



Statewide Trauma Service consultation

Response from the Women's
Mental Health Alliance

May 2022

Introduction

The [Women's Mental Health Alliance](#) (the Alliance) welcomes the opportunity to make a submission to inform the Expression of Interest for prospective consortia seeking to tender for the establishment and operation of the Statewide Trauma Service (STS). This submission has been drafted by Women's Health Victoria (chair of the Alliance) with input from members of the Alliance with expertise in trauma-responsive, gender-responsive mental health care. We also support the separate submission made to this consultation by Safe and Equal, who are members of the Alliance. We are happy to elaborate further on our submission or provide additional information upon request.

About the Women's Mental Health Alliance

The Alliance was established by Women's Health Victoria in 2019. It is made up of nearly 40 organisations and individuals who provide expert advice to policy makers and health services on the mental health of women and girls and undertake advocacy to ensure all women have access to evidence-based, gender-sensitive and trauma-informed mental health support. The Alliance works to ensure the voices of women with lived experience are centred in policy, advocacy and service delivery. It brings together consumer and carer advocates, service providers, clinicians, women's health organisations, human rights bodies and researchers.

The need for a gender-responsive Statewide Trauma Service

Globally, and in Australia, women are nearly twice as likely as men to suffer from a mental illness.¹ Poorer mental health and wellbeing among women and girls can be attributed to a combination of biological (sex), social (gender) and other factors. Due to the prevalence of violence against women (including domestic, family and sexual violence) in Victoria and Australia and the associated mental health impacts, the Women's Mental Health Alliance believes a specialist trauma-recovery service for victim-survivors of gender-based violence, including family and sexual violence is urgently needed. This is in addition to building the capacity of practitioners across the mental health system to meet the needs of victim-survivors and builds on the recommendations of both the Royal Commission into Family Violence and the Royal Commission into Victoria's Mental Health System. Accordingly, it is our position that the Victorian Statewide Trauma Service must be gender-responsive and have a key focus on trauma that comes from gender-based violence. Not only would building these considerations into the STS from its inception address a significant gap in mental health support for victim-survivors of family and sexual violence, it would also ensure the trauma-related recommendations of the Mental Health Royal Commission are delivered in a gender-responsive way to best meet the needs of women and girls.

¹ Yu S. (2018). Uncovering the hidden impacts of inequality on mental health: a global study. *Translat Psychiatr.* 2018;8: 98; Women's Mental Health Alliance (2021) [Snapshot of Australian women's mental health](#). Women's Health Victoria. Melbourne.

Approach to this submission

This submission has been informed by feedback from the Alliance Trauma Support Working Group, Alliance members' reflections on attending the [Department of Health's consultations on the STS](#), and a general meeting of the Alliance. Our submission is structured according to the three consultation questions. We have also added some recommendations on what the EOI should contain and the expertise needed to assess the EOIs.

At the consultation for the Statewide Trauma Service Consultation on 6th May 2022, it was identified that the intention of the Service is to deliver the most intensive support to people with complex and diverse needs, address identified service gaps rather than duplicate existing services, and translate research into practice. Evidence suggests there is a significant gap in our existing mental health system for services that address the intensive needs of women impacted by complex trauma as a result of violence.¹ For these reasons, this submission by the Women's Mental Health Alliance will focus on the trauma-related service need specific to women impacted by complex trauma, who are victim-survivors of domestic, family and sexual violence (DFSV), and childhood sexual abuse. The Women's Mental Health Alliance believes that by having a focus on supporting victim-survivors of DVSV with complex trauma related needs, the Statewide Trauma Service will fulfil its aim of addressing gaps, and supporting people impacted by complex, diverse and intensive needs.

Summary of recommendations

1. Breadth and depth of expertise the winning consortium should be able to demonstrate in the EOI to successfully support the STS' role in improving trauma capability:

The winning consortium should be able to demonstrate both expertise and experience in:

- Supporting victim-survivors of gender-based violence and the trauma impacts on their mental health, including alignment with the MARAM framework,
- Trauma-and-violence-informed practice,
- Gender-informed and culturally responsive mental health support, and
- Supporting workforce wellbeing.

2. What needs to be included in the EOI to ensure that the perspectives of people with lived experience (consumers and carers) is at the heart of the STS' design:

The EOI should require prospective consortia to demonstrate a strong lived experience representation, including:

- A history of co-design and governance with people with lived and living experience (LLE) of mental health issues and the mental health system.
- People with lived and living experience of mental health issues and the mental health system should be represented across all levels of governance within the consortia.
- A commitment to collaborative, participatory practice and to dismantling unnecessary power differentials and hierarchy between staff and service users.
- Ongoing commitment to co-design and consumer/survivor accountability, as well as evaluation led by people with lived and living experience.

3. What should a statewide specialised service delivery look like for trauma, and what provider competencies are required to support this?

A statewide specialised trauma recovery service should:

- Understand and address multiple forms of trauma, with a core focus on trauma resulting from gender-based violence
- Focus on supporting *recovery* from trauma
- Adopt a whole-of organisation approach to trauma and violence informed practice to avoid re-traumatisation
- Undertake research to build the evidence base on what works in trauma recovery and gender-informed approaches to trauma and guide evidence-based practice
- Develop training in trauma and violence informed practice for the wider mental health workforce
- Provide support at the systemic level to drive policy development and organisational change to facilitate implementation of trauma and violence informed practice across the mental health sector.
- Provide a mix of treatments and supports (including social support) as a part of recovery-oriented mental health care
- Have organisational policies and practices that are in line with the Multiple Agency Risk Assessment and Management Framework (MARAM) following the Royal Commission into Family Violence.
- Link in with specialist services to tailor trauma supports to people and communities across Victoria.

- Collaborate with the mental health, family violence and sexual assault response sectors, with the active support of the Victorian Government.²
- Have strong links and engage with community and community services, including youth workers and peer workers, to ensure that consumers are supported to stay in touch with, and reconnect with the community.
- Support meaningful co-design and co-delivery with people with lived experience of trauma by building in adequate timeframes, and ensuring evaluation is led by people with lived and living experience.

Provider competencies to support specialised service delivery must include:

- A comprehensive approach to workforce capability building particularly in gender-responsive practice, identifying and responding to victim-survivors of family and sexual violence, and understanding of the impacts of gendered violence on mental health.
- Intersectional gender competence - an understanding of the ways in which gender and other social factors influence women's mental health and delivery of mental health care to women
- Demonstrated commitment to the [SAMHSA principles](#) for a trauma-informed approach.
- Demonstrated ability to learn from, listen to, respond to and collaborate with people with lived experience.
- Competence in alternative models, not just existing mental health service delivery.

Consultation Questions

1. What breadth and depth of expertise should the winning consortium be able to demonstrate in the EOI to successfully support the STS' role in improving trauma capability?

In their EOI, the winning consortium should be able to demonstrate:

(i) expertise and experience in supporting victim-survivors of gender-based violence and the trauma impacts on their mental health, including:

² While in 2006 the Victorian Government identified the need to strengthen the connection between clinical and community mental health services and sexual assault and family violence services^[4], the lack of support to implement and monitor such strategies means that little to work has been done to strengthen these connections. The Royal Commission into Family Violence again highlighted the need for these sectors to collaborate.

- Experience providing services to women, girls and trans and gender-diverse victim-survivors of complex trauma including childhood sexual abuse, family violence, and sexual violence. This is important given the prevalence of these forms of abuse impacting women, and the service gaps for specialised trauma services for impacted women. Such service delivery experience would include demonstrated knowledge of how childhood sexual assault, family violence, and sexual violence impacts on mental health and best-practice for supporting victim-survivors including application of trauma and violence informed care (TVIC) and knowledge of complex trauma practice.
- Evidenced knowledge and practice wisdom about the impacts and service delivery needs for people affected by systemic trauma, institutional trauma, intergenerational trauma and complex trauma.
- Evidence of previous (and/or current) alignment with the MARAM Framework, commitment to align with the MARAM within the first 6 months, and mandated training for all staff. We note that private mental health services do not currently have to apply MARAM and public mental health service alignment is inconsistent and minimal, with no timeframe. Nonetheless, it is essential the STS aligns with MARAM.
- Evidence of adherence to the Family Violence Information Sharing Scheme (FVISS) and the Child Information Sharing Scheme. This is important for the safety of family violence victim-survivors who receive support from the STS, to ensure confidentiality and to stop the service colluding with perpetrators.
- Evidence of effective cross-sector collaboration, preferably with the family and sexual violence sectors.

(ii) expertise and experience in trauma-and-violence-informed practice, including:

- Demonstrated expertise in understanding trauma- and violence-Informed care (TVIC). TVIC is about 'recognizing that most people affected by systemic inequities and structural violence have experienced, and often continue to experience, varying forms of violence with traumatic impact. Such care consists of respectful, empowerment practices informed by understanding the pervasiveness and effects of trauma and violence, rather than 'trauma treatment' such as psychotherapy'.³
- Whole-of-organisation knowledge of TVIC, including what trauma actually means, knowledge that different types of trauma (e.g., DFSV, natural disasters, war, torture, incarceration, neglect) require different approaches, understanding of multiple traumas.

³ Browne, A. J., Varcoe, C. M., Wong, S. T., Smye, V. L., Lavoie, J., Littlejohn, D., ... & Lennox, S. (2012). Closing the health equity gap: evidence-based strategies for primary health care organizations. *International journal for equity in health*, 11(1), 1-15.

- Considering trauma through a holistic lens that includes mental health, alcohol and other drugs (AOD) and family violence, along with all other forms of trauma that people can experience
- A commitment to not using seclusion and restraint practices.
- A demonstrated understanding of the impact of power differentials (within organisations and between staff and service users) - coercion exists around involuntary treatment and simply operating under the Mental Health Act.
- Specialist expertise in trauma support for children who have experienced sexual abuse (as early intervention promotes better outcomes).

(iii) experience delivering gender-informed and culturally responsive mental health support, including:

- Applied knowledge of how gender inequality, gender bias, and gender norms such as stereotypes contribute to poor mental health for women, and lead to women's mental health not being prioritised and being poorly understood. Examples of such gender inequality include the gender pay-gap, women bearing an unequal distribution of unpaid care responsibilities, sexist advertising, under-representation of women in leadership roles, exclusion of women from medical research, stigma and discrimination and violence.
- An intersectional, gender-responsive approach to trauma and mental health. The STS model of care must reflect an understanding of how trauma impacts women, girls, trans and gender-diverse people, take a biopsychosocial rather than biomedical approach, and offer some capacity for service users to choose gender of the staff working with them.
- Provision of culturally safe and appropriate services for Aboriginal and Torres Strait Islander peoples, LGBTIQ+ and migrant and refugee people.
- Experience working with diverse cohorts impacted by trauma including asylum seekers and refugees, people who identify as LGBTIQ, people with disability, First Nations People and migrants and people from culturally and linguistically diverse backgrounds. This is important as experiences of violence and abuse are more likely to impact these diverse groups, and the impacts of trauma are compounded by the intersecting structural oppression facing diverse communities. This should include partnerships with First Nations organisations and communities including partnering with the Aboriginal-led Healing Centres.
- The above can be achieved through experiencing delivering *contextually-tailored care* which is about 'expanding the concept of patient-centred care to include services that are explicitly tailored to the populations served and local contexts. This

may include organizational tailoring to address the local population demographics and social trends (e.g., programs or services addressing HIV, seniors, women's or men's issues, support for new immigrants, etc.).⁴ With the addition of *inequity-responsive care*, which 'explicitly addresses the social determinants of health as legitimate and routine aspects of health care, often as the main priority', and *culturally competent care*, which 'takes into account not only the cultural meaning of health and illness, but equally importantly, people's experiences of racism, discrimination and marginalization and the ways those experiences shape health, life opportunities, access to health care, and quality of life'.⁵

(iv) A demonstrated commitment to workforce wellbeing:

- A consistent workforce is paramount to addressing and healing trauma. Constant staffing changes leads to clients disengaging and ceasing involvement with service providers. Staff delivering trauma service needs to be supported to mitigate the risks of vicarious trauma and burnout.
- Vicarious trauma can be addressed by providing staff with regular and adequate clinical supervision, peer supervision and reflective practice. Reflective practice should align with a model of trauma and violence informed care and embed an intersectional lens with critical reflection. Additionally, vicarious trauma can be mitigated by a commitment to ensuring staff are trained, such as through the Blue Knot Managing Wellbeing and Recognising Vicarious Trauma training.
- Commitment to appropriate trauma-informed training. This training will include theoretical knowledge of the neurobiological impacts of trauma, of how systemic oppression causes trauma, alongside a practical skillset with resources, tools and modalities that can be drawn on to provide a tailor-made service to each survivor. Knowledge needs to be broad enough to avoid a one-size-fits-all approach. This knowledge will both support effective service delivery for trauma survivors, and support staff wellbeing and through adequate resourcing for staff to deliver services.
- Mirroring the values of service delivery, the consortium should demonstrate expertise in trauma -informed leadership, to ensure trauma-and-violence-informed-care are applied on all levels of the Trauma's Service organisational set up.
- The service will provide capacity building for non-clinical staff.

⁴ Browne, A. J., Varcoe, C. M., Wong, S. T., Smye, V. L., Lavoie, J., Littlejohn, D., ... & Lennox, S. (2012). Closing the health equity gap: evidence-based strategies for primary health care organizations. *International journal for equity in health*, 11(1), 1-15.

⁵ *ibid*

2. What needs to be included in the EOI to ensure that the perspectives of people with lived experience (consumers and carers) is at the heart of the STS design?

The EOI should require prospective consortia to demonstrate a strong lived and living experience (LLE) representation, including through the following:

- A history of co-design and governance with people with LLE of mental health issues and the mental health system.
- Representation of people with lived and living experience of mental health issues and the mental health system across all levels of governance within the consortia. While people with diverse LLE of trauma should be involved, women's complex trauma as a result of violence should be central to the lived experience expertise of the winning consortium, as women are one of the largest and most under-served groups for trauma recovery.
- Application of an intersectional lens to lived experience involvement, with a focus on groups most under-served by the mental health system, and most impacted by complex and systemic forms of trauma. In addition to women, this would mean a strong focus on lived experience expertise from First Nations people, LGBTIQ+ people, and migrants, refugees and people from culturally and linguistically diverse backgrounds.
- Demonstrate how consumers/survivors led the development of the consortia's application.

More broadly, the EOI should refer as relevant to the following considerations:

- Engagement with or review of other Lived Experience panels/frameworks, such as the [Victim Survivors' Advisory Council](#) from the Family Violence Royal Commission, to inform best practice and what doesn't work well.
- When utilising the knowledge of people with LLE, processes are required to ensure that those involved are well supported, currently stable, have a current lapse/relapse prevention/management plan, and have safe and trusted supports that they can access as required.
- While trauma experiences and responses vary hugely between individual people, the defining feature of all experiences is a loss of power. The STS itself (not just the winning consortium) must 'flip' existing imbalances and have people with lived experience in power (including leadership roles, budgets, etc.).

3. What should a statewide specialised service delivery look like for trauma, and what provider competencies are required to support this?

A statewide specialised service delivery should:

- Understand and address multiple forms of trauma with a core focus on trauma resulting from gender-based violence (predominantly experienced by women, girls, and trans and gender diverse people), given the high prevalence of gendered violence and its significant mental health impacts.
- Focus on supporting recovery from trauma, including victim-survivors of gendered violence, via specialist treatment and support.
- Adopt a whole-of organisation approach to trauma and violence informed practice to avoid re-traumatisation. This includes:
 - alternative de-escalation methods to seclusion and restraint practices.⁶ Research with women who have been subject to restrictive practices indicates that relational approaches to service provision may be especially important in avoiding the use of seclusion and restraint on women and providing safe and therapeutic services for them.⁷ The Safewards program,⁸ which is a best practice model for improving relationships, reducing restrictive interventions and promoting positive staff-consumer interactions, should be adopted by the STS.
 - recognition of how socio-cultural factors (e.g., gender inequality, power differentials, colonisation and disenfranchisement) give rise to victimisation, are barriers to seeking support,⁹ and contribute to behaviours that may be considered 'difficult' but need to be understood as appropriate responses or adaptations to trauma.¹⁰
- Undertake research or research partnerships to build the evidence base on what works in trauma recovery and gender-informed approaches to trauma and guide

⁶ Women's Mental Health Alliance (2021) Gender analysis of the recommendations of the Royal Commission into Victoria's Mental Health System - [Recommendation 54: Towards the elimination of seclusion and restraint](#). Women's Health Victoria. Melbourne.

⁷ For example, Gill Aitken and Kate Noble, 'Violence and Violation: Women and Secure Settings' [2001] (68) *Feminist Review* 68; CG Long et al, 'Effective Therapeutic Milieus in Secure Services for Women: The Service User Perspective' (2012) 21(6) *Journal of Mental Health* 567; Georgie Parry-Crooke and Penny Stafford, *My Life: In Safe Hands* (Research Report, London Metropolitan University, 2009).

⁸ Fletcher J et al (2017) [Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement](#) International Journal of Mental Health Nursing.

⁹ Quadara A (2015). Implementing trauma-informed systems of care in health settings: The WITH study: State of knowledge paper (ANROWS Landscapes, 10/2015). Australia's National Research Organisation for Women's Safety. Sydney

¹⁰ Funston L (2019) In the business of trauma: an intersectional-materialist feminist analysis of 'trauma informed' women's refuges and crisis accommodation services in Sydney and Vancouver [Thesis] University of Sydney. Sydney Digital Theses. 2019 (4699)

evidence-based practice.¹¹ An example is the new [Women's Trauma Recovery Centre treatment model](#) designed by the Illawarra Women's Health Centre and University of New South Wales. The model provides comprehensive and long-term support to women who have experienced domestic, family and sexual violence.

- Develop training in trauma and violence informed practice to address the well-documented lack of confidence and competence within the mental health workforce in addressing issues of physical, emotional or sexual violence with clients.¹² Workers would benefit from training on, for example: noticing trauma responses; not forcing disclosure; creating safety; building trust; supporting choice and control; and offering to teach self-regulation skills.
- Provide support at the systemic level to drive policy development and organisational change (including supporting leadership) to facilitate implementation of trauma and violence informed practice across the mental health sector.
- Provide a mix of treatments and supports, including psychotherapy and social support as well as medication, as part of the development of 'recovery-oriented' mental health care. Recovery-oriented mental health care acknowledges that trauma arising from experiences of violence and abuse is prevalent among mental health service users. It also acknowledges the importance of relationships, lived experience and social context.¹³ This is particularly important in relation to women with LLE of trauma, who are at risk of over-medicalisation and pathologising of trauma responses.
- Have organisational policies and practices that are in line with the Multiple Agency Risk Assessment and Management Framework (MARAM) to adhere to legislation and requirements following the Royal Commission into Family Violence. This includes identifying and responding to family violence with risk assessments and safety planning. Capability-building in information-sharing must be aligned with the requirements of the Family Violence Information Sharing Scheme and Child Information Sharing Scheme.
- Link in with specialist services (including women's services and migrants and refugee services) to tailor trauma supports to people and communities across Victoria.

¹¹ Due to the lack of evaluative evidence to inform organisation and systemic trauma-informed change, [ANROWS recommends](#) that research be conducted to examine the following questions:

- How can we ensure that trauma-informed care is meeting the needs of women who have experienced both mental health issues and sexual violence?;
- How can we better integrate mental health and sexual violence service paradigms and approaches to trauma-informed care?;
- How can we enact trauma-informed care in practice when dealing with women who have experienced both mental health issues and sexual violence? and;
- How can we successfully implement trauma-informed care at an organisational level within complex health systems

¹² Kelsey Hegarty, G. M., Mohajer Hameed, Jane Koziol-McLain, Gene Feder, Laura Tarzia, Leesa Hooker., (2020). [Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis](#). *PLOS ONE*, 15(6).

¹³ Quadara A (2015). Implementing trauma-informed systems of care in health settings: The WITH study: State of knowledge paper (ANROWS Landscapes, 10/2015). Australia's National Research Organisation for Women's Safety. Sydney.

- Collaborate with the mental health, family violence and sexual assault response sectors, with the active support of the Victorian Government.¹⁴
- Have strong links and engage with community and community services, including youth workers and peer workers, to ensure that consumers are supported to stay in touch with, and reconnect with the community.
- Support meaningful co-design and co-delivery with people with lived experience of trauma by building in adequate timeframes, and ensuring evaluation is led by people with lived and living experience.

Provider competencies required to support this are:

- **A comprehensive approach to workforce capability building**, particularly where there are areas of significant gaps in knowledge and skills, e.g., gender-responsive practice, identifying and responding to victim-survivors of family and sexual violence, and understanding of the impacts of gendered violence into mental health practice including how mental illness is weaponised as part of family violence¹⁵, and trauma- and violence-informed practice [for more detail please see page 18 of the [WMHA submission to Victorian Mental Health Workforce Forum](#)].
- **Intersectional gender competence** - an understanding of the ways in which gender and other social factors influence women's mental health, together with the capability to respond to women's needs and experiences, including:
 - Understanding the role of gender as a social determinant of mental health and the importance of a biopsychosocial model – this includes prioritising an understanding of mental distress in the context of women's lives and the ability to work with women in a way that values and supports their social roles, for example as unpaid caregivers, and recognises the constraints these roles place on accessing services;
 - Capacity to recognise and address gender-based discriminatory attitudes and behaviours and the impact these have on women's mental health and trauma recovery
 - Implementing actions to counter gender bias and gendered attitudes, stereotypes and inequalities in research, training and clinical practice

¹⁴ While in 2006 the Victorian Government identified the need to strengthen the connection between clinical and community mental health services and sexual assault and family violence services^[1], the lack of support to implement and monitor such strategies means that little to work has been done to strengthen these connections. The Royal Commission into Family Violence again highlighted the need for these sectors to collaborate.^[2]

¹⁵ Chief Psychiatrist's guideline and practice resource: family violence (2017), Chief Psychiatrist Guideline Family Violence Project Advisory Group, Department of Health and Human Services [Victoria], Melbourne, p. 33.

- Gendered cross-cultural awareness [for more detail please see pages 35 – 40 of [WMHA submission to the Victorian Mental Health Workforce Forum](#)]
- Understanding of the structural context in which violence occurs, so as to not pathologise the individual.
- Demonstrated commitment to the [SAMHSA principles](#) for a trauma-informed approach.
- Demonstrated ability to learn from, listen to, respond to and collaborate with people with lived experience.
- Competence in alternative models, not just existing mental health service delivery.

Further questions and considerations

- Access: Where will the service be located and how will this influence its capacity to service the entire state, especially rural and regional areas? The service must not become metro-centric. The service also needs to be accessible to service users with differing needs (e.g., people with a disability, First Nations peoples, people from the LGBTQI+ community and people from migrant and refugee backgrounds). The service should offer flexible modes (e.g., outreach, on-site and online) and holistic services that align with a psycho-social model (i.e., case management and community engagement expertise alongside clinical).
- Mainstreaming of trauma and violence informed practice throughout the mental health and related sectors should be a medium-term goal for the Victorian Government to avoid the STS becoming the only site of trauma expertise.
- Sustainability: The Victorian Government will need to commit to an appropriate level of long-term funding to ensure the success of the STS.

Other recommendations

What should go in the EOI

The EOI criteria should ask consortia:

- To provide a strategy for potentially managing a working group including people who use violence as well as victim-survivors (noting people can be both perpetrator and victim) - as the STS will be providing support to people who use violence as well.
- How the STS will relate to existing services e.g., sexual assault counselling, AOD, FV, family violence, sexual assault, Centrelink, social services, justice system without siloing or duplicating.

Assessment of EOIs

It is also critical to consider the expertise needed to assess the EOIs – gender, intersectional, lived experience of trauma (including victim-survivors of gender-based violence) - to give the new STS the best chance of incorporating all of this from the start.

The Women's Mental Health Alliance would welcome the opportunity to have a representative on the tender panel to provide gendered expertise to the process if this were possible.