of the report is divided into two main sections: “Engaging staff in health systems change” and “Enacting and understanding change in health systems”. The introduction to Part B describes general health systems models in the violence against women area, followed by evidence of what works to change practitioner behaviour in the health system, including some details about normalisation process theory, a theory of implementation. This is followed by a description of consultations with staff at a major public hospital, a clinical mental health service, and two sexual assault services. The second section describes the process of enacting change at a major public hospital and a sexual assault service, followed by the findings of interviews with staff about how they understand health system change in the context of sexual violence.

In Part B we have included the broader context of family violence for several reasons: it was impossible to disentangle the two areas, as much of sexual violence is perpetrated in the family setting and some of the health system change was aimed at both sexual violence and family violence. As a consequence, we have asked about family and sexual violence in the practitioner’s interviews, as there had also been a focus of training and system change in both family violence and sexual violence.

## Health systems models

To best address the needs of women experiencing mental health problems and sexual violence, it is vital to strengthen health systems. Health systems are how people, institutions, and resources are organised to deliver services to meet the health needs of target populations, which in the WITH Study are women who have experienced sexual violence and mental health problems. Strengthening health systems in the violence against women area requires not only effective interagency integration, but capacity building, protocols, and referral networks (Garcia-Moreno et al., 2015).

In addition to women or patient centred care (Garcia-Moreno et al., 2015) a system response involves promoting:

At the health practitioner level:

- a culture of gender equitable attitudes;
- trauma-informed principles (respect, privacy, confidentiality, safety);
- a context of sufficient time allowed in consultations;
- a supportive environment with leaflets and posters; and
- an awareness about protocols and referrals.

At the systems level:

- coordination of internal and external referrals;
- protocols for identification, first line response, and referral;
- workforce support and mentoring;
- appointment of champions who have a deep understanding of sexual and family violence;
- finances allocated to services for sexual and family violence;
- leadership and governance demonstrated by policies;
- appropriate design of spaces; and
- information systems for evaluation (Hegarty, 2015).

The above model was described for the Royal Commission on Family Violence in Victoria from World Health Organization work on intimate partner and sexual violence (World Health Organization, 2013a, 2013b), with a focus on low and middle income countries. There have been several health systems models described in the international literature in New Zealand and the United States of America mostly focused on domestic or family violence rather than sexual violence and mental health (see Appendix A). They are described briefly in an appendix as background to the broader work on family violence, which includes sexual violence, occurring during the time of the WITH Study in Victorian hospitals.

We were unable to find a specific health systems model for mental health and sexual violence services, although as we have already discussed in our introduction and our state of knowledge report (Quadara, 2015), there are many general trauma-informed care guidelines that exist (Australian Women’s Coalition, 2010).

## Health systems change

We know that organisational change in healthcare is challenging, but research tells us that certain types of change-stimulating activities are more likely to result in long-term change than others (M. Johnson & May, 2015). In particular, organisational change that focuses on the work that people do with each other, and clarification of roles and resources and appraisal and feedback of the activities that are carried out have been found to be most effective (M. Johnson & May, 2015), compared to change that focuses on individuals. Combining such interventions is most likely to change behaviour.

A scoping review (Spalding et al., 2015) on knowledge

translation in the violence against women field recently found only four studies related to sexual violence and 20 related to domestic violence where strategies had been used to increase the use of evidence in practice. The majority of the included studies used educational interventions (predominantly staff training and the provision of resources). Ultimately, although the number of included studies was small and the evidence-base weak (no RCT studies were identified), the authors concluded that using a combination of strategies was the most likely facilitator of successful implementation of evidence-based practices and policies. For instance, staff training combined with organisational protocols, strategies that targeted both the individual and the organisation, and ongoing support and supervision were the most effective. Barriers to knowledge translation included a lack of time and privacy, and lack of staff confidence to address domestic or sexual violence.

Due to the limited evidence base in the VAW area (Spalding et al., 2015), we have chosen to draw on the evidence for different strategies to change health systems in general. Outlined below is evidence for particular types of strategies, taken from recent systematic reviews from all areas of health, none in the VAW area (as the systematic reviews focused on randomised controlled trials).

**Persuasive type strategies** include marketing and mass media, local consensus processes, and local opinion leaders. It is hard to separate the effect of marketing and mass media as they usually occur in conjunction with other interventions. Two systematic reviews of local consensus processes (Fleming, Browne, & Byrne, 2013; Oxman, Thomson, Davis, & Haynes, 1995) showed no clear improvement in practice or patient outcomes. A systematic review (Flodgren et al., 2011) found that local opinion leaders had a positive effect on professional behaviour change but it was difficult to ascertain effect on patient outcomes. Usually persuasive methods are not used alone, so it is not always easy to sort out the effects; however, local champions or opinion leaders are often recommended as part of a systems change process.

**Educational and informational strategies** include patient-mediated interventions, distribution of educational materials, educational meetings, and educational outreach (where the educator visits the practitioner one on one in the workplace). All these strategies have benefits for professional behaviour and management, with a smaller number of systematic reviews finding a benefit for patients (Chhina et al., 2013; Forsetlund et al., 2009; French, Green, Buchbinder, & Barnes, 2010). Training of practitioners in meetings and workshops is a standard part of systems change, although educational outreach (also known as academic detailing) is more likely

to be effective, but has greater resource implications due to the one-on-one nature and the travel involved.

**Action and monitoring strategies** to change behaviour include audit and feedback, as well as reminders to undertake an activity. In a systematic review (Ivers et al., 2012) audit and feedback led to improvements in professional practice and patient outcomes. Effectiveness is enhanced if the audit collects baseline measures and the feedback is delivered by a supervisor or a peer, is repeated, and results in an action plan. Computer-based clinical decision support systems, computerised information systems, and computerised reminders have been shown to be beneficial in improving the process of care, with some systematic reviews showing an effect on patient outcomes (Arditi, Rege-Walther, Wyatt, Durieux, & Burnand, 2012; Balas et al., 1996; Kastner & Straus, 2008; Shojania et al., 2009). However, audits need to be resourced, especially audits of patient records, whilst self-audits are variable in their quality of reporting. Computerised decision aids and reminders also have major resourcing implications, depending on the computer systems in place.

Recent systematic reviews (Chaillet et al., 2006; Medves et al., 2010) showed that multifaceted strategies, particularly for complex health care areas, are of more benefit. For example, interventions that link local opinion leaders, audit and feedback, and reminders were the most effective. (M. Johnson & May, 2015). Identifying the barriers to change before implementation and tailoring to overcome these is more likely to lead to success. A summary of the strategies outlined in this section that have been shown in systematic reviews to enact change are summarised in Table 2.

### Normalisation process theory (NPT)

The use of theory to inform any implementation of interventions and as frameworks for evaluations assists with effectiveness of organisational change. For the WITH Study we drew on normalisation process theory as it has been used widely in the health care sector but also has been used as a framework in the violence against women area (Hooker, Small, Humphreys, Hegarty, & Taft, 2015; Hooker & Taft, 2016; Spangaro, Poulos, & Zwi, 2011).

Normalisation process theory (NPT) is an evidence-based sociological theory developed by Carl May and colleagues that aims to clarify the processes by which interventions, new behaviours, or ways of doing things become embedded into everyday practice (May, 2013; May & Finch, 2009). It is particularly useful when trying to implement complex interventions into organisations such as healthcare settings (May et al., 2007). NPT understands implementation in

relation to the work that people do. It focuses on the meanings people attribute to the work, their capacity to carry it out, the ways the work is actually enacted in an organisation, and how people feel retrospectively about the work they have done. These are reflected in the core constructs of coherence (what is the work?), cognitive participation (who does the work?), collective action (how does the work get done?), and reflexive monitoring (why did it happen that way?) (May & Finch, 2009). By exploring the extent to which each of these constructs is addressed by an intervention, NPT can help to determine why it does or does not work in practice. Later in this report, we draw on NPT in order to understand the process of embedding a systems model of trauma-informed care in a large tertiary hospital.

The following sections of the report outline two stages of the WITH project that explored the following question:

*What factors influence the implementation of elements of a trauma-informed systems model of care for women experiencing mental health problems and sexual violence?*

The first section outlines a deliberative dialogue process with 33 staff (clinicians and managers) from the Women's Hospital and Northern Area Mental Health Service around how the delivery of trauma-informed care for women who had experienced both mental health problems and sexual violence could be strengthened and improved. Women's voices and digital stories from Part A of the WITH Study were used as part of this engagement stage, culminating in suggestions and directions for strategies to be implemented. The second section of Part B uses the case study of the Royal Women's Hospital to explore the implementation of a range of activities and initiatives around changing the system to support trauma-informed care for women who have experienced sexual or family violence. We report briefly on our work with the Northern Area Mental Health Service.

## Engaging staff

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### Background and aims

The integration of high-quality research evidence into the daily clinical work of health professionals to deliver effective patient care is an example of a practice that requires both behavioural and organisational changes to implement (Curran, Grimshaw, Hayden, & Campbell, 2011; Grimshaw, Eccles, Lavis, Hill, & Squires, 2012). There are numerous barriers to achieving this, including the complexity of professional behaviour change interventions that require collective action by multiple staff across hierarchical levels of an organisation and prove difficult to apply at an individual practitioner level (Clark, 2013). Moreover, environments in which health professionals work that value high patient-flows may place minimal value on knowledge translation of organisational or systems-level interventions. Thus a cultural shift is necessary to promote health systems change (Harding, Porter, Horne-Thompson, Donley, & Taylor, 2014) from a focus only on responding to the needs of the client in front of the health practitioner (Weng et al., 2013). Health professionals' awareness of and engagement in their organisational culture—the values, beliefs, and assumptions that are shared and shape workplace behaviour—is necessary to foster positive change processes that result in improved patient outcomes (Hemmelgarn, Glisson, & James, 2006; Miettinen & Virkkunen, 2005).

Despite the substantial value of multi-sectoral collaboration, there are many significant impediments to achieving this, including the differing organisational cultures, histories, knowledge bases, and underpinning philosophies (Lavis, Horrocks, Kelly, & Barker, 2005; Warshaw, 1989). Successful partnerships rely on a commitment to building trust, a shared sense of purpose, the development of institutional empathy, personal relationships, and leadership that creates an inclusive environment (Laing, Irwin, & Toivonen, 2012).

This section of the report describes consulting with staff from a variety of discipline backgrounds at a major public hospital, a clinical mental health service, and two sexual assault services to focus on envisioning what a trauma-informed systems model of care might look like in each of the participating services. Each service has an existing framework guiding its practice; the focus was on strengthening these frameworks and on how collaboration between mental health and sexual violence services could be facilitated. The question that was asked at the consultation was:

*What can we change at the service to further promote and embed a trauma-informed systems model of care for women who have experienced sexual violence and mental health problems?*

## Methods

In order to explore health practitioner views around how trauma-informed care could be more effectively delivered, four workshops were held between January and August 2016 with 33 staff (see Table 1). Recruitment of participants involved WITH team members consulting with senior management of the hospital and clinical mental health service, and attending team meetings to distribute expressions of interest, as well as the distribution of emails to all relevant staff inviting participation. Personal approaches were also made to particular key staff.

A deliberative dialogue method was used. Deliberative dialogue is a form of discussion aimed at finding the best course of action (Boyko et al., 2014). It allows evidence to be considered together with the views and experiences of those involved with the issue. Deliberative questions take the form "What should we do?" and the group does not need to reach consensus on the topic to move forward. Notes are taken during the workshop but they are not usually audio-recorded.

Ground rules for deliberative dialogue (Shultz & Hamdon, n.d., p. 4):

- Focus on the approaches, considering the pros and cons of each.
- Everyone is encouraged to participate, but you have the right to pass.
- Speak your mind freely, but don't monopolise the conversation.
- Listen carefully to others and maintain an open mind.
- Help to develop one another's ideas; ask clarifying questions.
- Engage in friendly disagreement, but don't personalise a conflict.
- Don't get stuck arguing about facts and figures or evidence.
- Confidentiality will be respected—what is said in the room stays there.

The process works best when people come to the meeting informed by written briefs beforehand. We provided the following short summaries below for participants to read before they came:

- thematic analyses of interviews with 33 women recruited through the Women's, Northern Area Mental Health Service, and Centre Against Sexual Assault (CASA House) to foreground their voices in the discussion;
- the features of a systems model of care identifying what the hospital or clinical mental health service had already developed;
- evidence for effectiveness of different methods of systems change within hospitals; and
- a synthesis of the above in table form (see Table 2).

**Table 1** Organisational location of staff who attended the four deliberative dialogue sessions

Service	Number of staff
Centre for Women's Mental Health	5
Centre Against Sexual Assault (CASA House)	6
Northern Area Mental Health	4
Northern Centre Against Sexual Assault	4
The Royal Women's Hospital	13
Inner Melbourne Community Legal service (at the Women's)	1
Total	33

**Table 2** Summary of women's interview themes, health systems models, and change evidence

Women's voices' themes	Health systems model	Evidence of what works best
<p><b>Connect me</b></p> <p>Women want:</p> <ul style="list-style-type: none"> <li>• Awareness and easy access to trauma-informed services</li> <li>• Referral to other services where needed</li> <li>• Better service integration</li> </ul> <p>Barriers:</p> <ul style="list-style-type: none"> <li>• Lack of funding</li> <li>• Inflexible service system</li> <li>• Lack of ongoing support</li> </ul> <p><b>Hear me</b></p> <p>Women want:</p> <ul style="list-style-type: none"> <li>• Validation</li> <li>• To connect with the right person</li> <li>• To build trust with services</li> </ul> <p>Barriers:</p> <ul style="list-style-type: none"> <li>• Not being listened to</li> <li>• Feeling that no one can help</li> <li>• Lack of sexual assault training</li> </ul> <p><b>Heal me holistically</b></p> <p>Women want:</p> <ul style="list-style-type: none"> <li>• To be treated as an individual</li> <li>• To thrive, not just survive</li> <li>• Practical help</li> </ul> <p>Barriers:</p> <ul style="list-style-type: none"> <li>• Different paradigms</li> <li>• Lack of individualised care</li> </ul>	<p><b>Create cross-hospital leadership and momentum</b></p> <ul style="list-style-type: none"> <li>• Strategies to engage the hospital personnel from the top down</li> </ul> <p><b>Changing culture</b></p> <ul style="list-style-type: none"> <li>• Identifying prevailing culture within the hospital and building capacity for change</li> <li>• Partnerships with hospital consumers with lived experience</li> <li>• Ensuring staff safety</li> </ul> <p><b>Laying the foundation through policy, procedures, and guidelines</b></p> <ul style="list-style-type: none"> <li>• Adaptation and development of relevant policies, protocols, and guidelines to identify and document experiences of family violence and subsequent referrals (integrated with family violence sector)</li> </ul> <p><b>Building capacity and capability</b></p> <ul style="list-style-type: none"> <li>• Increasing key staff competencies</li> <li>• Provision of clinical training to improve knowledge and ability of staff to identify and respond to family violence</li> <li>• Provide support to clinicians undertaking the work</li> </ul> <p><b>Building partnerships with wider community and family violence sector</b></p> <ul style="list-style-type: none"> <li>• Support consumer participation and consultation</li> <li>• Increasing referrals of victims/survivors within health services and externally</li> </ul> <p><b>Evidence leads best practice</b></p> <ul style="list-style-type: none"> <li>• Improve data collection</li> <li>• Evaluating success of the model</li> </ul>	<p>Tailoring of multiple strategies to overcome the barriers in the complex system.</p> <p>Tailoring of multiple strategies to overcome the barriers in the complex system.</p> <p><b>Persuasive strategies</b></p> <ul style="list-style-type: none"> <li>• Local opinion leaders</li> </ul> <p><b>Educational strategies</b></p> <ul style="list-style-type: none"> <li>• Educational outreach</li> </ul> <p><b>Action and monitoring strategies</b></p> <ul style="list-style-type: none"> <li>• Audit and feedback</li> <li>• Computerised decision aids</li> <li>• Reminders</li> </ul> <p><b>Potential issues</b></p> <ul style="list-style-type: none"> <li>• Resources</li> <li>• Staff</li> <li>• Finances</li> <li>• IT infrastructure</li> </ul>

## Survivor voices

The workshops began with showing one of the digital stories developed for the WITH Study. The WITH Study has a firm commitment to listen to and be guided by the voices of victims/survivors. Consequently, two survivors were approached to co-facilitate the deliberative dialogue workshops. A 2-hour training session was held with both of them and regular contact was made before and after each workshop.

One of the facilitators later reflected on her experiences:

For me personally, my participation in the workshop was one of the most powerful things I've done in terms of healing. As you know, I've done other advocacy work in the past, so it felt very exciting to be able to do that at this level, with the people and organisations who work directly with women in my situation. I've worked in public education for several years so I have some idea about issues around funding, adequate time, and resources for service provision, and systemic change. I appreciate that there are challenges but the main sense that came out of every workshop was that everyone wants to make sure women are receiving the best possible care.

One of the co-facilitators presented on her experience at the conference Nursing Network on Violence Against Women International in October 2016. She discussed how there are many issues to address when working with survivors of abuse and violence, including their stage in the healing process. Furthermore, there is a need to ensure duty of care and to provide support when working with survivors. Managing expectations and having clear communication about roles is also important. Issues of setting boundaries, time commitment, and payment need to be clear. This co-facilitator gave the WITH Study work a Triple AAA Rating on providing Agency, Alliance, and Appreciation.

## Procedure and analysis

Each workshop was held at a convenient site for practitioners, usually one of the service workplaces. At each workshop there was a team member who led the workshop, a co-facilitator, and another team member who took notes, including any non-verbal expressions of support or dissent for suggestions. Photos were taken of the white boards to aid memory. The research team met to review all the material, to discuss the main strategies suggested, and to categorise them as outlined below.

## Key findings

The following main themes and suggestions were collated from the deliberative dialogue session notes in response to the question:

*What can we change at the service to further promote and embed a trauma-informed systems model of care for women who have experienced sexual violence and mental health problems?*

Details of suggestions related to each theme were discussed in the deliberative dialogue sessions. Suggestions were only included if they were reinforced by multiple staff.

### Relationship building between teams: "opportunities to dialogue"

Many people across the four workshops suggested there was a need for a real commitment to relationship building between mental health and sexual violence services and additional resources invested to support this, rather than services only connecting during the times when difficulties arise or when there is need for troubleshooting complexities.

The following specific suggestions were proposed to strengthen communication and relationships:

- reciprocal information sessions between the different departments: a sharing of work;
- point case discussions; and
- creating stronger multi-disciplinary teams or providing co-therapy to understand women's stories holistically.

### Education and training

At each deliberative dialogue there was reference by the vast majority of participants to the need for education and training of staff and discussion on the need for training to include the voices of all women, especially women from diverse backgrounds.

Suggestions included:

- increase comprehensive education on trauma-informed or sensitive care for all staff across the organisation (including front-of-house or reception staff);
- develop online training modules, online competencies, or mandated training for staff;
- educational outreach is required, with champions driving the work;
- include tools and resources in training that help staff to engage in trauma-informed and trauma-sensitive practice;
- use women's voices more in the training and education of staff—e.g. use digital stories as a means of hearing from women; and
- use evaluation as an element of training and education.

### Terminology, shared language, and clear roles

These were discussed at each session. The dialogue workshop with a greater number of management staff identified that having shared language or understanding of trauma-informed care across services and between departments in the hospital or services would be beneficial to care. It was also acknowledged that trauma-informed care needed clarifying and that different services and staff may have different understandings of trauma-informed or sensitive care. There is a need to develop a consistent sensitive practice, gender sensitive, and trauma-informed care framework. Further, with regard to organisational strategies or frameworks that reference violence against women or trauma-informed care, there needs to be an understanding of how well these are embedded in practice in different parts of the organisation. Some staff may not know what these strategies mean in practical terms.

Many participants across the four workshops proposed that trauma-informed care should be embedded at all levels across the system and that organisations would benefit from reflection on the following questions:

- Does the service or hospital have a consistent understanding around a “social model of care” or “sensitive care”, and is this the same as trauma-informed care?
- How do other departments of the hospital apply trauma-informed care to their work practices?
- What are the barriers to applying trauma-informed care?
- To what level should we offer trauma-informed care?
- What are the expectations of the hospital in regards to trauma-informed care and what is the role of staff?

### Service integration and coordination of internal and external referrals

Strengthening communication and integration is fundamental to providing trauma-informed care. A whole of service response is required. The following suggestions were proposed:

- Share case notes or tools to support integration—for example, access to shared intranet and technology that supports clinical staff.
- Provide staff with clear roles and responsibilities for responding to patients who have experienced violence, and with a flow chart for clinical care.
- Form clear referral pathways and guidelines for referrals.
- A main person could be responsible for care but able to refer to other services while still keeping in touch with the client and continuing to see her—similar to case manager roles in other health areas.

- Use reciprocal secondary consultations—for example, provide phone advice from professional to professional while the woman is seeing one service (this could support women so they don’t have to physically access the other service).
- Services should recommend external providers for other consumer needs that cannot be addressed by the service they are currently attending.

### Workforce support and mentoring

Many participants identified the need to strengthen the support of the workers to undertake this sensitive challenging work.

Suggestions included:

- clinicians at the frontline should be supported and practice self-care so that they can care for others;
- trauma-informed counselling for staff that includes the provision of debriefing for all staff, including non-clinicians; and
- ensure any employee assistant programs are trained in dealing with abuse and violence issues.

### Some participants identified the need for strong leadership and governance

This included:

- champions (team leaders, advocates, clinical champions) to coordinate and promote trauma-informed care and promote trauma-informed work; and
- policies that endorse the importance of the work and encourage thoughtful reflection before speaking or acting.

### Information systems for evaluation

The following ideas were proposed in regards to clinical practice that is informed by women’s voices and responsive to feedback from women:

- evaluation to include women’s experiences, including focus groups and telephone interviews of consumers;
- audit processes that would allow regular progress updates to practitioners to encourage and motivate them; and
- there was an acknowledgement of intention to prevent women from falling through the cracks in the system by monitoring of negative experiences.

## Enacting and understanding change

*Laura Tarzia, Alyssa Fooks, Kirsty Forsdike, Sabin Fernbacher, Kelsey Hegarty*

### Introduction

During the WITH Study in October 2015-January 2017, there was significant change and activity generally in mental health and sexual violence services, in hospital settings, and in clinical mental health settings across Victoria. This section of the report describes the context of a particular public hospital (the Women's) and the Northern Area Mental Health Service that the WITH Study was working with, the consultations and changes that were specifically enacted as part of the WITH Study, and how we endeavoured to understand those changes in the systems. The two specific sites in Victoria were chosen as they had already enacted a lot of work over the last decade in the violence against women area. However, we primarily worked with the Women's and its associated sexual violence service. At this hospital site, we collected individual staff accounts about how the system has enabled or hindered care provided to women who have experienced mental health problems and sexual violence. We also provide an evaluation of a vicarious trauma workshop and the use of a family violence (including sexual violence) identification form in the emergency department of this hospital.

We begin by outlining the context within the Women's and how we enacted and understood change in that setting. We then conclude by discussing the limited engagement and enactment of some training with the Northern Area Mental Health Service and Northern Centre Against Sexual Assault. These individual staff accounts and evaluations, together with the deliberative dialogue findings, will then be drawn together in the final chapter—with the Part A findings from women's voices—to give an in-depth view of the complexity of these collective experiences.

### Context of systems change at the hospital site

Public hospitals have been required to respond to the National Plan to Reduce Violence against Women and their Children and the Royal Commission into Family Violence recommendations. The hospital involved in the WITH Study, the Royal Women's Hospital, currently has many elements of a health systems model for trauma-informed care or "sensitive practice" for responding to violence against women (Garcia-Moreno et al., 2015; Schachter, Stalker, Teram, Lasiuk, & Danilkewich, 2008; The Royal Women's Hospital, 2015). The Women's model uses a sensitive practice framework (Schachter et al., 2008) which promotes a way of operating as a health professional that is designed to increase a patient's sense of safety, respect, and control, ultimately reducing the risk of re-traumatisation for survivors, who may choose not to disclose abuse when questioned. For over a decade, the Women's has led the way in Victoria by developing a range of innovative and responsive programs for women experiencing all forms

In summary, the above section has outlined the key points that were made by staff across the workshops and across the different health sites. These focused on seven main areas for change:

- relationship building;
- education and training;
- shared understanding of language and roles;
- service integration and coordination of referrals;
- workforce support;
- leadership and governance; and
- information systems for evaluation.

### Challenges

There were several challenges in engaging and recruiting participants to the WITH Study workshops. These included:

- the busy nature of workplaces and demand of services;
- the practicality of all attending when not co-located;
- the varying engagement of different disciplines;
- changeover of staff at the services, so that earlier consultations by the WITH team had to be re-done with new staff; and
- maternity leave and sabbatical leave of three key WITH staff members impacted on engagement strategies.

The main strategy to overcome these challenges involved employing an "insider" from the hospital, Alyssa Fooks, who had a great understanding of how the complex system and culture at the Royal Women's Hospital worked.

### Conclusion

This section of the report has outlined how the WITH Study engaged with staff to explore their views on what might be good to change within their system to enable more effective delivery of trauma-informed care to women experiencing mental health problems and sexual violence. This involved four deliberative dialogue workshops with 33 staff. The main themes emerging were the need for relationship building between teams; a shared understanding of roles and language; integrated care and coordination of referrals; more workforce support; leadership and governance; and information systems for evaluation. The next section explores how the WITH project went about enacting and understanding change within the service systems.

of violence, from early intervention and response services, training and guidelines for clinical staff, crisis care for women after sexual assault, and case management of women at risk of family violence. This has included integrating legal and health services for women at risk of violence in their partnership with Inner Melbourne Community Legal Centre.

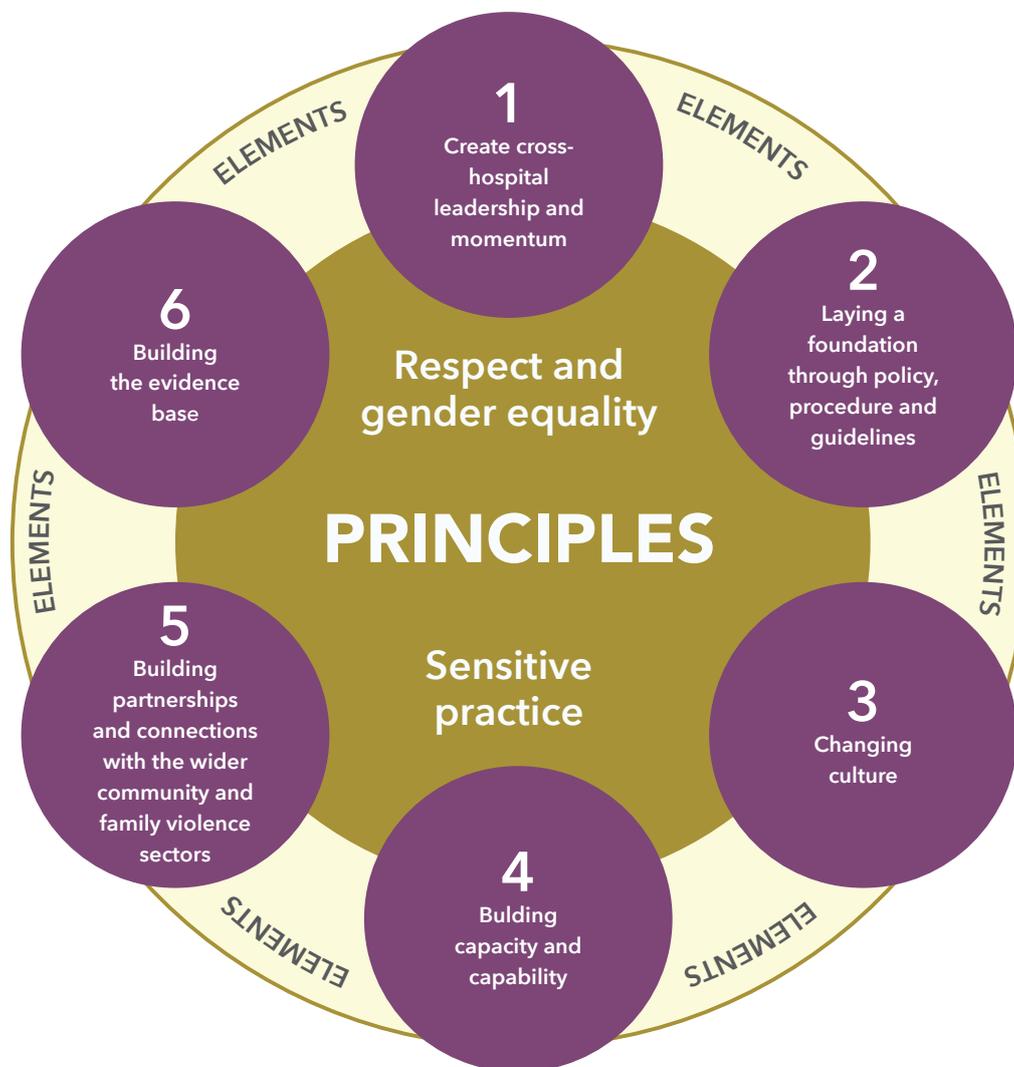
The Centre for Women's Mental Health (CWMH) provides mental health services to outpatients and inpatients of the Women's Hospital who require psychiatric or psychological assessment and intervention. The Centre provides an extensive range of services to women, including individual and group work, assessment, and treatment. It also offers specialist secondary consultation, education, and resources to external and internal health professionals seeking advice and support when working with women with mental health problems. The CWMH team comprises consultant psychiatrists, psychiatric registrars, a psychiatric consultation-liaison nurse, clinical psychologists, and an infant mental health clinician.

The Centre Against Sexual Assault (CASA House) is a department of the Women's Hospital but is not co-located on site. CASA House works to challenge the silence that surrounds sexual assault and to ensure that victims/survivors are provided with necessary support. CASA House offers a range of counselling, support, and advocacy services for victims/survivors of sexual assault, including 24-hour crisis care support following a recent sexual assault (within the last 2 weeks), short to medium-term counselling and advocacy support, a range of support groups, 24-hour telephone counselling and support, professional secondary consultation and debriefing, and community and professional education.

A key program in the Women's Hospital setting has been the Strengthening Hospital Responses to Family Violence (SHRFV) project funded by the Victorian Government. This project was established to increase the capacity of hospitals to respond to and prevent violence against women and their children, including sexual violence. There have been three stages to this project, with the Women's Hospital and Bendigo Health leading the program of work. The first stage commenced in 2014 between the Women's, Our Watch, and Bendigo Health, which was evaluated by Our Watch (Kearney & Gleeson, 2015). In their evaluation they commented on the complexities of hospitals as organisations and the lengthy time needed for review and approval of new policies, procedures, and guidelines that impacted on ability to enact change within 12 months. Further, they noted the lack of ability to record identification and response to family violence in different areas of the hospital as a key challenge.

When considering what change could be enacted as part of the WITH Study, it was important to consider how any work may either fit in with or expand the current SHRFV model (see Figure 3) and the prevent in /of violence against women strategy at the hospital. The WITH Study provided an opportunity and additional resources to build on the SHRFV work by choosing aspects of the model that could be enacted or consolidated and explored as part of the WITH Study. The Victorian hospital service model developed by SHRFV (including sexual violence) has six key elements, which are outlined in Figure 3.

Figure 3 Service model for family violence (including sexual violence) at the Royal Women's Hospital



## Consultation

Key to enacting change is consultation with management within the hospital service about any recommendations arising out of the WITH Study. The WITH team further consulted with hospital management by providing them with a recommendation brief (outlined below) synthesising the findings from:

- the state of knowledge literature review (Quadara, 2015);
- the evidence base for change in health systems outlined above;
- the ideas and suggestions from staff involved in the deliberative dialogue workshops;
- the recommendations and voices of women who had lived experience of violence from Part A; and
- the placing of these findings in the context of the existing work being undertaken at the hospital.

Importantly, many of these recommendations connect with the existing work of the CWMH and CASA House, the strategic focus of the hospital prevention of violence against women work, and the SHRFV work. For example, the hospital is already exploring having a joint position between the CWMH service and CASA House.

## Recommendations to enact from the WITH Study synthesis

Each recommendation has been organised under headings, which connect to components and evidence that drive systems change (Spalding et al., 2015). While these recommendations are likely to be relevant to a wide range of services, we specifically proposed in italics some changes to enact at the hospital.

### Service integration and coordinated case management

- Adapt or further develop relevant policies, protocols, and guidelines. The Women's hospital is in the process of updating the violence against women policy and family violence identification response and referral guideline. *It was proposed that this guideline could be updated to include sexual violence and mental health responses and referrals.*
- Embed case coordination, where there should be a main person coordinating care but who is able to refer to other services at the Women's Hospital.
- Develop a whole-of-service response, rather than concentrating only on sexual violence and mental health.
- Build further partnerships, including referrals with the wider community and the sexual violence sector.

### Training and support of practitioners

- Mandated education or training with online competencies for all staff, including administrative staff. Creating Exceptional Experiences for Women, a mandated training course for all practitioners that provides consumer stories to help inform practice, could include sexual violence or trauma-informed care case studies.
- Provide joint professional development to enable staff to get to know each other's services and provide reflection or training for clinicians to practice self-care.
- Develop further local consensus processes on roles and responsibilities of staff. Further develop a shared language across services through development of recommendations through an online process of endorsement of statements as to how the hospital could be working in this area.
- Develop further local champions and opinion leaders in the area of sexual violence, mental health, and trauma-informed care.

### Monitoring and evaluation

- Improve data collection on identification of sexual and family violence and referral within the hospital to enable feedback and reflection. *Explore the referrals to internal services at the hospital from the Women's Emergency Care centre using the family violence identification and referral tool.*

- Audit of training in sexual and family violence across the Women's as a baseline snapshot. *Survey selected staff (CWMH or CASA House and social work) or all departments across the hospital to see their current level of readiness to undertake this work.*
- Progress updates that encourage practitioner participation in integrated care. *Undertake a random audit of the files of selected clinics to obtain a baseline level of cross referrals within the hospital system for women experiencing sexual and family violence and mental health problems.*
- Improve understanding of practitioners' barriers and opportunities for engaging in this work. *Interview a selection of staff from CASA House and CWMH about their trauma-informed work and what changes in the system have assisted or might assist them.*

## Recommendations to enact at the hospital site

The WITH team then further consulted widely with the SHRFV team, strategy and planning team, hospital executive, and leadership of relevant departments to determine which of the above suggestions were most likely to be enacted within the time frame of the WITH Study. The WITH team proposed and gained support for the following specific activities to be enacted at the hospital that would build on the evidence, the SHRFV model, and prevention of violence against women work within the hospital (see Table 3).

**Table 3** Actions undertaken at the Women's Hospital May 2016 to January 2017

Recommendation	Specific actions undertaken
<b>Adapt or further develop relevant policies, protocols, and guidelines.</b>	Violence against women guideline includes a flowchart for family violence and sexual assault. This guideline was updated to include sexual assault and mental health responses and referrals.
<b>Improve understanding of practitioners' barriers and opportunities for engaging in this work.</b>	Interviewed a selection of staff from specialist services about their trauma-informed work and what changes in the system might assist them.
<b>Provide joint professional development to enable staff to get to know each other's services and provide reflection or training for clinicians to practice self-care.</b>	Vicarious trauma workshop—collaborative training delivered by the sexual assault service and mental health services for staff.
<b>Improve data collection on identification of sexual and family violence and referral within the hospital to enable feedback and reflection.</b>	12-week trial and evaluation of a family violence and sexual violence identification and response tool in the emergency department. Supported through obtaining leadership support, encouraging champions, posters, staff support, and reflection sessions, as well as social work presence in the emergency department.

During the process of undertaking the WITH Study, the context for each organisation required significant consideration. The considerable amount of work already in progress at the hospital assisted the process of developing and enacting change in that setting and provided leverage at the hospital because of the focus on violence against women as a strategic direction.

Ensuring that interventions or behaviour change initiatives are understood is vitally important (May, 2013). The next section reports on the outcomes from the interviews with practitioners, the evaluation of the vicarious trauma training, and the trial of the family violence and sexual violence identification tool. In particular, the section discusses how we explored practitioners' views on any changes that had occurred in the hospital system in this area or changes that they would like to see in the system.

## Understanding change

As the state of knowledge report (Quadara, 2015) for the WITH Study showed, there has been very little evaluation of interventions in the area of trauma-informed care and violence against women. The scope and timing of the WITH Study did not allow us to conduct a rigorous pre-post evaluation process. As an alternative, we mainly aimed to explore practitioners' understanding of some of the behaviour

change work undertaken by the WITH Study and the work being done as part of the Strengthening Hospital Responses to Family Violence (SHRFV) project at the Royal Women's Hospital. Little is known about how well the SHRFV model is understood in practice, or whether any improvements are needed.

The process had three separate components which are described in more detail below:

1. Qualitative semi-structured interviews with staff working across a range of departments within the hospital. These interviews focused on trauma-informed care and sensitive practice and the organisational factors that could promote or impede its effective delivery.
2. A feedback survey immediately following the vicarious trauma workshop.
3. Outcomes of the 12-week trial of the family violence identification and response tool in the emergency department.

## Methods

Participants for the health practitioner interviews were recruited primarily by a WITH Study team member employed at the hospital attending staff meetings across a range of departments. Interested participants were provided with a plain language sheet and consent form, and liaised directly with the research team member in order to coordinate a mutually convenient interview time with one of three interviewers from the WITH Study team. The team conducted a brief training session prior to commencing the interviews to ensure consistency in approach and questioning style. Interviews were conducted on-site at the hospital and lasted between 15 and 50 minutes. The interview guide asked participants to reflect on their experiences delivering sensitive care for women who had experienced violence (particularly sexual violence), the barriers and facilitators to effective delivery of sensitive care, and any organisational changes that had impacted on their work in this area. Interviews were audio-recorded and transcribed verbatim. Thematic analysis was used to identify key ideas within the data. An initial round of coding was carried out on all transcripts by a member of the research team to determine preliminary themes. Cross-coding was then carried out as a team to determine the final coding framework and ensure methodological rigour. The remainder of the transcripts were then coded in more detail using the revised framework. The coding framework is shown in Appendix C.

The feedback survey for the vicarious trauma workshop was a paper-based document delivered to all participants on completion of the session. Staff were able to evaluate the workshop and provide suggestions for future delivery.

Data from the 12-week trial of the family violence identification and response tool were entered into an Excel spreadsheet and reviewed with a focus on areas for improvement.

## Key findings

### Health practitioner interviews

A total of 27 female staff participated in an interview in December 2016 or January 2017. Participants were aged between 27 and 61 years (mean age of 44 years), worked in a variety of departments, and had roles as diverse as social workers, nurses and midwives, sexual assault counsellors, clinical directors, program leaders, liaison officers, physiotherapists, and psychiatrists.

Participants had worked in their roles for an average of 10.6 years (range of 1 to 33 years; median of 9 years) and at this particular hospital for an average of 3.6 years (range of 6 weeks to 11 years; median of 2 years). The training these participants had attended in relation to domestic violence and sexual assault varied widely from extensive training due to the specialist nature of their work to almost non-existent.

The majority of the health practitioners interviewed had a strong understanding of what trauma-informed care or sensitive practice meant in the context of women who have experienced family or sexual violence. Many spoke about the importance of “finding the right moment” and “creating opportunities” for women to disclose through normalising their experiences and building trust. Further, the need for “warm referrals” to services, where health practitioners actively assist women to access external support, was highlighted. In some cases, staff perceived sensitive practice as being willing to go beyond referrals and to actually accompany women to a service or provide practical support in other ways. Although there was a perception that some groups of clinical staff did not have adequate levels of training and awareness around trauma-informed care and sensitive practice, for the most part, there was a sense of a shared focus on the issue as important.

In terms of how the organisation could further enhance trauma-informed care or sensitive practice for women who have experienced violence, analysis of the health practitioner interviews revealed an overarching theme of “talking is good, but action is better”. Participants felt strongly that effective delivery of trauma-informed care and sensitive practice needed to be embedded into their everyday work, in addition to being part of the hospital’s profile and public message. In order for this to happen, resources (both financial and in terms of capacity) were critical.

The following sub-themes illustrate this in more detail:

### Spaces and places

The majority of staff emphasised the importance of having quiet, private spaces in which to engage in “difficult conversations” with women around family and sexual violence. The degree to which this was possible varied between departments, with some environments being more challenging than others. For instance, in the emergency department, there was very little opportunity to speak with women privately, which staff perceived as a barrier to being able to provide sensitive care.

Well the fact that everything is just a curtain as the door means that anyone walking past can hear your conversation, so it makes it a bit difficult. (Participant 4)

Similarly, social work staff pointed out that some wings of the hospital where post-natal care was provided did not have a designated consultation room. As social work was not located in close proximity to the maternity wards, this made it challenging to speak confidentially with patients:

To ask a woman who’s just had a baby to come down to social work, to one of our rooms, is just not feasible. (Participant 17)

Beyond the issue of privacy, some staff also pointed out that the physical design of spaces within the hospital was not always conducive to sensitive practice. For instance, busy waiting rooms could be problematic for stressed and traumatised women. One staff member gave the following example:

I guess there's a little bit less freedom [in a hospital] to do or to have or to trial things that you think might help with people's anxiety levels. I know in other services they've had certain areas that people might go and sit, that might be a bit different or that might be more comfortable, less stimulating, things like that. (Participant 5)

### Working together, inside and out

Health practitioners highlighted the importance of working together, both within the care team, across the hospital, and externally with community services. At all levels, communication and a shared understanding were critical to the delivery of effective trauma-informed care and sensitive practice.

I think it's really important to share it [care] across the team, because sometimes...women know that they might click with one person versus another, and to not be territorial, or to be offended by that, but know that we're working on it as a team. (Participant 15)

Amongst the wider hospital we need to work together...I know we're in a hospital and we're defined by a medical hierarchy and all of that. But how can we support the woman the best that we can if we're not all working together? (Participant 6)

Communication and working together was perceived as beneficial not only for women, but also for the staff themselves:

I think the fact that you do have these relationships. That you don't feel like, I'm the only person looking after this, and I'm holding this risk. You know it's a team, and you know you've got backup. (Participant 15)

In terms of working with external services, it was vital that staff had clear referral pathways to follow. Several staff felt that external partnerships could be strengthened still further by increasing the co-location of key services.

It's always been my dream that there would be—we'd have more partnerships with external services that would have maybe sessional times here that people could—you can book them into an appointment like you would the legal appointments and you just go and see somebody and make that an easier process. (Participant 11)

In particular, some staff mentioned the challenges around referrals for sexual violence when the service was not currently located on site:

I think would be wonderful is if we had a [sexual assault service] office here at the hospital...That would, I think, be fabulous, because if something then does come up and it's immediate, someone could go here straightaway if they needed to. Not that that would necessarily happen, but it would be nice to think that is possible or it could be linked in around other appointments. (Participant 19)

We weren't aware that CASA was part of us [the hospital] until a few years ago. Even then, it's still hard I think. A lot of it is geographical. If we were co-located you'd have easier discussions. Quite often I look across the gap in the buildings and I see whether the social worker I want is there in the room. If they're there, I'll just walk across. (Participant 15)

It's a bit sad that there is such a sort of isolation of us over here [at CASA]...I think there's probably a lot of lost opportunity there for more resources and support (Participant 22)

Where a collaborative approach was lacking, there was a strong perception that this negatively impacted the care staff were able to provide for women, and potentially risked re-traumatising them. For instance, a staff member from the emergency department described the following situation:

There was someone down in [the space allocated to the sexual assault service], and we weren't really sure what was happening. I'm presuming we would know what was going on, but we didn't hear from anyone to say what was happening to this person. I kept thinking, "oh my God, I hope she's not down there on her own", and how isolating that is. (Participant 2)

Part of working together was recognising each other's areas of expertise and respecting each other to take the lead on particular aspects of care. A social worker described in detail how this process could work effectively:

My area is maternity, so if she's [a woman] continuing to have maternity care with us, yeah I'd look to [the sexual assault service] to be the experts in that field and so I offer that support to her while she's here in the hospital. If she consented to that and was seeing [the sexual assault service] I would still have a role around preparing for this baby, getting practical supports, and just the emotional support of seeing her when she comes in for clinic appointments. But she also still has the expertise of [the sexual assault service], and the [sexual assault service] worker could then communicate what might be appropriate to put into a birth plan. (Participant 17)

On the other hand, at times the hospital's approach to working with women who had experienced violence was perceived as being siloed, with little crossover in the work that people were doing:

For me it's just the disjointed nature of it [that is a barrier]. I think that's not improving for me and that's probably making things more complex, but other than that, I'm still delivering what I do. It takes longer and that's always a challenge. (Participant 11)

There are lots of times when I think to myself...there must be women that disclose sexual assault all of the time. We're not getting referrals from many other departments at all, really, which if you think about it statistically, that's pretty unlikely. When we're all working together, it's going to be a benefit to people that perhaps need both services. Then we can streamline those pathways and it doesn't feel as bitsy and lacking in sensitivity. (Participant 23)

### Balancing competing needs

Many of the health practitioners raised balancing a range of competing needs as a challenge when delivering trauma-informed care and sensitive practice. These competing needs appeared in a variety of contexts within the hospital itself, as well as when dealing with patients. In the workplace, staff struggled to find the time to deliver trauma-informed care and sensitive practice effectively when other competing demands encroached on their limited time. They also found negotiating with other staff who had different priorities challenging.

Within the hospital, every service thinks that their particular interest group is—should be—the priority. I have to spend a lot of my time saying I understand what you're saying, but within that we have to prioritise across the whole range of services. (Participant 14)

It's all about being quick and getting people in and out. That's not really, I don't know, compatible with providing really good sensitive care where you're trying to let them have time to talk and deal with that. (Participant 4)

You might see on the screen we've got a system where we can see other calls coming in. We can see that there might be a few people waiting on the counselling line to come through and they're queuing. There might be two calls queuing. You're also on one and then the police emergency line goes, so you're not being able to respond to the current demand, and that does have an impact. (Participant 3)

Patients also often presented competing demands that needed careful navigation. Often this occurred when partners were present at consultations, and staff needed to balance a woman's privacy with her safety and their own safety.

He [partner] was protective towards her but aggressive towards us...We would have liked to have asked the question [about violence] but I thought...she would probably tell him the minute he came back into the room, they're asking me this. Then he would have just blown up. That was how I could see that scenario going. So I didn't feel safe myself delving into that one. (Participant 9)

Child protection also presented a challenge for staff. Mandatory reporting compels health professionals to make a report if they suspect a child is in danger, and this sometimes conflicted with what they felt was best for the woman.

It's my experience that child protection can often be quite detrimental or harmful to a woman at the point of disclosure because the onus is still put on the woman to keep the rest of the family safe. (Participant 11)

### Ongoing training and education

Consistent with the literature around trauma-informed care, staff highlighted training and education as a key component of care delivery. Specifically, it was emphasised that training needed to be ongoing, so as to capture the constantly shifting and changing workforce within the hospital setting. It was also suggested that training needed to be mandatory, as particular groups of staff members did not always make the effort to attend.

When you offer training, quite often you're preaching to the converted in that those who attend are actually the ones who'd already have an interest in this field...they really want to learn more and develop their practice. Whereas you're not going to get the people in the training who there are real issues with their practice, and how they would respond. (Participant 17)

I think there needs to be almost—we have to think about how we get staff to these trainings. If it was by invitation only, then maybe that's not the way to go. Maybe the higher echelons of the medical fraternity need to go, for a start, so that they understand about it. (Participant 2)

Key to the delivery of training and education was tailoring it to the particular needs and level of experience of the staff attending. For instance, social work staff felt that much of the training delivered at the hospital was too basic.

We've discussed that with the family violence working group, and we were looking with Clinical Ed and everyone about developing a tiered model. But really it is 101, and then there's more advanced depending on people's skill set. (Participant 17)

For experienced staff elsewhere in the hospital, there was also a need for more advanced or specific training:

All our training tends to be very generic, whereas I think the next stage is really to think about the needs of different cultural groups. How do you raise these issues with groups where there's taboos about talking about things like that? (Participant 14)

As physios we could...run a little in-service about connecting other people doing internal examinations to the keys of muscle triggers and body language, physical body language, that would alert you as a clinician to step more gently and give strategies to help women to be able to relax their pelvic floor better. (Participant 19)

Joint training was also suggested as a key way to overcome some of the fragmentation of service delivery:

[Sexual violence service staff] went out and did some training around trauma-informed practice actually...with the pregnancy advisory service. Then we had a cluster of referrals. (Participant 23)

In addition to formal training, the importance of practicing and learning skills on-the-job was emphasised. Staff needed opportunities to practice raising the issues and responding to women:

You're taught to ask people about their vaginas and their secretions and their mucus and everything else. They are difficult conversations; this is another difficult conversation, but the more you practice it, the easier it will get. (Participant 11)

### Supporting workers

Being supported by the hospital was critical for the health practitioners interviewed. The emotional strain that doing the work took on staff could result in burnout, compassion fatigue, and vicarious trauma. It was important to staff that they receive support around this and be provided with opportunities to reflect and debrief:

I think a bit more recognition from probably leadership teams and management that we do deal with case sensitive, really sensitive cases, and that maybe just support workers to do the best they can with them, to understand that vicarious trauma and understand that it's okay to say when we're feeling burnt out or how to work around having a bit of time out from that. (Participant 13)

One of the things that we're putting in place next year is having peer-resourcing sessions. We've [a trainer] coming in actually to do those with the staff every second month, so that's really good. Having someone that the staff can actually meet with and just talking about particular issues in their work that they want to talk about as a team. (Participant 3)

In departments outside of social work or CASA, however, it was not always common practice to debrief or discuss difficult cases with colleagues:

That's not a common thing within physio. We don't really do debriefings. (Participant 19)

Reflecting on the work and how the work impacts on them—I don't think there's a culture of that. There is a culture in social work, and I think social work can lead the way in demonstrating how useful that is. (Participant 7)

Having opportunities to debrief with other staff was not only seen as a way of reducing the harms of vicarious trauma, but was also perceived as beneficial from a professional development point of view.

There needs to be opportunities for supervision and reflective practice so they can think about how they apply these ideas to their particular role in the hospital. (Participant 7)

### Sensitive practice from the ground up

Staff felt that the recent increase in focus on the issues of family violence, sexual violence, and sensitive practice had been positive developments at the hospital. They perceived that the organisation as a whole was committed to responding to the issues, which, in turn, made them feel more supported in carrying out their trauma-informed work. Importantly, however, staff felt that senior executives and management at the hospital needed to listen more carefully to health professionals working on the ground. While the public profile of the hospital and its commitment to research and trauma-informed policy were viewed positively, staff noted that they needed additional support in order to actually embed trauma-informed care and sensitive practice more firmly into their everyday work. There was still a perception that bureaucracy and a lack of resources (e.g. funding, personnel) could hamper the real work of providing sensitive care.

We should be positioning ourselves to be on the cutting edge of this stuff and developing new programs, new supports, and that it just can't all be about—and this is not a criticism of anybody—but it can't just be about research and about doing the bigger kind of, look at us, the Women's Hospital. It has to be embedded in the groundwork and what we actually practically do to assist women. (Participant 11)

A “top-down, bottom-up” approach was suggested, whereby staff on the ground had the opportunity to feed back up to upper management, with increased consultation around violence against women events or policy developments:

Sometimes the top-down approach doesn't always consider that we've been working in this field for a really long time. It's our core business, that this is what we do all the time...it's just making sure that communication is trickling all the way down, and that we've got an opportunity to feed back up our knowledge and what we would see as maybe some holes in the planning, or something like that. (Participant 17)

[We need to address] what's happening between staff and the hierarchy and the power differences, and people feeling they're at the bottom of the totem pole and that their work isn't being recognised and they don't have a say about patient care. (Participant 7)

In summary, from interviews with practitioners, several themes arose about the importance of space and places, the need to work together internally and externally, the challenge of balancing competing needs, the idea that training should be tailored, and the need to support workers and create sensitive practice from the ground up.

#### Emergency department vicarious trauma workshop

Twelve clinical staff attended the vicarious trauma workshop jointly facilitated by mental health and sexual violence services within the hospital. On completion of the workshop, staff provided written feedback via a survey. Staff were very positive about the session, evaluating it as “very worthwhile” and “very encouraging of an open space to share ideas”. Staff felt that the workshop “made me think about the subject and how we can address it in the future as a team” and de-stigmatised vicarious trauma. The cross-department facilitation between mental health and sexual violence services was viewed positively. Based on the engagement and staff feedback, this session will be replicated in other areas of the hospital.

#### Family violence and sexual violence identification tool trial

There were 12 completed forms collected from the emergency department during the 3-month period. The reasons that clinical staff chose to enquire about family violence were linked to known family violence indicators. Table 4 highlights the issues staff identified.

The health practitioners at the hospital reported a wide variety of factors that raised their suspicions of potential domestic violence, sexual assault, or both. These ranged from identifying suspicious interaction between the patient and her partner whilst attending the hospital and behavioural and physical indicators in relation to the patient. For example, health practitioners reported that a patient who was “pale, withdrawn”, avoiding eye contact, or who appeared “teary, anxious, fiddling, softly spoken, and hesitant” raised their suspicions as well as patients attending with unexplained, suspected somatised physical symptoms. Interactions between the partner and patient that raised their suspicions included incessant contact by the partner whilst the patient was attending hospital and the patient not wishing to speak to their partner when they called.

Eleven women were directly asked about violence; six women did not disclose violence and, of these, two were referred to their local general practitioner; one woman was given a Safe Steps brochure; and one had social work from the Women's already involved. Of the five patients who did disclose violence, two patients were given Safe Steps brochures, one patient had an internal referral to social work with follow-up and was admitted to the hospital, one patient was transferred to the birthing assessment centre (and assessment centre staff informed of her situation), and another patient was provided with a brochure (not described). One successful referral was made to social work and another referral was made to CASA.

The tool is a significant policy and cultural change process and this trial has to date only had limited success in being taken up by the staff, despite the change being supported through obtaining leadership support encouraging champions, posters, staff support and reflection sessions, and a social work presence in the emergency department.

#### Suggestions to improve the process

- Ensure that, where the tools are being used, there are senior clinical staff allocated on every shift within nursing and midwifery and medical staff who are responsible for supporting staff to complete the tool.
- Continue to strengthen pathways into the specialist family and sexual violence services and continued collaboration with social work and other internal support services to streamline the referral processes.

**Table 4** Indicators of family violence prompting enquiry and use of the family violence identification and referral tool

	Psychological presentation	Physical presentation	Partner behaviours	Repeat presentations	Relationship concerns	Legal order	Recent separation	Previous family violence
1						X		
2	X	X						
3	X	X	X					
4	X						X	
5	X	X	X	X				
6	X				X			
7					X			
8	X	X						
9	X					X		
10			X				X	
11						X		X
12								X
13								X

## **Ethical considerations: working with staff**

The ethical consideration to consider when talking to health professionals depends upon the sensitivity of the topic and the context within which research interviews take place. In WITH, both the topic, family violence and sexual violence, together with the context, workplace systems, had the potential for adverse risk to be experienced by participants. The topic had the potential to cause distress to the participants, even if the focus was on care provided to patients rather than their own personal experiences. However, we were mindful that talking about patient care could trigger memories of personal experience or vicarious trauma. All interviews were therefore undertaken by experienced qualitative researchers who were sensitive to the questions being asked and explained to the health professionals that they did not have to answer any question they felt uncomfortable answering and could stop the interview at any time. Distress protocols were also followed.

Confidentiality was another key consideration. Health professionals speaking of their workplace may fear the consequences of their employer knowing what they have said within interviews. Consequently, all data were de-identified so that what was said could not be connected to any individuals. All identifying information was kept securely in locked storage or password-protected electronic folders.

## **Conclusion**

The findings of the hospital staff interviews highlight the need for a systems model of trauma-informed care for women who have experienced violence to be focused on the everyday work and actions of staff on the ground. The principles of trauma-informed care or sensitive practice need to be embedded into the everyday work that health practitioners do on the ground, and this practical knowledge then needs to be fed up the chain to senior management. Staff need to be supported and resourced in order to be able to do the work, in terms of tailored training, capacity building, and the physical environment in which they work. The implications of these findings in terms of implementing a systems model of trauma-informed care for women who have experienced violence will be discussed in more detail in the next chapter.

The next section discusses the findings and implications of the research. It synthesises the findings from Part A and B to develop a health systems implementation model for use in health settings.

# Discussion and implications

## Introduction

This section of the report overviews the WITH Study with a description of the research question, the context in which the study was undertaken, and the main findings, which we then synthesised into the Health Systems Trauma and Violence-Informed Implementation Model. This implementation model, our main implication for policy and practice, could be used in conjunction with any existing health and violence service framework related to violence against women or family violence. We conclude this chapter with the lessons learnt, strengths and limitations of the WITH Study, and implications for future research and knowledge translation.

The WITH Study explored the following question:

*How can we promote and embed a trauma-informed systems model of care, responsive to women and practitioners, into the complex system of mental health and sexual violence services?*

## Context

During the time of the WITH Study, there was a large amount of activity in the space of mental health and sexual violence services. In Victoria, public hospitals have responded to the National Plan to Reduce Violence against Women and their Children and the Royal Commission into Family Violence recommendations through the Strengthening Hospital Responses to Family Violence project funded by the Victorian Government. (Kearney & Gleeson, 2015). The evaluation (Kearney & Gleeson, 2015) stated how the complexities of hospitals as organisations and the lengthy time needed for review and approval of new policies, procedures, and guidelines impacted on ability to enact change within 12 months. Further, they noted the lack of ability to record identification and response to family violence in different areas of the hospital as a key challenge. We have experienced the same difficulties enacting and understanding change within the complex system of the hospital. Hospitals have a strong hierarchy, with many layers of management and governance, and the amount of consultation and approval required to enact change is very time-consuming for researchers from an outside organisation (May et al., 2007).

In clinical mental health services, the Service Guideline for Gender Sensitivity and Safety (Victoria. Department of Health, 2011b) provides specialist mental health and alcohol and drug service staff and leaders with guidance to support care that is sensitive to gender-related issues, is responsive to individual needs, and considers the range of factors that impact on people's wellbeing, including trauma and violence. The WITH Study engaged with NAMHS and northern Centre Against Sexual Assault through staff consultations (see limitations section); however, the majority of the health systems change work was undertaken at the Royal Women's Hospital. Most of the following discussion in this report thus relates to the particular context of the hospital.

Below, we discuss the key findings briefly and then we propose the Health Systems Trauma and Violence-Informed Care Model to inform implementation of changes.

## Key findings summary

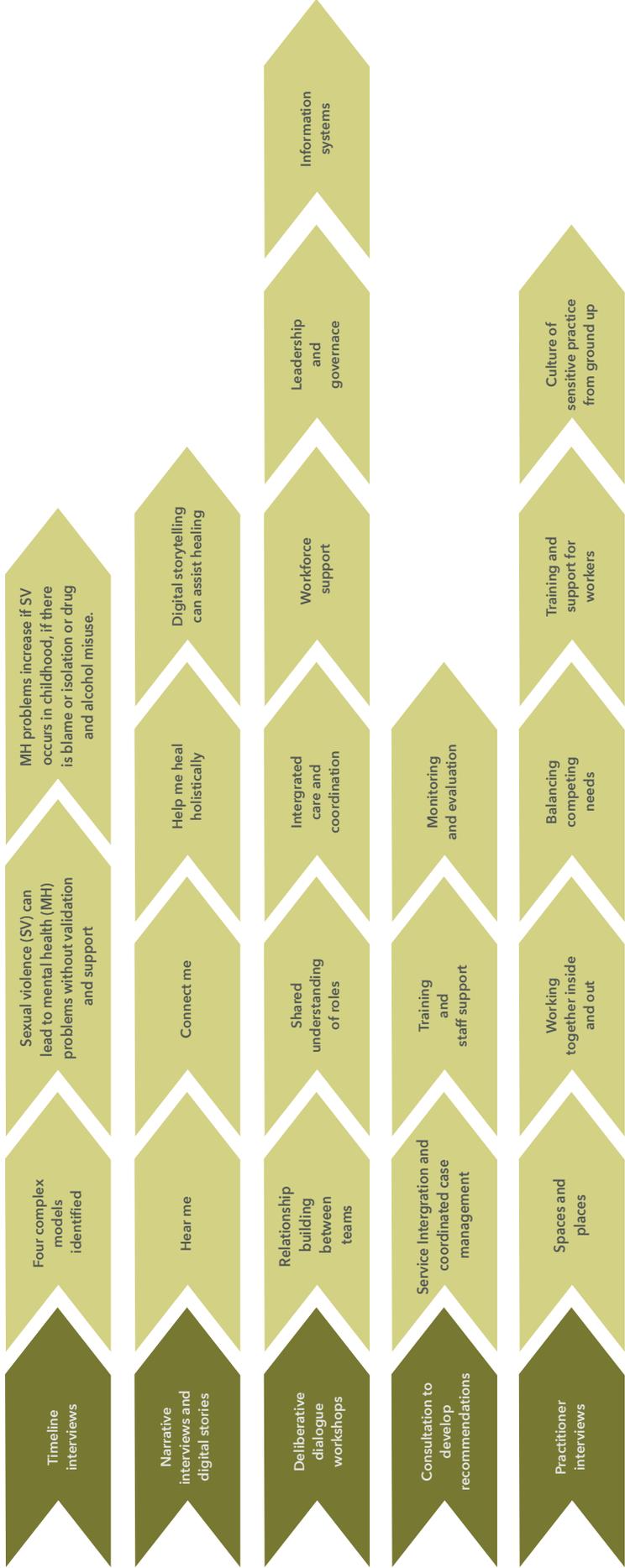
From women's and practitioner's voices, it was felt that often a holistic service model was lacking in health services generally, particularly when dealing with the complex needs of many women who experience life at the intersection of sexual violence, mental health problems, and structural forms of oppression and marginalisation. In particular, participants identified challenges for services supporting women with multiple compounding factors, such as family violence, alcohol and drug problems, and being from Aboriginal and Torres Strait Islander or culturally and linguistically diverse backgrounds (Mitra-Kahn, Newbiggin, & Hardefeldt, 2016; Stathopoulos & Jenkinson, 2016). Women and practitioners emphasised the importance of being able to easily access appropriate ongoing trauma-informed services that share information, provide referrals, and support women in accessing help for their complex issues not only during crises. It was important that the whole organisation from the environment to the reception staff be trauma-informed.

For trauma-informed care to be enhanced in the hospital system, there were changes in the system that practitioners in the WITH Study identified as necessary to enhance the sensitive model of practice at the hospital. There are many barriers and facilitators to change in health systems and the factors listed below were identified across both the hospital and the clinical mental health service as requiring some work. There is a need for:

- relationship building between teams;
- a shared understanding of roles and language;
- integrated care and coordination of referrals internally and externally;
- training of staff to identify and respond to the challenge of meeting women's many competing needs;
- more workforce support to engage with this sensitive work;
- leadership and governance to create a culture of sensitive practice from the ground up;
- improved information systems for monitoring and evaluation; and
- better environments in which to undertake the work that are private, confidential, and safe.

Figure 4 summarise all the findings of the WITH Study, which are then integrated to form the new Health Systems Trauma and Violence-Informed Implementation Model, described in the next section.

Figure 4 Integrating key finding themes from the WITH Study



## Recommendations

### Implications for women, practitioners, and health systems

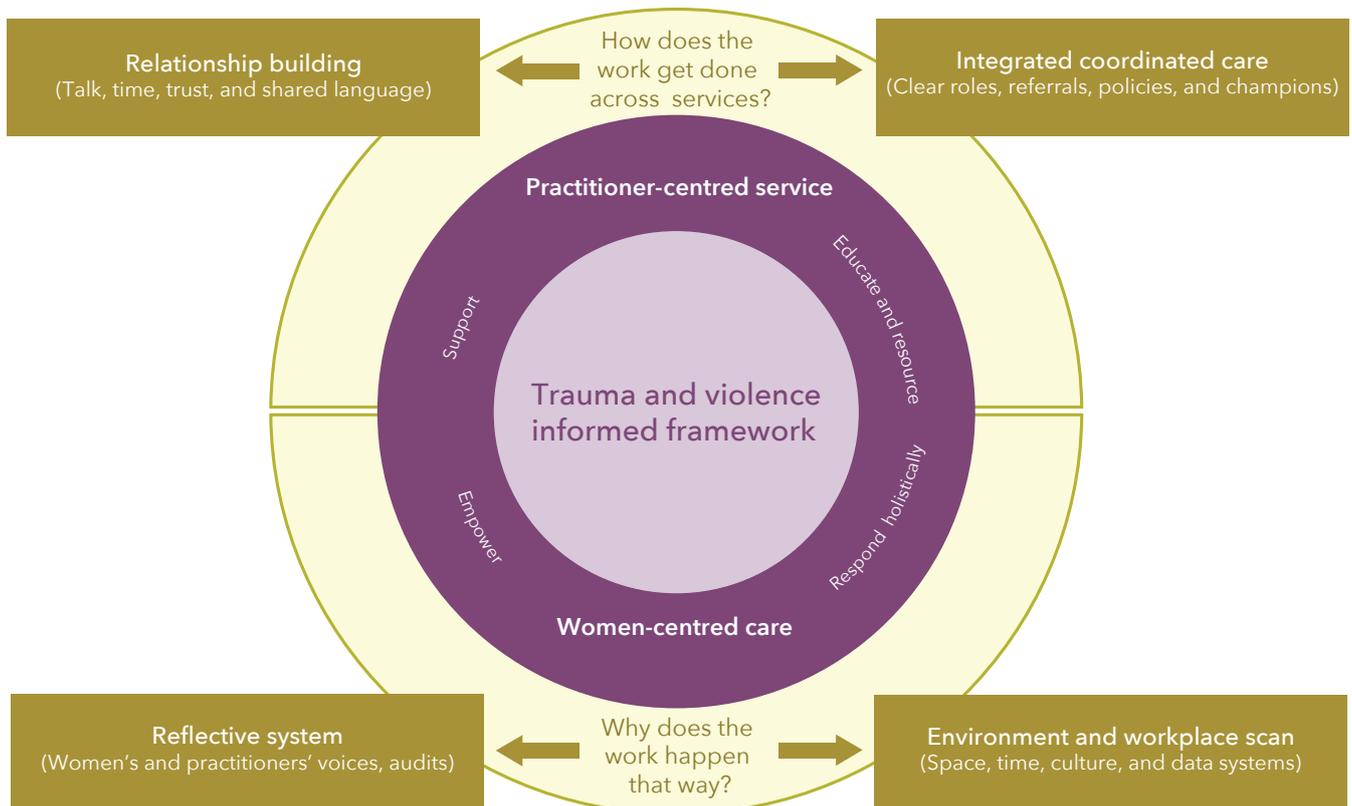
The importance of trauma-informed care and empowerment approaches to women was clearly articulated by women who had experienced mental health problems and sexual violence and in the voice of the staff and practitioners. In particular the importance of responding to needs of diverse women and multiple associated issues (family violence, child abuse, alcohol and drug issues) was highlighted. There are many terms used for this type of care and approach, but we feel that adoption of a trauma and violence-informed framework will encompass the requirement for a holistic response to women experiencing mental health problems and sexual violence (see Box 2 [Varcoe et al., 2016]).

Figure 5 outlines how this TVIC framework underpins a women-centred care approach (empowerment and a holistic response) (Garcia-Moreno et al., 2015) and a practitioner or staff-centred service (focusing on supporting practitioner needs and providing education and resources). These approaches are needed for women and practitioners to feel they are entering a safe and supportive health setting.

#### Box 2

Trauma and violence-informed care (TVIC) expands the concept of trauma-informed care to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person’s life. This brings into focus historical and ongoing violence and their traumatic impacts so that problems are not seen as residing only in psychological state, but also in social circumstances.

Figure 5 Health Systems Trauma and Violence-Informed Care Implementation model



There are several health systems models for violence against women in operation globally (Garcia-Moreno et al., 2015). When applying the lens and context of mental health and sexual violence services from the WITH Study, we have integrated our findings and the literature to focus on four main building blocks to enact change or implement features of the above woman and practitioner-centred approaches. These building blocks, based on evidence of what works most effectively to implement change in health systems, are outlined below. They are based on normalisation process theory (May et al., 2009), which aims to clarify the processes by which interventions, new behaviours, or ways of doing things become embedded into everyday practice. This theory helps understand implementation in relation to the work that people do. It focuses on the meanings people attribute to the work, their capacity to carry it out, the ways the work is actually enacted in an organisation, and how people feel retrospectively about the work they have done.

Key to health systems change is asking two questions from this theory: *How does the work get done across services?* and *Why does the work happen that way?*

### How does the work get done across services? (Collective action)

**Relationship building** was a very strong theme across both the studies involving women and staff participants to enable improvement within the health system. They described how teams within services and different services needed to be connected through opportunities to **talk** together and develop **trust** over **time** and a **shared understanding** of their different frameworks and roles (Wathen et al., 2011).

**Integrated co-ordinated care** was seen to be a requirement for enactment of a trauma-informed framework and care. This involves very **clear roles** described for staff and **referral pathways** mapped internally and externally. In addition, **policies** supporting the trauma-informed work and staff “**champions**” within the service to drive the work are needed.

### Why does the work happen that way? (Reflexive monitoring)

A **reflective system** was highlighted by staff participants as being needed to enact improvement in the delivery of trauma-informed care. This included hearing more from **women** about what they would like changed in the system as well as to provide feedback to practitioners. **Staff** input into and feedback to management about changes in strategy, policies, and resources was also essential. **Audit** of how women flow through the system on their pathway to safety and wellbeing and what practitioners enact would allow quality improvement to be monitored.

**Environment and workplace scan** on a regular basis would allow improvements in areas that practitioners and women described as requiring attention. These included better **spaces** to have private and confidential discussions, and review of workflow patterns to allow sufficient **time** to engage with women on these sensitive topics. Assessment of **culture**, values, and beliefs that occur within a workplace can impact any change process. Monitoring and evaluation also requires better **data systems** to be developed.

This model is proposed to be complementary to existing health systems models in the area of violence against women and to assist workplaces to implement changes. The building blocks are areas of focus for an organisation to pay attention to.

The next section outlines the lessons learnt from the WITH Study. We hope that other researchers working in this area will find these useful.

## Lessons learned about enacting change

The main lesson learned was that enacting change takes more time than anticipated, with the need to build up trust with health services over a series of engagement and consultation activities. Further, there was varying engagement across different disciplines, and the WITH Study team needed to pay careful attention to the language used when consulting with mental health and sexual violence services.

In addition, there is a dilemma in health systems, and hospitals in particular, between concentrating on providing a women-centred service and at the same time needing to pay attention to supporting practitioners and integrating services. The tension between direct service by practitioners and the provision of time to be able to discuss their roles and responsibilities, develop guidelines and protocols, talk and understand each other, and attend training—all with the support of management—was obvious in the WITH Study. The busy nature of workplaces and demand of services and the practicality of meeting together, particularly when not co-located, resulted in a longer time line to consult and enact change.

Finally, the need to embed project staff within a service to enact and understand change is essential. This can be as complex as understanding how the system and culture at the site works, to the simple ability to look at people’s calendars to organise meetings. The informality of running into people in the corridor should also not be underestimated. All health system change research requires this type of insider person to be on board during the study.

## Strengths and limitations

The WITH Study integrated the voices of women and staff from a hospital, three sexual assault centres, and a clinical mental health service. The strength of the WITH study is in the inclusion and innovative methods and analyses of women's voices in Part A, as there has been limited research in the area of mental health problems and sexual violence that involve women with lived experience. However, in Part B there was limited consultation across the services and the staff and the practitioner voice is not necessarily representative of the settings. Nonetheless, integration of all themes across the studies in parts A and B, combined with the use of theory and evidence, provides stronger support for the Health Systems Implementation Model than basing it on an individual study.

Two additional sites were originally planned for the WITH Study, however we were only able to engage with the clinical mental health service in a limited way and unable to engage with the community mental health setting due to the context of change in that sector. The Northern Area Mental Health Service context is guided by the Service Guideline for Gender Sensitivity and Safety (GSS) developed by the Victorian Government and includes guidance for support care that is sensitive to gender-related issues and trauma-informed care. The GSS guideline discusses the need to accommodate the vulnerabilities of women who have a mental illness and have experienced unwanted sexual contact. This model of care incorporates all levels of an organisation, including environment, management and leadership, direct contact, practitioner support, referral pathways, information sharing, protocols and policies, and community linkages. The Northern Centre Against Sexual Assault is not under the same governance as NAMHS and is not co-located. Despite this strong health system model, the WITH team engaged staff from these sites in the deliberative dialogue workshops and there was to be some training by the sexual violence service staff of the mental health staff around the issue of trauma-informed care in February 2017. There was insufficient time to engage at the hospital site and the two different service managements located in two different places.

Further, work within the community mental health context was unable to be undertaken as originally envisioned. During 2014-2015, the state government of Victoria implemented major service reforms in the mental health community support sector. A recommissioning process was undertaken in 2014 and new service models were implemented, seeing the mode of service delivery change from group based, largely in-house services, to an individual outreach and case management model. New eligibility criteria were also introduced as part of the new service model, with an age cut-off of 65 years introduced into mental health community support services.

As a result of this and the recommissioning, a substantial number of mental health consumers were required to transition to new services or exit services in late 2014 and into 2015. This reform understandably created significant upheaval for staff, consumers, and carers in the sector and it took services the majority of 2015 to stabilise, establish their client loads, and work within the new service model. Organisations had significant burdens placed on them in terms of reporting, and the introduction of the Federal Government mental health reforms via the National Disability Insurance Scheme (NDIS) created additional instability. Over 2015 and 2016, the NDIS model and questions regarding the transitioning of consumers again to another service model have pre-occupied the sector. Many organisations have also been involved in government consultations and in-house consumer consultations about the NDIS. As a result of these sector changes, we made the decision not to engage with community mental health services for the WITH Study to interview consumers and implement the proposed WITH model due to the increased burdens and instability being experienced within the sector during this time.

## Knowledge translation

Translational outcomes were embedded in the research design. Findings are currently being applied to inform and review service delivery at the hospital site and the area mental health service. The process of the WITH Study itself played a role in developing the research capacity of staff at the hospital site. The team plan some brief presentations to the hospital executive, brief reports to practitioners and staff involved in the WITH Study, community reports to women who participated, and fact sheets for policy-makers. Translation will also be focused on national and international policy and practice, an objective that will be achieved by way of future peer-reviewed publications.

The main knowledge translation activity will be implementation of a trauma-informed, knowledge translation exhibition (Part C) targeting health practitioners and the general public. The knowledge translation exhibition will be displayed and will include:

- digital stories developed by women during the WITH Study;
- 10-15 individual women's and practitioner's stories, presenting a diversity of experiences of trauma-informed care for women experiencing mental health and sexual violence;
- high-quality photographic portraits and short personal stories, presented on panels or banners, which can be exhibited in various sites and contexts;
- social media techniques to disseminate the exhibition's messages nationally; and
- a report on the implementation and impact of the initiative at the conclusion of the stage.

The specific research question will be:

*How can we engage with the community through an exhibition to effectively impart personal narratives of trauma and recovery and messages about care?*

The exhibition will aim to explore and explain the challenges and impact of trauma-informed care by presenting the voices of women (as digital stories, quotes) who have experienced mental health problems and sexual violence alongside those of staff and practitioners (as images, quotes) working in services that cater to these needs. In doing so, the exhibition will articulate how new interventions, strategies, or work practices have the potential to change systems and processes, leading to better outcomes and holistic care for women who have experienced both mental health problems and sexual violence. This knowledge translation exhibition (Part C) will form a separate linked ANROWS report later this year.

## Implications for research

The above model can be used alongside existing frameworks that services use to implement change with their systems. There is a need for more qualitative and quantitative work about women's experiences of mental health problems and sexual violence and the care they access on their pathway to recovery. Similarly, more work needs to be undertaken in greater detail about what practitioners understand the enablers are to delivering trauma-informed care. Testing and further validation of the Health Systems Implementation Trauma and Violence-Informed Model is needed in health settings.

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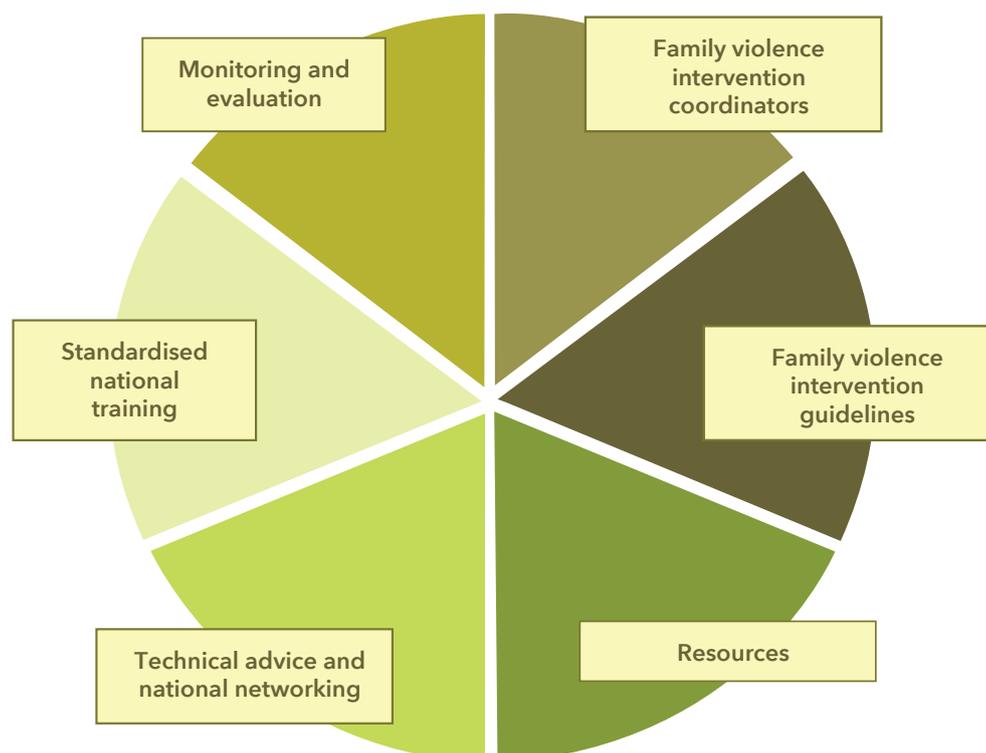
# Appendix A: Existing systems models in a violence against women context

## New Zealand

The Violence Intervention Program (VIP) is premised on a standardised, comprehensive systems approach supported by six program components funded by the ministry (Figure 6). These components include:

- District Health Board Violence Intervention coordinators.
- Ministry of Health Family Violence Intervention Guidelines: Child and Partner Abuse (2015).
- Resources that include a Ministry Family Violence website, a VIP section on the Health Improvement and Innovation Resource Centre website, posters, cue cards, pamphlets, and the VIP Quality Improvement Toolkit.
- Technical advice and support provided by a National VIP Manager for District Health Boards (DHB), National VIP Trainer, and national and regional Family Violence Intervention Coordinator networking meetings.
- National training contracts for DHB staff, midwives, and primary care providers.
- Monitoring and evaluation of DHB family violence responsiveness (Koziol-McLain & McLean, 2015).

**Figure 6** Ministry of Health VIP systems support model



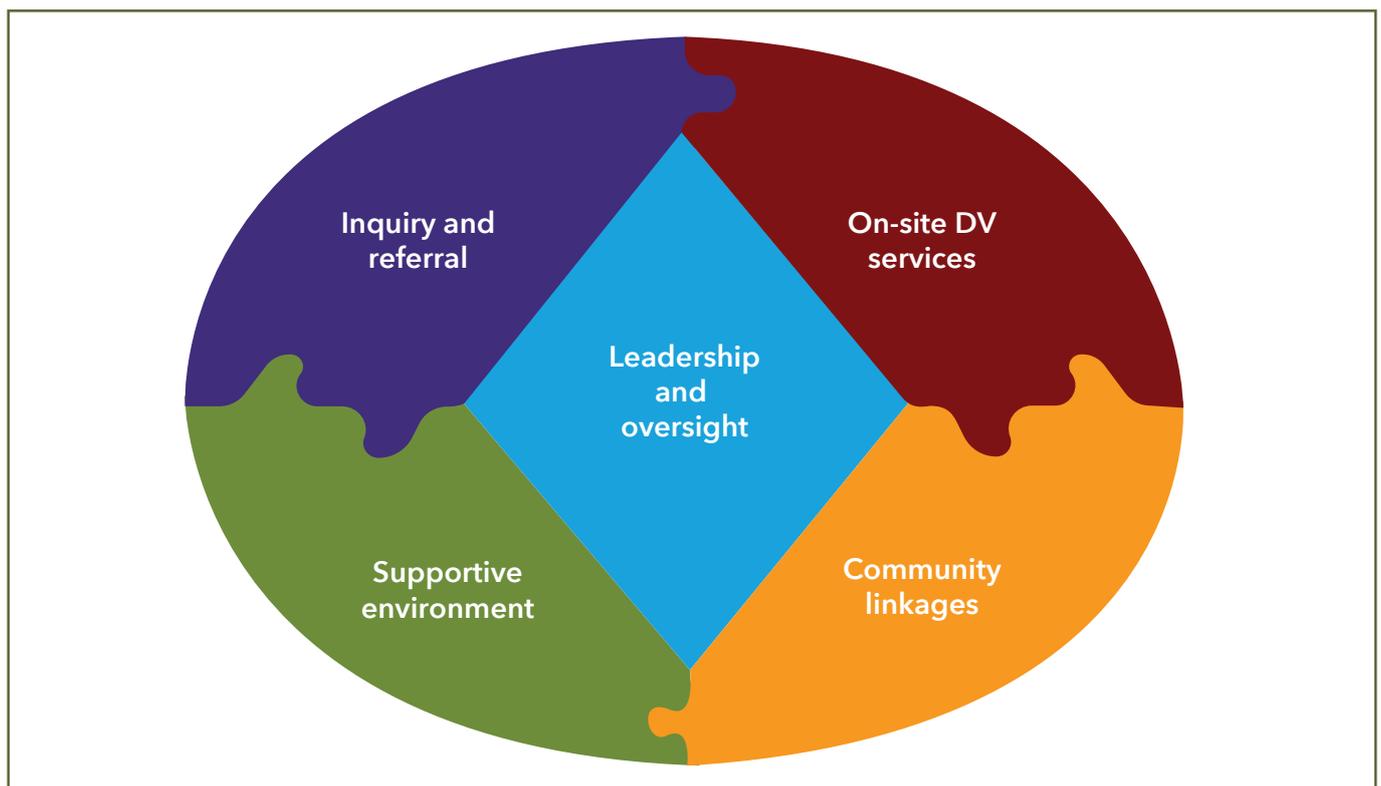
## United States of America

Over the last 10 years, Dr Brigid McCaw and Kaiser Permanente (a large private US health insurer) have undertaken system changes in health (Kaiser Permanente, 2017) with a demonstrated sixfold increase in identification of domestic violence (including aspects of sexual violence) by members. The program is underpinned by leadership and oversight and involves:

- information for participants and a supportive environment;
- routine clinician screening
- referral supported by online tools and resources, online support services—including mental health care—and access to a crisis line; and
- community linkages to domestic violence advocacy services. (Hegarty, 2015)

The US system is very different to the Australian system, with doctors and nurses being employed by Kaiser Permanente, and electronic health records being more widespread. The program is sustained by one part-time doctor director, one full-time program director, and one administrative support, a part-time analytic and health education consultant. Each medical facility has a multidisciplinary team chaired by a physician champion to establish the approach, provide training, and respond to quality improvement data.

**Figure 7** Kaiser Permanente Health System Model



# Appendix B: Health practitioner interview guide

Firstly, thanks very much for taking the time to talk to me. As you know, we're interested in finding out more about sensitive care at the Women's and what clinicians think about it. By sensitive care we are really talking about engaging with patients in a way that increases feelings of safety, respect, and control. It recognises person-centred care as a general principle in public health, allowing clinicians and hospitals to consider the many contributing factors to a person's health and target their responses appropriately.

So with that definition in mind:

1. Could you tell me about your experiences of providing sensitive care to women who have experienced sexual or family violence?
  - Prompt: Can you think of any examples of a time when you had a patient who was experiencing sexual violence or family violence and how you provided sensitive care for them?
2. What has helped you to deliver sensitive care?
3. What has made it difficult to deliver sensitive care?
4. How have any recent changes at the hospital impacted on your delivery of care?
  - Prompt: Any things at an organisational level? For example, coordination or referrals? Protocols? Workforce support and mentoring? Appointment of champions? Finances for violence against women services? Leadership? Appropriate design of spaces? Ways to evaluate the work being done?
5. What would you like to see changed at the hospital to assist you in providing sensitive care?
6. Is there anything else you would like to add on this topic?

# Appendix C: Health practitioner interviews coding framework

Organising Theme	Basic Theme
Spaces and places	Finding the right moment
	We need privacy to have the conversation
	Hard to speak to women alone
	Creating opportunities
Working together inside and out	Greater partnerships with external services
	Lack of cross-department communication
	Siloed approach to violence against women work
	Communication within the care team
	Warm referrals and clear referral pathways
	More than just referrals
Responding to competing needs	Men's rights
	Child protection
	More time needed to do trauma-informed care
	Privacy vs safety
Training and education	Cooperative training across departments
	Tailored training
	Trauma-informed is learned over time or on the job
	Preaching to the converted
	Workforce constantly changing
Supporting workers	Vicarious trauma
	Opportunities to reflect
Sensitive practice from the ground up	Top-down and bottom-up
	Moving towards a culture of trauma-informed care across the hospital
	Bureaucracy
	Resources needed to do trauma-informed care

ANROWS

# ANROWS

