ANROWS

AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY

to Reduce Violence against Women & their Children

Compass

Research to policy and practice

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Women's Input into a Trauma-informed systems model of care in Health settings (the WITH Study): *Key findings and future directions*

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ANROWS Compass (Research to policy and practice papers) are concise papers that summarise key findings of research on violence against women and their children, including research produced under ANROWS's research program, and provide advice on the implications for policy and practice.

This report addresses work covered in ANROWS research project 1.9 "Women's Input into a Trauma-informed systems model of care in Health settings (the WITH Study)". Please consult the ANROWS website for more information on this project. In addition to this paper, ANROWS Landscapes and ANROWS Horizons papers are available as part of this project.

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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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Introduction

Trauma-informed care seeks to create safety for patients by understanding the effects of trauma (including past and present violence), and its close links to health and behaviour (Quadara, 2015). However, there is no current model outlining how services can optimally undertake trauma-informed care when both mental health problems and a history of sexual violence are present. There is a strong relationship between women experiencing sexual violence and poor mental health. The relationship can be understood as extremely complex, requiring collaboration between multiple sectors to provide effective care. Mental health and sexual violence services often see the same women; however, commonly there is a lack of communication and cross-referral between services (Quadara, 2015).

This report presents a summary of key findings of 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), and the implications for policy and practice. The WITH Study, based in Victoria and New South Wales, aimed to understand how to promote and embed a trauma-informed organisational model of care, responsive to women and practitioners, into the complex system of mental health and sexual violence services. Our research included:

Part A (see Figure 1)

- an ANROWS state of knowledge report (Quadara, 2015);
- qualitative work (interviews, multimedia digital storytelling) with 67 women; and

Part B

- qualitative work (case study approach using discussion groups and interviews) with 72 staff at a major public hospital, a clinical mental health service, and three sexual violence services.

The final part of the study will involve a knowledge translation exhibition. This will form a separate linked ANROWS report, and we will develop journal papers and fact sheets for practitioners explaining our findings. The WITH Study was based on participatory action research and feminist principles (Burgess-Proctor, 2015); therefore we intentionally focused on the voices and lived experience of women, with two survivors working as research assistants to co-facilitate staff workshops.

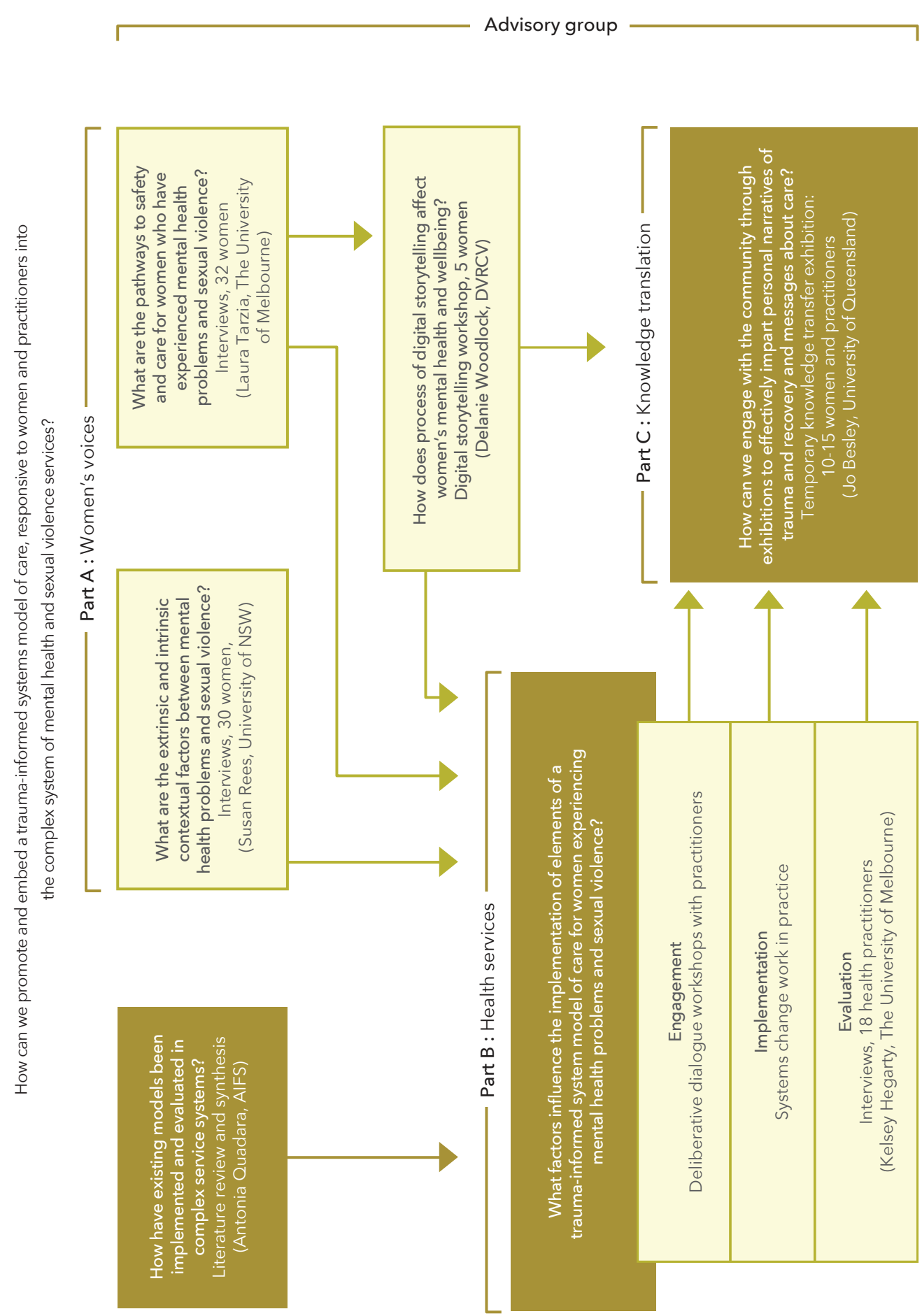


Figure 1 Overview of WITH Study

Key findings

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 following were important factors leading from sexual violence to mental health problems:

Disclosure issues:

- disclosure of sexual abuse being ignored or blamed on the child or young woman by a family member, absence of a trusted other to disclose sexual violence, disclosure of sexual violence being minimised or ignored by others;

Isolation issues:

- early childhood sexual abuse or parental neglect heightens risk of future experiences of sexual violence and then, with anxiety symptoms, alcohol and drug use in later life; and
- isolation from significant others during their lifetime increasing the risk of being "targeted" by potentially abusive men.

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 the studies in Part A suggests that, from women's perspectives, to recover from sexual violence and mental health problems:

- 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 dependent on, holistic services that understand their individual experiences and respond accordingly to empower women;
- women were connected to services and services were connected with each other;
- there was a need to support both "surviving" and "thriving", including practical help that facilitates a positive recovery process;
- digital storytelling was a process that could assist women in this transformation to thriving, although it required supporting women if they became distressed as they remembered their experiences;
- women needed to understand the concept of male power and how it is associated with violence and to realise that many other women experience sexual violence;
- there was a benefit in moving away from a reliance on alcohol and drugs, and proactively avoiding people who are violent;
- women were able to use medication, if needed, to alleviate depressive and anxiety symptoms and engage in therapeutic social activities.

Some women felt that a holistic service model was lacking, particularly when dealing with the complex needs of those 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, not only during crises. It was important that the whole organisation, from the environment to the reception staff, be trauma-informed.

Factors influencing implementation of a trauma-informed health systems model of care

There are many barriers to change in health systems. For instance, with limited time available, there often tends to be a focus on direct service to clients over talking with other services. The main facilitating factors emerging from the workshops with staff and consultation with stakeholders across the service settings were as follows:

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

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 or legal requirements, the need to tailor training to individual workers, the need to support workers, and the importance of the delivery of sensitive practice being guided from the ground up.

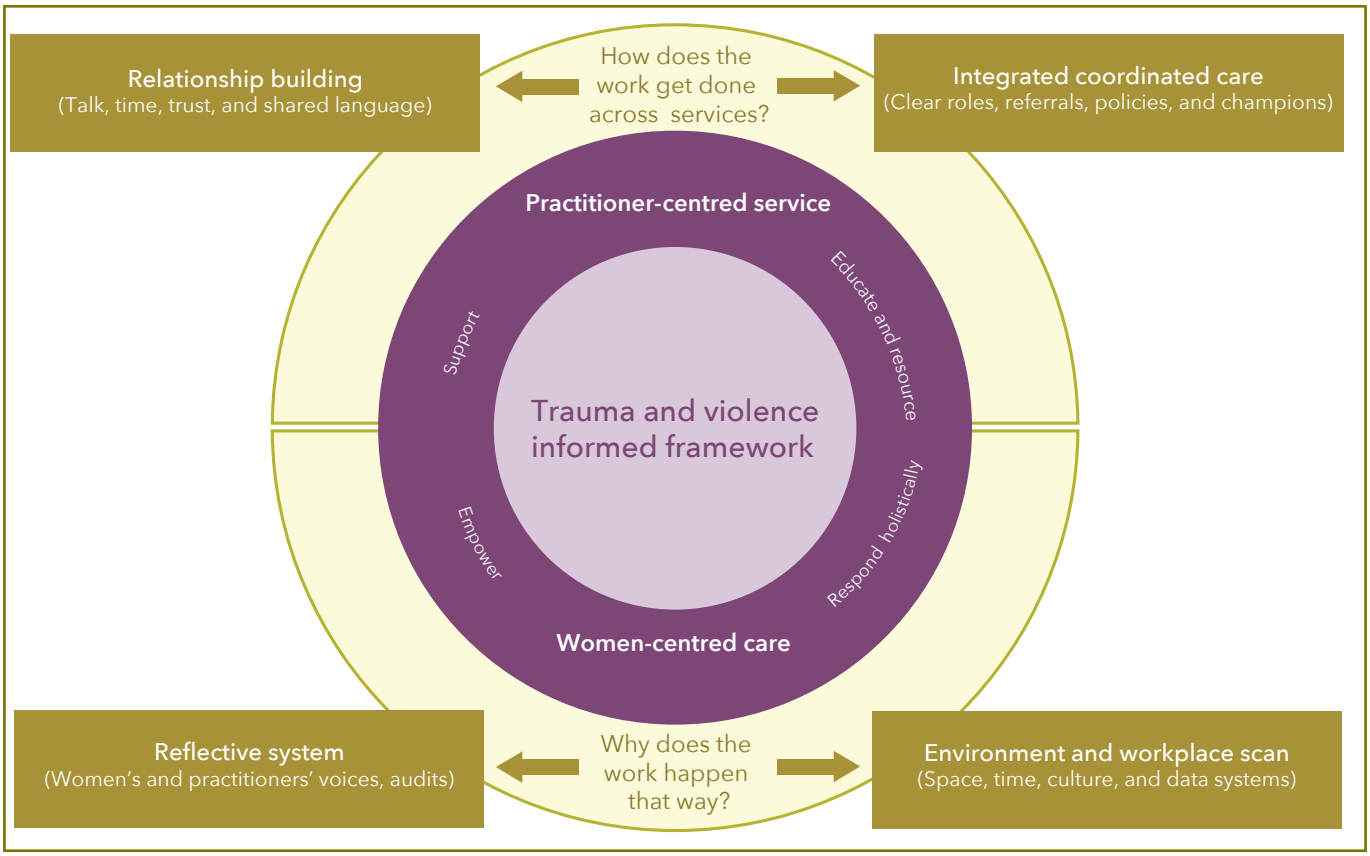
Implications for women, practitioners, and health systems

The importance of trauma-informed care and empowerment approaches was clearly articulated by women who had experienced mental health problems and sexual violence and by staff and practitioners. In particular the importance of responding to the needs of diverse women and women with 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 encompasses the requirement for a holistic response to women experiencing mental health problems and sexual violence (see Box 1).

Figure 2 outlines how this trauma and violence-informed framework underpins a woman centred care approach (empowerment and a holistic response) (Garcia-Moreno et al., 2015) and a practitioner or staff-centred service (focused on supporting practitioner needs and providing education and resources). These approaches are required for women and staff 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 to enact change or implement features of the above women and practitioner-centred approaches.

Figure 2 Health Systems Implementation Model



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)

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

- Relationship building was a very strong theme across the studies, involving women and staff participants to enable improvement within the health system to happen. They said that teams within services and different services need 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 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 and feedback to management into changes in strategy, policies, and resources was also essential. Audits of how women flow through the system on their pathway to safety and wellbeing, as well as what practitioners are enacting, would allow quality improvement to be monitored.
- Environment and workplace scans on a regular basis would allow improvements in areas that practitioners and women described as requiring attention. These areas 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 within a workplace can impact any change process. Monitoring and evaluation also requires better data systems to be developed.

These building blocks 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. 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?*

The above implementation 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, three 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, as there has been limited research in the area of mental health problems and sexual violence that involved women with lived experience. However, the inclusion of only English-speaking women limits our findings, as does the inclusion of participants from a small range of services. In addition, 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, combined with the use of theory and evidence, provides stronger support for the Health Systems Implementation Model than if it had been based on an individual project.

Implications for health service policy-makers

Testing and further validation of the Health Systems Implementation Trauma and Violence-Informed Model is needed in health settings. This would entail addressing the building blocks in any implementation of violence against women or trauma-informed interventions and evaluating the process and outcomes. If this model does assist organisations to develop further their delivery of trauma-informed care, then adoption into Victorian government policies on gender sensitivity and safety and recovery from mental health may be warranted.

There is a need for more research to inform policy-makers that incorporates women's voices about the care they receive when they experience mental health problems and sexual violence. Similarly, more work needs to be undertaken in greater detail about what practitioners understand the enablers are when delivering trauma-informed care.

Implications for health service practitioners and managers

Women during their lifetime often experience sexual violence and mental health problems and they present to multiple services seeking holistic women-centred care. They wish to be listened to and connected across services in an integrated way. Women have multiple complex needs that require a system response (sufficient time, confidential space, strong leadership) that supports practitioners to deliver trauma-informed care. Implementing such a response is to be facilitated by managers and practitioners working on how to build relationships across teams and services and how to structure systems to integrate and coordinate care. Further, there is a need to reflect more on what women say they want in health settings and what practitioners say will assist them to optimally deliver care.

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, which included 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

A concept that emerged in the 1980s in relation to substance abuse. Now used in the context of trauma, mental health problems, and sexual violence. 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.

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