

# Building partnerships between mental health, family violence and sexual assault services

Project report



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## Contents

<b>The Partnerships Project</b>	<b>1</b>
<b>Policy context</b>	<b>2</b>
<b>Definitions</b>	<b>3</b>
Mental health problems and mental illness	3
Family/domestic violence	3
Sexual assault, sexual abuse, sexual violence and sexual harassment	3
<b>Mental health, domestic violence and sexual assault services</b>	<b>5</b>
Mental health services	5
Domestic/family violence services	5
Sexual assault services	6
<b>The issues: prevalence and interrelationships</b>	<b>7</b>
Family violence and sexual assault	7
Women’s mental health	7
Impact of violence and abuse on women	8
Diversity of women’s needs and experiences	9
Impact of violence and abuse on children	10
<b>Messages from project participants</b>	<b>11</b>
The value of service partnerships	11
Factors that help or hinder collaboration	12
Partnerships in practice	16
<b>Recommendations</b>	<b>20</b>
<b>Appendix 1: The consultation process</b>	<b>23</b>
<b>Appendix 2: Further resources: interstate and overseas examples</b>	<b>27</b>
<b>References</b>	<b>31</b>

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## The Partnerships Project

*The Partnerships Project aimed to improve outcomes for women with a mental illness who have experienced sexual assault and/or family violence.*

The Building Partnerships Between Mental Health Services, Family Violence and Sexual Assault Services project (the 'Partnerships Project') was established to improve outcomes for women with a mental illness who have experienced sexual assault and/or family violence. Specifically, the Partnerships Project aimed to:

- facilitate improved relationships and service collaboration between family violence, sexual assault and specialist mental health services
- improve service access and referral pathways between family violence, sexual assault and specialist mental health services
- improve service delivery outcomes for female consumers of mental health services.

The Mental Health Branch of the Department of Human Services conducted the project in collaboration with the department's former Community Care Division (Family and Community Support Unit) and the Office of Housing (Home Finance and Community Programs Unit). Representatives of these areas formed a management group to oversee the project. A project reference committee was also established, comprising representatives of clinical mental health services, sexual assault services, domestic/family violence services, consumer and carer groups, Victoria Police, and management group members.

The Partnerships Project included:

- an initial statewide forum bringing together workers from the family violence, sexual assault and specialist mental health service sectors
- a review of relevant literature
- a consultation process involving managers and workers from the three sectors
- a second statewide forum to provide feedback on the results of the project.

The consultations with service providers and other stakeholders aimed to identify strategies for strengthening collaboration between mental health, domestic violence and sexual assault services. Appendix 1 provides details of the consultation process.

This report describes the findings of the Partnerships Project. An additional outcome of the project was an awards program acknowledging examples of 'best practice' in collaborative service delivery. The Minister for Health, the Honourable Bronwyn Pike MP, presented the awards at the second statewide forum held on 19 November 2004. Award-winning projects are highlighted in this report (see pages 16–19).

## Policy context

*A commitment to undertaking the Partnerships Project was part of the Victorian Government's Women's Health and Wellbeing Strategy.*

The Victorian Government's *Women's health and wellbeing strategy 2002–2006* (Department of Human Services 2002a) highlights the need for collaboration between services funded to respond to the needs of women with a mental illness who have experienced domestic violence and/or sexual assault. The strategy notes that women with a mental illness may have poor access to mainstream domestic violence and sexual assault services, and that some mental health workers lack confidence and experience in dealing with sexual assault and domestic violence issues. A commitment to undertaking the Partnerships Project was included in the strategy's 2002–03 action plan (Department of Human Services 2002b).

Other key Victorian Government policy documents relevant to the Partnerships Project, including those released since the project was undertaken, include:

- the government's social policy action plan, *A fairer Victoria* (Department of Premier and Cabinet 2005), which outlines a range of initiatives to support vulnerable women and children. The commitments contained in *A fairer Victoria* include an expansion of mental health services and significant reform and strengthening of family violence programs
- the *Women's safety strategy: a policy framework 2002–2007* (Department for Victorian Communities 2002). The Victorian Government Women's Safety Strategy brings together 11 ministers and their respective departments to work towards reducing both the level and the fear of violence against women. The policy framework has a section discussing safety issues for women with a mental illness (p. 42), which highlights the fact that women with a mental illness are often vulnerable to violence, but may be disbelieved by health professionals when they disclose violence. The government recently released the *Women's Safety Strategy progress report 2005*, which details achievements made since the Women's Safety Strategy was launched (Department for Victorian Communities 2005a).
- *Reforming the family violence system in Victoria: report of the Statewide Steering Committee to Reduce Family Violence*. The steering committee was established in 2002 in the context of the Women's Safety Strategy. A community and government partnership, the committee's main task was to provide advice on multiagency and integrated responses to family violence, building on information about successful interstate and overseas approaches and the knowledge and practice experience of its members. The report provides broad directions for system reform in Victoria. The recommendations informed the budget investment of \$35.1 million over four years outlined in *A fairer Victoria*
- *Changing lives: a new approach to family violence in Victoria* (Department for Victorian Communities 2005b). This publication provides details of the government's plans to improve Victoria's response to family violence. The Minister for Local Government and Minister for Housing, the Honourable Candy Broad MP, has been appointed Minister responsible for coordinating this whole-of-government initiative
- *Victoria's mental health service: tailoring services to the needs of women* (Department of Human Services 1997). This document observes that women have special mental health needs that should be taken into account in the way mental health services are delivered. It explores the issues impacting on women using public mental health services and promotes ideas, strategies and examples of good practice that may assist in improving service responses
- *New directions for mental health services: the next five years* (Department of Human Services 2002c). As part of its 'expanding service capacity' direction, *New directions* foreshadows initiatives to strengthen mental health service provision for women, particularly those with dependent children. The need to build partnerships between mental health, sexual assault and domestic violence services is mentioned in this context (p. 20).

## Definitions

This section defines key terms used in this report and briefly discusses how these concepts are described in current literature.

### Mental health problems and mental illness

The term ‘mental health problem’ is used to describe a broad range of emotional and behavioural difficulties. Mental health problems encompass less severe emotional and behavioural problems as well as ‘mental illnesses’ and ‘mental disorders’, which generally refer to severe and/or persistent states with clinically recognisable sets of symptoms. These symptoms are characterised by alterations in thinking, mood and/or behaviour (or a combination of these) and associated distress and/or impaired functioning. The Mental Health Branch web site describes ‘serious mental illnesses or disorders’ as conditions in which:

...a person’s ability to think, communicate and behave appropriately is so impaired that it significantly interferes with his or her ability to deal with ordinary demands of life. Without effective treatment and support, the outcome for the person may be significant disability and/or disadvantage ([www.health.vic.gov.au/mentalhealth](http://www.health.vic.gov.au/mentalhealth)).

### Family/domestic violence

Two main terms are used to describe violence in the home: ‘domestic violence’ and ‘family violence’. Other terms include ‘gender violence’, ‘intimate partner abuse’ and ‘intimate partner violence’.

In this report, the terms ‘domestic violence’ and ‘family violence’ are used interchangeably; however, it is recognised that many people now favour the term ‘family violence’ because it is more inclusive of violence outside the ‘male partner towards female partner’ category and can encompass violence perpetrated by other family members, including violence across generations or between siblings.

The Victorian Women’s Safety Strategy definition of family violence is:

Violent, threatening, coercive or controlling behaviour that occurs in current or past family, domestic or intimate relationships is called family violence. This encompasses not only physical injury but direct or indirect threats, sexual assault, emotional and psychological torment, economic control, property damage, social isolation and behaviour which causes a person to live in fear (Department for Victorian Communities 2002, p. 20).

Indigenous communities usually prefer the term ‘family violence’ because it reflects the concept of extended kinship and encompasses harmful, violent or aggressive behaviours that occur within families, extended families, kinship networks and communities (Victorian Indigenous Family Violence Task Force 2003).

The terminology relating to family violence involving children has also changed over time. Whereas children were once said to be ‘witnesses’ to family violence, they are now usually described as having been ‘exposed to’ or ‘affected by’ or ‘living with’ violence. These terms are preferred because they emphasise the harm that is occurring to such children, even when they are not direct targets of violence (see p. 10).

### Sexual assault, sexual abuse, sexual violence and sexual harassment

The terms ‘sexual assault’ and ‘sexual abuse’ describe non-consensual sexual behaviour. This can include incest, child sexual assault, and sexual assault and rape (of adults). The broader term ‘sexual violence’ takes all these categories into account. Sexual violence includes any form of non-consensual or forced sexual activity or touching, including rape. It is carried out against the woman’s will using physical or threatened force, intimidation or coercion (Mouzos & Makkai 2004).



The definition of 'sexual assault' used by the Victorian Law Reform Commission (2001) and the Australian Bureau of Statistics further describes the non-consensual nature of this behaviour. Sexual assault is defined as 'a physical assault of a sexual nature directed towards another person, where that person does not give consent, gives consent as a result of intimidation or fraud, or is deemed legally incapable of giving consent because of youth or temporary or permanent incapacity'.

The term 'sexual harassment' is used to describe unwelcome sexual advances, unwelcome requests for sexual favours or unwelcome but not overtly violent sexual conduct towards another person.

'Child sexual assault' occurs when an adult or someone bigger than a child uses his or her power or authority over a child or takes advantage of a child's trust or respect to involve a child in sexual activity. The person may use tricks, bribes, threats and/or physical force to make the child take part in sexual activity and to stop the child from telling anyone about it. Child sexual assault can involve a broad range of sexual acts, including touching a child's genitals or breasts, masturbating in front of a child, flashing or oral sex (New South Wales Commission for Children and Young People, [www.kids.nsw.gov.au](http://www.kids.nsw.gov.au)).

Sexual assault and family violence are forms of gender-based violence because they are predominantly—although not exclusively—perpetrated by men against women and occur in a context of power differences and inequality between men and women in society (Department for Victorian Communities 2002).

## Mental health, domestic violence and sexual assault services

The Partnerships Project concerned three sectors of the public health and community services system. A description of each sector appears below.

### Mental health services

For the purposes of this report, the ‘mental health sector’ refers to:

- clinical mental health services provided as part of general Victorian health services
- psychiatric disability rehabilitation and support services delivered by non-government organisations.

These services are targeted at people who are severely affected by mental illness. They are often called ‘specialist mental health services’ to distinguish them from the wide range of other services, including general practitioners, community health centres and private mental health professionals, which provide mental health care to people with less complex mental health problems, such as mild to moderate anxiety or depression.

Most clinical mental health services are part of a group of services known as an area mental health service, with each area mental health service serving a geographically defined catchment population. There are separate services for adults (21 areas), aged persons (17 areas) and children and adolescents (13 areas). Each area mental health service provides a range of community-based mental health services, as well as inpatient facilities for people who are acutely unwell. Recent initiatives, such as primary mental health and early intervention teams, emphasise the role of area mental health services in providing specialist advice, consultation and education to other service providers. Area mental health services also have access to specialist statewide and regionalised services, such as eating disorder programs and mother/baby units.

The psychiatric disability rehabilitation and support services sector provides non-clinical support services and programs for people with serious mental illness and related psychiatric disability. These services aim to create opportunities for recovery and empowerment. Key service types include carer support, respite, psychosocial rehabilitation day programs, mutual support and self-help, residential rehabilitation, and home-based outreach.

The Mental Health Branch’s web site, [www.health.vic.gov.au/mentalhealth](http://www.health.vic.gov.au/mentalhealth), provides further information about the Victorian mental health system.

### Domestic/family violence services<sup>1</sup>

Many different family support agencies, youth services and community health centres provide family violence support, often without specific family violence funding. In this report, the ‘family violence sector’ refers to the following Department of Human Services-funded services:

- refuges
- family violence outreach services
- services, including information, education, individual and group support, telephone counselling and referral, for children and young people experiencing or recovering from family violence
- services, such as individual and/or group counseling, telephone counseling and referral and court support, for men who have a history of violent and abusive behavior towards family members
- regional family violence networkers employed by community service organisations in each Department of Human Services region to raise awareness of family violence and promote coordination between relevant community agencies

<sup>1</sup> Since the Partnerships Project was completed, a process of reform has begun in this sector. The description given in this document is of the family violence sector as it was in 2004–05.

- specific central agencies, including:
  - Women’s Domestic Violence Crisis Service, a central point of contact and coordination for women’s entry into high security family violence refuge accommodation
  - Domestic Violence Victoria, responsible for policy and sector development
  - Immigrant Women’s Domestic Violence Service, which supports women and children of culturally and linguistically diverse backgrounds through shared case management and secondary consultation to family violence services
  - Domestic Violence and Incest Resource Centre, which provides information, training and secondary consultation on family violence issues.

The Domestic Violence and Incest Resource Centre web site, [www.dvirc.org.au](http://www.dvirc.org.au), provides further information about domestic/family violence services in Victoria.

## Sexual assault services

The Department of Human Services funds 25 sexual assault support services, including 15 centres against sexual assault (known as CASAs).

Sexual assault services in Victoria provide counselling, casework, group work and/or advocacy for recent or past victims of sexual assault. The Sexual Assault Crisis Line provides an afterhours sexual assault crisis response. It can be the first point of contact for victims of recent sexual assault. Nine CASAs provide a crisis care response for recent adult and child sexual assault.

Crisis care services provide assistance in the initial period after a sexual assault (usually the first 72 hours). Services include crisis counselling, a medical examination and follow-up. Workers liaise with forensic medical officers, police and other medical staff. Crisis care services for children and young people subject to child protection intervention are provided by paediatric forensic medical services. Some agencies provide specific services for children and young people displaying sexually abusive behaviour.

In addition to direct sexual assault services, there are also a number of agencies that deliver training and professional consultation to community service providers.

For details of sexual assault services in Victoria go to [www.casa.org.au](http://www.casa.org.au).

## The issues: prevalence and interrelationships

*'Trauma and violence in women's lives can be both a precursor to psychiatric diagnosis and a complicating factor for women already experiencing mental health difficulties' (Morrow 2002, p. 33).*

Mental illness, family violence and sexual assault are all major health and social problems and there are significant interrelationships between them. This section discusses some of the key issues in these areas, drawing on the literature search conducted for the Partnerships Project.

### Family violence and sexual assault

The high prevalence of family violence and sexual assault has been widely documented. The Australian Women's Safety Survey (Australian Bureau of Statistics 1996) provides an overview of violence against women in Australia. The survey found:

- Of women who had ever been in a relationship, 42 per cent had experienced violence from a previous partner.
- Fifty per cent of sexual violence and 75 per cent of physical violence by men against women is perpetrated by the woman's boyfriend, partner, ex-partner or a family member.
- An estimated 1.2 million Australian women (18 per cent) aged 18 years and over have experienced sexual violence since the age of 15 years.
- Overall, 38 per cent of all Australian women experience personal violence in their lifetime. They are more likely to experience physical violence in their own homes than in other locations.
- Up to 80 per cent of violence against women is not reported to the police.

The *World report on violence and health* (World Health Organization 2002) provides a global perspective, examining 48 population surveys from around the world. Reported rates of assault by an intimate male partner during a woman's lifetime varied widely, from 10 per cent to 69 per cent. The report notes that 'in some countries nearly one in four women report sexual violence by an intimate partner, and up to one-third of adolescent girls report forced sexual initiation' (p. 18).

### Women's mental health

*'Women experience mental ill-health differently to men and have particular needs which should be taken into account in the way mental health services are delivered' (Department of Human Services 1997, p. iii).*

Population studies show that women are twice as likely as men to be diagnosed with depression (World Health Organization 2001; Morrow & Chappell 1999). Depression in women 'is not only the most frequently encountered women's mental health problem, but ranks as the most important women's health problem overall' (Astbury 2000, p. 31). Women are also more likely to experience anxiety disorders, including panic disorders, agoraphobia, social phobia, eating disorders and post-traumatic stress disorder. They are by far more likely to receive a diagnosis of borderline personality disorder than men, who have higher rates of antisocial personality disorders.

The Victorian mental health policy document, *Tailoring services to meet the needs of women* (Department of Human Services 1997, p. iii) notes that women may experience mental illness differently from men and that the specific needs of women should be taken into account in the design and delivery of mental health services.

## Impact of violence and abuse on women

*'While it is clear that ordinary, healthy people may become entrapped in prolonged abusive situations, it is equally clear that after their escape they are no longer ordinary or healthy' (Herman 1992, p. 97).*

The impact of violence and abuse on women's physical and mental health has been widely discussed and documented. Recent research by the Victorian Health Promotion Foundation (2004) reveals that intimate partner violence is the leading cause of death, disability and disease among women aged 15 to 44 years. Survivors of abuse tend to have poorer general health and are more likely to suffer from chronic pain, such as headaches, back pain and chronic pelvic pain, and from reproductive health problems (Campbell 2002; Victorian Health Promotion Foundation 2004). Astbury (2002, p.409) reports that 'many of the most important health risk behaviours are increased following violence; these include higher rates of smoking, drinking alcohol and using other drugs'. Survivors of violence may 'self-medicate' or use alcohol or drugs in order to cope with the psychological impact of trauma.

Violence and abuse have particularly detrimental effects on victims' emotional and mental health and have been linked to the development of mental illness (Carmen, Reiker & Mills 1984; Mullender 1996). While there is debate about the extent to which abuse causes mental illness, it is clear that sexual and physical abuse histories are common among women and girls who have been diagnosed with mental illnesses, and that mental health problems are common among women who have been physically or sexually abused. For example:

- An estimated 50–80 per cent of women using psychiatric services have a history of sexual abuse/assault (Cox 1994).
- In a study of people with mental health problems presenting to hospital emergency departments, up to one-third of psychiatric diagnoses were attributable to family violence (Roberts et al. 1998).

- Golding (1999) found that just under half (47.6 per cent) of all abused women suffered from clinical depression compared with 10–20 per cent of women in the overall community.
- A survey by the Sexual Assault Resource Centre in Western Australia (2004) found that 54.8 per cent of people attending the centre (following a recent assault or because of past sexual abuse) had been diagnosed with a mental health disorder and 20.6 per cent experienced drug and/or alcohol problems. Of those who had experienced sexual assault both as children and adults, 71.0 per cent had a mental health or substance abuse problem.

A large body of research has focused on the association between sexual abuse in childhood and mental health problems later in life. While statistics vary, the findings generally indicate a high correlation between childhood sexual abuse and poor mental health. The high prevalence of childhood sexual abuse histories among consumers of mental health services has been widely documented (Weller 2002). Studies have demonstrated links between childhood sexual abuse and many specific mental health problems, including eating disorders (Mullen et al. 1993), borderline personality disorder (Herman et al. 1989), depression, and post-traumatic stress disorder (Herman 1992). There is also an established link between the severity of the abuse and the probability of developing a mental illness in adulthood (Mullen et al. 1993).

Among women with an established mental illness, relationships between the illness and the experience of violence/abuse can be complex. Women with mental illness are often vulnerable to abuse and violence, particularly when acutely unwell and if they are poor, homeless or living in unsafe housing. Women with mental illness often find it difficult to access support services and to exercise their legal rights, including ending abusive relationships.

Women with mental illness have reported that they are often disbelieved if they report physical, sexual or psychological violence to police, service providers or health professionals (Department for Victorian Communities 2002). Consumer feedback indicates that women with a history of sexual assault or abuse may feel vulnerable in acute psychiatric inpatient units and other unfamiliar treatment environments, particularly if their admission is on an involuntary basis (Department of Human Services 1997).

Despite the very real and profound emotional and psychological impact of violence and abuse, participants in the Partnerships Project pointed out the courage of many women who have experienced abuse and their strength in coping with the effects of abuse.

## Diversity of women's needs and experiences

*Aboriginal women are more than 45 times more likely to be victims of domestic violence than non-Aboriginal women.*

Some groups of Australian women are at particularly high risk of experiencing sexual assault, family violence and associated mental health problems. Notably, Aboriginal women have a very high rate of assault. The Victorian Indigenous Family Violence Task Force (Department of Community Services 2003) reports that Aboriginal women are 45 times more likely to be victims of domestic violence.

Consultations conducted for the Partnerships Project suggested that mainstream agencies often struggle to respond in culturally appropriate ways to the complex health and mental health needs of Aboriginal women (see page 13). Combined with the entrenched disadvantage and racism that many Aboriginal people have suffered, this means that Aboriginal women may feel disempowered to leave or change abusive situations and to recover from trauma.

Women from culturally and linguistically diverse communities may also be more likely than 'mainstream' Australian women to be victims of violence and sexual assault. Experiences of trauma or torture, including rape and sexual violence, are frequently reported in many newly emerging refugee communities. Additionally, many migrants have past experiences that affect both their long term mental health and their ability to trust government services. Mental health issues, including post-traumatic stress disorder, and difficulties in adjusting to Australian life may contribute to high rates of domestic violence in some ethnic groups.

Recent consultations conducted for the Victorian Department of Communities' Culturally and Linguistically Diverse Women's Project and as part of a forthcoming strategy on cultural diversity in the mental health sector suggest that the following factors impede appropriate service access for women from non-English speaking backgrounds:

- lack of knowledge of services
- the language barrier, and failure of mainstream services to make appropriate use of interpreters
- greater rates of family care and reluctance to involve government agencies
- reluctance to seek treatment due to stigma and shame.

Other groups of women with greater vulnerability to violence and/or mental health problems include sex workers, homeless women, and women in institutional settings (Department of Human Services 2001).

Women with a disability have been identified as being at particularly high risk of violence, with evidence of a much greater prevalence of sexual assault among this group than the mainstream community (Sobsey & Doe 1991).

## Impact of violence and abuse on children

*Early experiences have an effect on emotional development, the organisation of behaviour and personality. Experience shapes brain functions, and early experiences shape the foundation of life's behavioural responses...Early intervention in trauma is not just for the child, or the parent: it is for the future too (cited in Department of Human Services 2004a, p. 1).*

Although the Partnerships Project focused on adult women with a mental illness, it is important to keep in mind that many women who are assaulted, including those with mental illness, have dependent children who may be exposed to the violence they are experiencing. It is estimated that one-quarter of Australian children and young people have witnessed acts of violence against their mother or stepmother (Victorian Community Council Against Violence 2002).

Whether they are witnesses to violence or the targets of abuse, these children are at risk of disturbed behaviour and emotional problems. Children may also be affected by interventions to provide for the safety of their mother and/or themselves. These include police involvement, changes of home and school, and intervention by child protection services.

Participants in the Partnerships Project pointed out that the protective capacity of women towards their children might be lessened in times of abuse; however, research suggests that many women who are experiencing domestic violence will act to protect their children if the children become targets of abuse (Sirles & Franke 1989). Fear of children being removed from the home can add to the distress of women experiencing family violence.



## Messages from project participants

*'The more whole the service system is, the better chance the woman has to be whole. It is not her responsibility; she shouldn't bear the split.'* (Project participant)

This section describes the feedback given by service providers and other stakeholders consulted for the Partnerships Project.

### The value of service partnerships

What can sexual assault, family violence, and mental health services offer each other?

- Advice, support and consultation to assist in care planning and delivery for individual clients
- Information, education and training so that workers can better identify and respond to women with combined sexual assault/family violence/mental health problems
- Shared care: joint service provision for women with mental illness who have experienced violence
- A referral option for clients whose needs cannot be met by a particular service

As discussed in the previous section, there is considerable overlap between sexual assault, family violence and mental illness: it is often the case that individual clients receive assistance from more than one service type, either concurrently or at different points in time. The existence of a common set of interests and a shared client group suggests that mental health, sexual assault, and family violence services need to work together to share information, to impart advice and expertise, to coordinate service provision and to work collaboratively for individual clients.

Participants in the Partnerships Project unanimously agreed on the value of collaboration and partnerships between mental health, sexual assault, and family violence services. They identified the benefits of such relationships as follows:

- better outcomes for clients/consumers. Participants believed that good working relationships between agencies help staff to work more effectively with clients. Good relationships were thought to contribute to a smooth transition for clients being referred from one service to another because staff are better able to navigate the service system, feel positive about referring to the other organisation, and pass on this confidence to clients. In the case of shared clients, good relationships help to ensure the different providers are working towards the same goals. The critical success factors for effective shared care are discussed on page 19
- skill development for staff. Where there were good relationships between agencies, staff felt more skilled in dealing with complex issues involving mental illness and abuse. They particularly valued opportunities for secondary consultation and cross-sector professional development
- increased staff satisfaction. Positive relationships between services contribute to staff satisfaction in many ways. Workload and stress can be reduced as a result of staff being able to 'share the burden' and obtain assistance from professionals with complementary skills. Also, staff who feel respected by their colleagues experience a sense of professional gratification and are less likely to feel burnt out and undervalued.



## Factors that help or hinder collaboration

Project participants identified the following keys to successful ongoing collaboration:

- active support by agency management and leaders
- commitment to the time and other resources needed to build and sustain partnerships
- communication and respect. Success depends on the strength of interpersonal relationships
- formal mechanisms for communication, information sharing and mutual skill development
- shared understanding of professional roles and responsibilities
- government policy direction promoting collaboration between services.

Participants were asked to describe the relationship between mental health, sexual assault and family violence services in their region and to comment on what they think helps or hinders collaboration between the sectors.

The range of experiences varied. At the positive end of the spectrum, relationships were described as ‘pretty good’ ‘useful and pragmatic’, and ‘working well’. Relationships that were not working well were described as ‘appalling’, ‘difficult’, (like feeling like) ‘a distant relative’, ‘polite but busy’, and ‘confusing.’

Participants had many suggestions about what makes collaborations work or not work. Factors seen as contributing to strong partnerships include:

- management support and leadership
- formal activities between services, rather than informal relationships between individual workers
- recognition of ‘cultural differences’ between agencies, and efforts to understand and respect other ways of working

- willingness of service providers to acquire an understanding of other service sectors and issues outside their ‘core business’
- ‘systemic’ factors, including organisational and funding arrangements that encourage integrated service delivery
- government policy direction promoting collaboration between services.

Participants’ comments about each of these factors are outlined below.

### Management support

The endorsement and support of senior management was considered vital to creating a workplace culture that fosters collaboration with other services. Once this endorsement was provided, staff and funding could be allocated more easily to partnership activities. Conversely, lack of management support was experienced as a hindrance to collaboration, resulting in ad hoc and reactive efforts to work together.

### Informality

Currently, collaborations between the three service sectors are mainly informal, although there are regional variations. While informal arrangements can work well, they tend to rely on individual staff members ‘getting on’ and may not outlast staff changes.

Formal collaborations take time and resources to develop, implement and monitor. The first step in formalising the relationship between services might be a written document clarifying roles and boundaries, target groups and intake criteria. Participants thought that the process involved in developing joint activities, such as protocols, was often as important as the end product because it strengthens relationships between workers and mutual understanding of the services they provide.

## Culture and paradigms

*'I don't believe mental health staff should treat diagnosis; they should treat the person.'*  
(Project participant)

Although they all deliver public services for vulnerable members of the community, the organisations from the different service sectors involved in the Partnerships Project have very different cultures and ways of working with clients. Participants spoke about the difficulties of working across these 'paradigms'. They believed that the differences between services, while not insurmountable, should be recognised and talked about.

Workers from the sexual assault and family violence sectors commented on what they saw as an overly 'medicalised' culture within mental health services. They felt that when a woman was referred from their services to a mental health service, the focus of her care shifted entirely to the mental illness, medication and symptomatology. For example, disclosures of abuse were sometimes discounted as delusions or the woman's symptoms were 'put down to mental illness' rather than being an understandable reaction to abuse.

While some sexual assault and family violence workers believed that mental health services have an overly 'medicalised' approach and do not take enough account of the social context of women's illness, mental health participants commented that some sexual assault and family violence workers did not fully understand the role of clinical mental health services, which is to provide specialist, medically orientated treatment to people who are severely affected by mental illness. It was stated that mental health services work at a 'different part of the support continuum' from sexual assault and family violence services, indicating the worker's view that the clients seen by mental health services have higher levels of personal and social dysfunction than most of the women assisted by sexual assault and family violence services.

Despite these differences, participants believed that respect for other professionals' expertise and the constraints of other organisations was necessary for positive collaboration. Related attitudinal factors include:

- 'openness and 'trust'
- willingness to 'let go of territory' by recognising that one's own service cannot provide everything the client needs
- willingness to prioritise collaborative work despite limited resources
- persistence when faced with difficulties.

The difficulty of finding common ground as a result of differences in philosophy and language was seen as an important factor contributing to failed collaborative efforts. Some participants described 'a hierarchy of professions' and believed that some groups (for example, mental health clinicians) tended to view people from other organisations (for example, homelessness services) as not being trained professionals.

Aboriginal workers talked about the lack of culturally appropriate service responses for Aboriginal women. Aboriginal agencies try to manage the complex health and mental health needs of their clients in an holistic way, but often find it difficult to engage other services in working in this way. Aboriginal workers said that although they are frequently approached by mainstream organisations for advice about being more culturally sensitive, there was a lack of follow-through:

They come and want to talk to us about how to make services more accessible to Aboriginal people. We give them heaps of suggestions and then we never hear from them again.  
(Project participant)

Participants in the Partnerships Project did not specifically raise issues about women from migrant and refugee backgrounds; however, as discussed on page 9, these women may be more likely to have experienced violence and sexual assault than women from the mainstream Australian community. Other research and consultation processes have indicated that health and community services need to make special effort to engage and respond appropriately to women from culturally and linguistically diverse backgrounds (Department of Human Services 2004b, 2005a).

### Understanding of other service sectors

*'We are the specialists in mental illness, but there are some specialists out there who can assist and even ease the workload.'* (Project participant)

As discussed briefly under 'Culture and paradigms' (see page 13) workers from the three sectors involved in the Partnerships Projects require information and education about the role of each other's services and what they have to offer. A thorough understanding of other service sectors is necessary to assist clients to access those services when needed and to ensure realistic expectations when referrals are made or shared care arrangements are entered into.

Workers also need to be open to learning about areas outside their 'core business'. For example, knowledge of the signs and symptoms of mental illness will help sexual assault and family violence workers to identify high risk clients and to make appropriate and timely referrals to specialist mental health services. These workers may also feel empowered to manage their clients' less serious mental health problems, perhaps in consultation with mental health clinicians.

Similarly, education about sexual assault and family violence issues and services can help mental health staff to provide the best possible response to people who disclose abuse and to identify additional sources of support for their clients.

It is also important that there is general understanding within organisations of the worth of collaborative work with key service partners. Communication of successful joint activities and their benefits to individual agencies and/or clients can help to build commitment and enthusiasm for collaboration.

### Systemic issues

*'We need each other and we generally want to be collaborative. How can we say yes rather than no?'* (Project participant)

Collaboration takes time and resources; this can pose a problem for services that are already stretched. Small organisations, such as family violence and sexual assault services, have limited resources, while most clinical mental health clinicians, even though part of much larger organisations, have very high caseloads. The following comments reflect these concerns:

(Mental health staff sometimes) don't want to know about domestic violence; its just another thing they need to deal with. (Project participant)

People don't know each other's fields very well and they are overwhelmed with their own work. (Project participant)

Participants in the Partnerships Project commented that when organisations are under-funded or otherwise under pressure they tend to be crisis-driven, reactive and rigid. Although a focus on 'core business' is understandable in these circumstances, participants thought that collaboration with other services could actually reduce workplace stress. For example, when care for a client is shared, roles and responsibilities and 'who does what' need to be clarified. This may require extra work initially, but is more efficient in the long run. Despite this, many participants believed that the demands on their own services made it difficult to put the necessary time into building relationships with other services.

They noted there were few positions specifically funded to create links between organisations. Exceptions include family violence prevention network positions and the health promotion officer positions in child and adolescent mental health services.

Rigid funding arrangements were thought to contribute to services operating as silos; this in turn contributes to workers' lack of knowledge about other fields and services. The fragmentation of the service system and 'over-specialisation' of services were some of the major issues discussed in the consultations. Participants noted that referral pathways are not always clear to clients and staff and that it is sometimes difficult to refer women to specialised support services because of targeting criteria or waiting long times. Finding support options for women with high prevalence mental health disorders, such as anxiety and depression, was considered particularly problematic.

Rural organisations have the added problem of the distance they may need to travel to meet with colleagues or which clients may need to travel to receive services; however, in some regional centres, the smallness of community and the small number of organisations providing services resulted in greater collaboration.

## Policy direction

Government policy direction or specific initiatives can provide the impetus for collaborative work between services. For example, the Loddon–Mallee region of the Department of Human Services used the mental health policy *Tailoring services to the needs of women* (Department of Human Services 1997) to develop a strong regional response to the issues raised in the document. The region undertook its own consultations and prepared a three-year action plan, which a reference group monitored. There was strong support from the regional departmental contact officer and senior management of the mental health service. The funding and service agreement and the hospital service agreement at that time included a requirement to 'actively participate, where appropriate, in the implementation of the strategies identified in the regional women's mental health strategy plan'.

At the time the *Tailoring services* document was released, the Department of Human Services' Mental Health Branch had a system of making additional 'quality bonus' funding available to encourage area mental health services to work on specified high priority issues. Some of this funding was targeted at sexual assault and family violence issues.

Policies directing services to focus on core business, and a lack of integrated service planning at a regional level, were regarded as stumbling blocks to collaborative practice between services. Participants also commented that many initiatives to support inter-service relationships receive only short term funding and do not go beyond the pilot stage; the same ideas may resurface at a later stage without building on previous work.

## Partnerships in practice

### **Service Partnership Award Winner: S.E.A. Change**

*S.E.A Change is a Mildura-based support group for women who have experienced family violence. Focusing on building self-esteem and assertiveness, the S.E.A. Change motto is: 'I can't change the direction of the wind, but I can adjust my sails to always reach my destination'. Local service providers, including the mental health service, report increased knowledge of and support from other services involved with the client group.*

### **Service Partnership Award Winner: Collaboration between Eastern Health and Woorarra Domestic Violence Service**

*This project was developed in response to a growing awareness that many consumers of the Outer East Mental Health Service had experienced domestic violence and that pain and trauma were hindering their recovery from mental illness. The project included family violence training and secondary consultation for mental health clinicians, consumer brochures and posters, service provider meetings, data collection, and development of referral processes to help mental health consumers to access family violence and other support services.*

### **Service Partnership Award Winner: Collaboration between Mallee Sexual Assault Unit, Mallee Domestic Violence Services, and Northern Mallee Mental Health Service**

*In 1990, the increasing number of inter-agency referrals led to the development of a protocol between the three service sectors. This marked the beginning of a series of collaborative endeavours, including: a 'portfolio holder' system in each service; changes to mental health triage/intake processes to assist in early identification of abuse/assault; collaborative case planning; reciprocal staff training; and jointly facilitated support programs for women*

The consultations revealed many examples of current and past collaborations between the service sectors. Informal collaborations included visits to other services, once-off staff development or secondary consultation, and guest speakers at staff meetings or client support groups. There were also planned and ongoing collaborations, although some were time-limited. These included training and staff development programs, formal protocols, network and liaison meetings, staff exchange, regular secondary consultations, and regular visits to other services. In some areas, there are social activities between teams or services. The Mallee Sexual Assault Unit and Mallee Domestic Violence Service ('the Mallee Integrated Service'), for example, invites new staff from mental health services to breakfast get-togethers. Although they are informal, these meetings are quite 'institutionalised' and occur on a regular basis.

Other examples of collaboration follow.

## Meetings and forums

Participants in the Partnerships Project gave several examples of service networks that meet regularly:

- Two metropolitan area mental health services (Northern and Central East) employ a women's mental health consultant whose role includes resourcing local service networks. These networks, which have been maintained over several years, focus on staff development and cross-sector information sharing.
- The Partnerships Project has provided the impetus for Northern Area Mental Health Service to initiate meetings involving the local sexual assault service, family violence services and family support services.
- The Northern Mallee Area Mental Health Service has run a successful mental health network for many years. Although the network does not focus specifically on women's issues, it has provided a place for organisations in the area to exchange information on a regular basis.

- The Community Health Plan Implementation Committee in Bendigo has representatives of a broad range of services, including psychiatric disability and rehabilitation support services and community agencies.

Project participants noted that it is necessary to review the aims of regular meetings from time to time to avoid ‘meeting for the sake of meeting’.

There were also examples of one-off forums or conferences aimed at getting service providers together to discuss issues relating to mental illness and family violence and/or sexual assault.

### Training and professional development

Numerous examples of training and staff development across service sectors were provided to the Partnerships Project. Most staff development is conducted on an ad hoc basis; for example, a family violence refuge worker conducting an information session on family violence issues for mental health workers. The following are examples of more formal training and professional development activities:

- The Domestic Violence and Resource Centre provides bi-annual training on ‘working with women with mental illness’ for services funded by the Supported Accommodation Assistance Program (including refuge and domestic violence outreach workers). The Domestic Violence and Resource Centre collaborates with mental health staff to develop and deliver this one-day training. The centre also delivers training on family violence to staff at NorthWest Mental Health. The training program was established in collaboration with the NorthWest Mental Health Training Unit.

- The NorthWest Mental Health Training Unit has taken a lead role in ensuring services in the network have access to training on sexual assault issues. The Bouverie Centre delivers annual training on working with sexual assault within a mental health context. The training unit has also convened the ‘network for mental health workers addressing sexual abuse issues’. This group meets monthly and aims to support clinicians by providing opportunities for case presentations and discussion.
- West CASA and the Midwest Area Mental Health Service developed and delivered one-day training and an associated training manual, *Working together in responding to sexual assault*.
- The Eastern family violence prevention networker has developed and delivered a training package on ‘working with dual diagnosis<sup>2</sup> and family violence’ in collaboration with staff from local mental health and drug treatment services.

Orientation sessions (to provide information about a service to staff of other services) were another form of professional development noted in the consultations.

Mental health services and the Mallee Integrated Service are negotiating interagency staff exchange programs.



## Secondary consultation

Secondary consultation in which a professional provides advice or input to another service provider's assessment or care planning processes is another way to transfer knowledge between workers. In the examples Partnerships Project participants gave, secondary consultation was usually provided on an ad hoc or as-needed basis; however, some services, such as the Maroondah Child and Adolescent Mental Health Service, have a designated position to undertake this work. A project worker employed by the Homelessness Agencies Resource Project has provided secondary consultations to the Eastern Domestic Violence Outreach Service for the past ten years. These sessions are provided on a monthly basis and provide the outreach team with the opportunity for case discussions and general discussion of ethical dilemmas (such as the balance between clients' right to confidentiality and the need to protect their safety and that of others). Other examples discussed in Partnerships Project consultations are noted below:

- The Mallee Integrated Service offers debriefing and secondary consultation to local mental health workers.
- The Victorian Women's Domestic Violence Crisis Service provided a mental health clinician with a secondary consultation session to assist in developing a safety plan for a consumer of the mental health service. This opportunity also enabled the mental health worker to explain the mental health system to the Victorian Women's Domestic Violence Crisis Service staff.

## Shared care

*'Although initially it may be more resource intensive for an agency to plan and work collaboratively with others, this input is outweighed by the benefits of more efficient use of resources and ultimately more robust results' (Department of Human Services 2005b, p. 5).*

Joint delivery of services to individual clients, including the development and implementation of individual shared care plans, is another way in which services build and maintain relationships with each other.

Effective shared care requires that services have a clear understanding of their respective roles and responsibilities, and clarity about who maintains overall case management responsibility in each case. It also requires good communication mechanisms and processes for sharing client information (subject to client consent).

Participants in the Partnerships Project believed that shared care approaches resulted in clients' needs being addressed in a coordinated way and by service providers with complementary skills and knowledge. As one participant said: 'It means that two people problem solve, rather than one'. Although this may seem like a duplication of effort, it can be much more efficient in the long run because the higher quality of service provision leads to better outcomes for clients. The service provider does not spend effort trying to be 'all things' to the client when better results could be obtained by getting specialist input from other service providers and integrating this into an overall care management plan.

Examples of shared care described in the Partnerships Project were mainly ad hoc responses to the needs of particular clients; however, representatives of the Victorian Aboriginal Health Service described the formal reciprocal arrangement their organisation has with the Aboriginal women's refuge Elizabeth Hoffman House. Under the agreement, the Victorian Aboriginal Health Service and Elizabeth Hoffman House provide continuity of support to women entering either service.

For example, women staying at the refuge receive Victorian Aboriginal Health Service assistance and can remain a client of the service after they move out of the refuge.

## Protocols

Some service providers consulted for the Partnerships Project had developed protocols or linkage agreements with other organisations. The protocols aimed to clarify roles and responsibilities, referral processes, and issues involved in the sharing of client information. While these were seen as making a positive contribution to collaboration, participants noted that all organisations involved must actually implement and monitor the protocols if they are to be a useful tool.



## Recommendations

General Department of Human Services policies and strategies, including the Primary Care Partnerships Strategy (Department of Human Services 2004c) and the Ambulatory Care Policy and Planning Framework (Department of Human Services 2006), strongly emphasise coordinated, community-based service provision for people with multiple and complex needs. Key program guidelines for the mental health sector have reinforced the message that collaboration with community ‘service partners’ is an integral part of effective mental health care and of managing demand for mental health services.<sup>3</sup> Service integration is also highlighted in recent sexual assault and family violence policies, including those discussed on page 2.

Two government committees—the Statewide Steering Committee to Reduce Sexual Assault and the Statewide Steering Committee to Reduce Family Violence—have ongoing roles in identifying cross-government initiatives to assist women who have experienced family violence or sexual assault. Building on the work of these committees, the government’s social policy action plan, *A fairer Victoria*, commits to significant reform and strengthening of services to support abused women (see page 2). In this context, the Partnerships Project report may inform the committees in considering how government can promote collaboration between family violence, sexual assault and mental health services; however, the partners themselves will have to undertake most of the work of sustaining partnerships and good collaborative practice. Because of the considerable overlap in their client groups, it is expected that the mental health, sexual assault and family violence sectors will work closely and collaboratively to ensure timely and appropriate inter-service referrals and to manage the care of their mutual clients.

The following recommendations are made on the basis of the consultations and literature review conducted for the Partnerships Project. Recommendations one to six are about increased coordination and collaboration between mental health, family violence and sexual assault services.

Recommendations seven to 11 specifically focus on improving care for consumers of mental health services who disclose experiences of family violence and/or sexual assault.

1. Mental health, sexual assault and family violence services should explore and create opportunities for collaboration with each other. These could include:
  - regular meetings or other forums for regular communication
  - orientation of staff to each other’s organisation
  - provision of training and information
  - planned cross-sector case discussions/presentations
  - special projects designed to meet the needs of clients that services have in common.
2. Mental health, family violence and sexual assault services should recognise the provision of consultation and advice to other service providers as a key part of their work. There should be staff within each service who can offer specific expertise in mental health, sexual assault and family violence issues.
3. Mental health, family violence and sexual assault services should designate a liaison person position within each service to consult and share information with other organisations providing services to women with mental health problems who have experienced family violence and/or sexual assault. This responsibility should be included in job descriptions and the designated worker should receive specialised training in meeting the needs of these clients with joint mental health and abuse issues.

<sup>3</sup> See *Triage program management circular*, *Discharge management program management circular*, and *Guidelines for participation in primary care partnerships* (all available at [www.health.vic.gov.au/mentalhealth](http://www.health.vic.gov.au/mentalhealth)).

4. Mental health, family violence and sexual assault services should provide their staff with access to information, training, secondary consultation and/or supervision to ensure they can appropriately respond to women with mental health problems who have experienced family violence and/or sexual assault. Training may include specific courses, in-service training and information exchange from staff of sexual assault/family violence services, and opportunities for short term staff exchange/orientation to other local services.
5. Mental health, sexual assault and family violence services should collaborate in developing local cross-sector protocols. The protocol should provide:
  - clear information about the roles and responsibilities of the various services, including targeting and eligibility, referral processes and requirements, and the types of services provided to clients
  - processes for inter-service consultation and collaboration or shared care when individual clients are involved with both mental health and sexual assault/family violence services.
6. When possible, service coordination tools and processes developed as part of the Primary Care Partnerships Strategy, including service coordination tool templates and service databases and directories, should be used as the vehicle for information exchange and referrals between mental health, sexual assault and family violence services.
7. Policies and practices in mental health services should recognise that many women using the services will have physical, sexual and/or emotional abuse issues. The Partnerships Project reaffirms the principles outlined in the 1997 mental health policy statement, *Tailoring services to meet the needs of women*. These are summarised in Table 1.
8. Mental health clinicians should consider the impact of past or current abuse on their patients' mental health and incorporate these issues in to assessment, treatment and care planning. The skills needed for this should be promoted in staff training, supervision and performance evaluation, and in the service's input to undergraduate training of mental health professionals.
9. Mental health services should aim to create an environment that engenders trust and feelings of security. This aim should be promoted in literature provided to consumers of the service. Performance in this area should be included in service reporting against the National Standards for Mental Health Services with specific reference to activities for women (specifically, reporting on safety (standard 2) and privacy and confidentiality (standard 5)).
10. Mental health services should refer women needing legal advice about violence and assault to an appropriate organisation.
11. As part of their complaints management mechanisms, mental health services should have clear processes for registering and responding to complaints about threats to or abuse of personal safety and privacy that occur in the context of mental health service delivery. The existence of these processes should be promoted to consumers of the service.

**Table 1: Principles outlined in *Tailoring services to meet the needs of women* (Department of Human Services 1997)**

Service area	Requirement of public mental health service
General service responsiveness	Provide a safe and non-threatening service environment.
	Respond appropriately to disclosures of abuse. Effective responses may include feedback that indicates belief, validation and understanding of the woman's experience. Specialised staff training and supervision may be needed to ensure appropriate responses to disclosures of abuse.
	Have clear processes for registering and responding to complaints about threats to or abuse of personal safety and privacy, particularly in inpatient and residential settings. Such processes should be clearly communicated and exist in addition to general complaints processes.
Triage/intake	Include information about past or current abuse revealed during the intake process into treatment planning.
Home-based and outreach services	Ensure female staff are available to provide outreach or home-based services to women, particularly where the woman lives alone or is a single parent.
Inpatient services	Recognise that female consumers may feel vulnerable in terms of safety and privacy in these settings, and ensure that policies, practices and facility design <sup>4</sup> minimise the risk of sexual assault and harassment.
	Employ least restrictive practice. If it is necessary for a woman in an inpatient setting to be secluded, involuntarily sedated or mechanically restrained, this should be done in a way that is minimally traumatising and in accordance with all relevant legislative requirements and Chief Psychiatrist guidelines. Where possible, female staff should perform these procedures.
	Clarify with female consumers the people who should and should not be informed of their admission to the service.
Extended care and community care units	Ensure staff are attuned to the safety and privacy needs of women residing in extended care services or community care units.

<sup>4</sup> Page 24 of the document outlines specific guidelines for the design of inpatient services and the use of existing facilities.

## Appendix 1: The consultation process

The consultation phase of the project involved a series of focus groups with representatives from family violence, sexual assault and mental health service sectors, as well as individual interviews with other selected individuals. A semi-structured interview guide developed by the project officer in collaboration with the management group was used to guide discussion in the focus groups and interviews.

A purposive sampling approach was used to select participants for the focus groups and individual interviews. Members of the management and reference groups were asked to make suggestions of consultation participants from their sectors. Regional contact officers (regional advisors) assisted with organising focus groups and some of the individual interviews.

Eleven focus groups were held across Victoria. Representatives of sexual assault, family violence, psychiatric disability and rehabilitation support services and clinical mental health services were invited to each focus group. One focus group was held in each Department of Human Services region, with the exception of the Loddon-Mallee region,

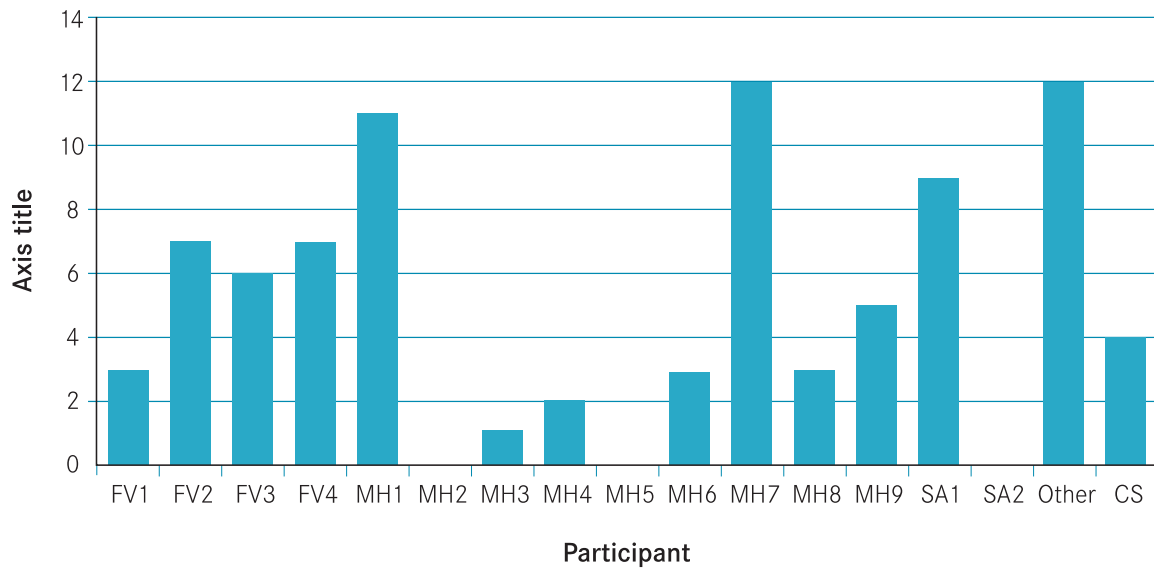
where one focus group was held in Mildura and one in Bendigo. In addition, a focus group was held with representatives of the family counselling team of the Victorian Aboriginal Health Service.

Participant numbers ranged from three to ten, with an average of six per focus group. In addition, 17 individual interviews were held (in person or over the telephone) with other key stakeholders. Overall, 85 participants (83 women and two men) were involved in the consultation phase: 68 people participated in the focus groups, while 17 people took part in the individual interviews.

Due to the time-limited nature and focus of the project, a number of potential stakeholder groups could not be included in the project. These include child and adolescent mental health services, facilitators of family violence support groups, child sexual assault services, and family support services with family violence funding.

The graph on the following page provides a breakdown of the participants who were involved from each service sector.

**Figure 1: Participation in Partnerships Project**




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FV1	domestic violence refuge
FV2	domestic violence outreach service
FV3	domestic violence networker
FV4	other FV (including men's behaviour change program, domestic violence resource centre, peak body FV services)
MH1	community mental health centre
MH2	community care unit
MH3	crisis assessment and treatment team
MH4	inpatient unit
MH5	mobile support and treatment service
MH6	primary mental health team
MH7	psychiatric disability and rehabilitation support service
MH8	specialised service (included aged mental health, eating disorder service)
MH9	other mental health (including research centre, training consultant)
SA1	Centre Against Sexual Assault
SA2	other sexual assault
Other	includes SAAP agency, SAAP/homeless networker, Community Health Centre, Victim Assistance Program, Koorie alcohol and drug service, Aboriginal co-operative, Indigenous health service, crisis homeless service, NSW Education Centre Against Violence, Department of Human Services regional contact officer (mental health), consumer
CS	combined service (Mallee Integrated Service)

## Participating organisations

- Academic, Melbourne University, School of Nursing
- Aged Persons Mental Health Service/Bendigo Health
- Aspire, Psychiatric Disability Rehabilitation Support Service
- Balgarnie Psychiatric Disability Rehabilitation Support Service/Grampians Community Health Centre
- Ballarat Centre Against Sexual Assault
- Bendigo Health Care Group, Psychiatric Services, RIP Program
- CASA House
- Centacare Psychiatric Disability Rehabilitation Support Service
- Centre for Rural Mental Health
- Chandler House, Eastern Health/Mental Health Services
- Child and Adolescent Mental Health Service/Mildura Base Hospital
- Child and Adolescent Mental Health Services, Grampians
- Cooronya Domestic Violence Services
- Department of Human Services, Bendigo (Mental Health)
- Domestic Violence and Incest Resource Centre
- Ballarat and District Aboriginal Cooperative (HACC and drug and alcohol services)
- Domestic Violence Victoria
- Eastern Domestic Violence Networker
- Eastern Domestic Violence Outreach Service
- Eastern Health Mental Health Program, Child and Adolescent Mental Health Service
- Education Centre Against Violence, NSW Health
- Emma House Domestic Violence Services
- Family Violence Networker, Barwon South West
- Family Violence Prevention Networker, Women's Health West
- Gippscare
- Gippsland Accommodation and Rehabilitation Support Services Inc
- Gippsland Centre Against Sexual Assault
- Gippsland Child and Adolescent Mental Health Service/La Trobe Regional Hospital
- Gippsland Women's Health
- Golden City Support Services, Community Support
- Grampians Family Violence Prevention Networker/Child and Family Services
- Gwen's Place
- HARP/Maroonah Child and Adolescent Mental Health Service/Eastern Health
- Indigenous Health Service, Yarra Valley Community Health Service
- Inner South Community Health Service
- Inner West Primary Mental Health Team
- Loddon Campaspe Centre Against Sexual Assault
- Mallee Domestic Violence Service
- Mallee Family Care
- Mallee Sexual Assault Unit
- Mosaic/Inner East Mental Health Services Association

- Northern Area Mental Health Service
- Northern Centre Against Sexual Assault
- NorthWest Mental Health Training and Development Unit, Melbourne Health
- Preston Creative Living Centre
- Primary Mental Health Team, Grampian Health Service
- Relationships Australia, Croyden
- Sale Community Mental Health/La Trobe Regional Hospital, Mental Health Service
- Sandridge Program/Richmond Fellowship
- South East Centre Against Sexual Assault
- South West Centre Against Sexual Assault
- Mid West Area Mental Health Service, Inpatient Unit
- South West Healthcare Psychiatric Service, Community Care Unit
- St Lukes Anglicare
- Mid West Area Mental Health Service, Inpatient Unit
- The Salvation Army Macarthur Street Centre
- Upper Murray Centre Against Sexual Assault
- Victorian Aboriginal Health Service, Family Counselling Service
- WAYSS Ltd
- Wesley Homeless Crisis Service
- West Hume Primary Mental Health Team
- Western Homelessness Assistance Network
- Western Region Outreach Service (psychiatric disability rehabilitation support service)
- Wimmera Centre Against Sexual Assault
- Wimmera Horizons
- Windemere
- Women Information Support Housing North
- Women's Domestic Violence Crisis Service of Victoria
- Women's Health West, Family Violence Networker
- Women's Resource, Information and Support Centre (domestic violence support service)

## Appendix 2: Further resources: interstate and overseas examples

The literature search conducted for the Partnerships Project revealed many examples of overseas and interstate resources designed to improve service outcomes for women with mental illness who are past or current victims of family violence and/or sexual assault. Some of these are noted here.

### Policies

Many countries, states and regions, as well as peak bodies or professional organisations, have developed policies on the provision of mental health services to women who have experienced sexual assault and/or family violence. In Australia, the SouthWest Sydney Area Health Service has developed a policy on domestic violence, which includes issues for women with mental illness (New South Wales Health 2004).

The Department of Health in the United Kingdom has produced a comprehensive policy and plan to address women's mental health and gender sensitivity in United Kingdom mental health services, including guidance in translating broad policies to implementation of actions at the local level (UK Department of Health 2003). The policy document covers organisational development, planning, research and evaluation, and provides general principles for workforce development and service delivery. There is a section on responding to abuse issues and collaborating with family violence and sexual assault services. Women's safety and security in mental health services is discussed, highlighting the trend in Britain towards women-only inpatient and community-based services.

Similar policies, if somewhat not as comprehensive, have been developed in the United States of America and Canada (Canadian Mental Health Association 1995). For example, the Domestic Violence and Mental Health Policy Initiative in Chicago is designed to mobilise a comprehensive response to the mental health needs of domestic violence survivors and their children (see [www.dvmhpi.org](http://www.dvmhpi.org)).

### Practice and service development guidelines

NSW Health has published the second edition of its *Guidelines for the promotion of sexual safety in NSW mental health services* (NSW Health 2004). The guidelines set directions for services 'to better meet the needs of consumers in matters related to sexual safety, inform the development of partnerships, and improve workforce training' (p. 1). The guidelines focus on three main areas: promotion of sexual safety, provision of effective responses, and workplace culture and learning.

The guidelines were produced in response to research by Women and Mental Health Inc<sup>5</sup> into sexual abuse of women patients in psychiatric institutions in New South Wales. The research report documented women's experiences and the systemic factors contributing to abuse. In addition to the guidelines, NSW Health's Centre for Mental Health provided funding to the Education Centre Against Violence to conduct training for mental health professionals (see later).

The Department of Health in Western Australia has developed a guide to help health care professionals respond to family/domestic violence (Department of Health 2001). The guide includes a section on clients who have a mental illness.

Queensland Health (2004) has produced a comprehensive set of guidelines on responding to sexual assault and promoting sexual safety in the state's inpatient mental health services. The guidelines are intended to inform the development of local area policy and procedures in acute care, extended treatment and high security inpatient services.

The American Medical Association has developed two documents relevant to this area: *Diagnostic and treatment guidelines on mental health effects of family violence and Strategies for the treatment and prevention of sexual assault* (American Medical Association 1995). Both documents provide information and guidance for practitioners working with clients who have experienced violence.

<sup>5</sup> Women and Mental Health Inc was formed in 1993. It is a non-government organisation working to improve attitudes and service provision to women who have or are experiencing a mental health problem. (Taken from organisational leaflet.)



The National Advisory Council on Violence Against Women and the Violence Against Women Office in the United States have developed a comprehensive toolkit to assist practitioners working with women who have experienced family violence (Mulder 2003; National Advisory Council on Violence Against Women & Violence Against Women Office 2003). The toolkit is aimed at a wide range of organisations, including military, education, workplace, health and mental health services. It provides suggestions on improving the standard of clinical care, professional education and curriculum development, and working collaboratively with other services.

Other guidelines from the United States include:

- *Mental health intervention in cases of domestic violence* by the Governor's Office of Child Abuse and Domestic Violence in Kentucky (n.d.)
- *Guidelines for mental health professionals* by the Office for the Prevention of Domestic Violence in New York State (n.d.).

Similar resources have been developed under the New Zealand Health Strategy (Ministry of Health 2000) and by Health Canada, which published the *Handbook on sensitive practice for health professionals – lessons from women survivors of childhood sexual abuse* (Schacter, Stalker & Teram 2001). In the United Kingdom, an organisation called Women's Aid has produced a document titled, *Principles of good practice for working with women experiencing domestic violence: guidance for mental health professionals* (Women's Aid 2005).

The Women's Health Bureau of British Columbia's Ministry of Health has developed a guide which assists services to develop policy and establish short and long term goals to improve their responses to women who have experienced violence (Morrow 2001). The guide is targeted at general health and mental health services and provides practical tools and examples of how to develop integrated community responses and prepare funding proposals.

## Service delivery models

A shared domestic violence and mental health case management position and associated case management model was developed between a domestic violence service and a local mental health service (Cleveland Centre) in North Carolina some years ago. A case manager provided 'flexible, client-centred interventions to women in both service settings (and) worked with women in the public mental health clinics around issues related to past and current experiences of domestic violence, providing traditional case management within a framework of advocacy and empowerment' (Warshaw & Moroney 2002). The case manager also provided support to women in domestic violence services. While this initiative was not evaluated, it was considered a success; however, due to funding restrictions (special funding was granted for a three-year period) it has been discontinued.

The literature search for the Partnerships Project also found several examples of support groups co-facilitated by representatives from the mental health and sexual assault/family violence sectors.

## Service networks

There are many examples of formal networks and regular meetings between mental health and family violence/sexual assault workers. The Domestic Violence and Mental Health Policy Initiative for the Chicago area foreshadowed 'regional working groups' and 'critical issue working groups' to improve collaboration between domestic violence and mental health providers'. Representation is drawn from mental health, domestic violence, and drug/alcohol services, as well as from city and state government offices. The stated purpose of the meetings is to facilitate coordination between service providers and (to develop) strategies for coordination of referrals, screening and assessment. Group meetings are a forum for agencies to problem solve, cross-train, and develop a greater understanding of what mental health providers and victim advocates can offer each other to address the mental health and safety needs of trauma survivors.

## Training

The Education Centre Against Violence, part of NSW Health, provides training and education for a number of professional groups. A three-day training module, Adult and Child Sexual Assault for Mental Health Workers, aims to educate mental health workers about the ‘incidence, dynamic, indicators and effects of both adult and child sexual assault’ (Education Centre Against Violence n.d, p. 1). This training is delivered in conjunction with the *Guidelines for the promotion of sexual safety in NSW mental health services*, discussed earlier. A two-day course, Interagency Responses to Domestic and Family Violence: Where to from Here?, aims to assist organisations within specific regions to collaborate across sectors.

Another example comes from a five-year plan, *Building connections*, by the New York State Coalition Against Sexual Assault in collaboration with the Mental Health Association in Ulster County (in the United States). The goals of the project are to ‘provide cross-training opportunities for both the existing public mental health system and the rape crisis centre network on effective treatment approaches’ (New York State Coalition Against Sexual Assault 2004, p. 1). The New York State Office of Mental Health provides funding for this initiative.

Other organisations that have developed training materials include the Pennsylvania Coalition Against Rape (Pennsylvania Coalition Against Rape various years), the National Centre for Injury Prevention, and Control Centres for Disease Control and Prevention (Osattin & Short 1998). These training manuals provide information about abuse and mental health and include overheads, session plans, and handouts for the training modules.

## Educational curricula

Some organisations have taken professional development a step further by developing curricula for courses at certificate and masters level. The Education Centre Against Violence within NSW Health delivers a certificate IV course in family/ domestic violence and sexual assault for staff of Aboriginal health services. The centre also delivers a unit for the New South Wales Institute of Psychiatry’s Continuing Education Program, titled Mental Health Outcomes of Adult and Child Sexual Abuse. Topics covered by this post-graduate program (Masters level) include foundations for working in sexual assault, working in partnerships, and clinical practice in sexual assault.

Another example is the student material developed through a collaborative effort by representatives of mental health, justice, rape crisis, and a number of other services in the United States (US Department of Justice n.d). This material, to be used in mental health courses, includes modules on understanding and responding to the trauma of victimisation’, rape trauma syndrome, and integrating awareness of victimisation into treatment (p. 1).

Health Canada has produced a guide to direct nursing education in relation to violence prevention, detection and intervention. Although not specifically targeted at psychiatric nurses, it is a useful guide that could be adapted for courses that educate (potential) mental health workers.

## Screening tools

Notwithstanding the debate about the value of screening service consumers for current and/or past abuse, a number of jurisdictions have produced screening tools for this purpose.

In New South Wales, routine screening for domestic violence is a statewide project funded by the Commonwealth and state governments under the Partnerships Against Domestic Violence initiative. This started as a pilot project by the Education Centre Against Violence; following an evaluation, it is now being extended across the state. Birthing services, mental health, drug and alcohol, and early childhood services are part of this second stage of the project. Training, following the 'train the trainer' concept, is provided to staff to prepare them for implementing routine screening at service intake. Flowcharts outlining response pathways, as well as information for clinicians and women, have been produced. Outcomes to date show an increased level of connection between health/mental health services and community organisations.

## Consumer resources

While there are many information booklets, brochures, videos and other resources addressing issues of abuse, there are few resources specifically developed for people with mental illness. However, Queensland Health, in collaboration with a range of organisations, has produced a resource booklet for consumers of mental health services who have experienced sexual assault: *Untangling the web: a resource for people with mental illness who are survivors of sexual abuse* (Queensland Department of Health 2003).

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