# Violence against women and mental health

**ΛNROWS**

## Background

**To effectively meet the needs of women at the intersection of gender-based violence and mental health impacts, improved collaboration and coordination is required across mental health, sexual violence, domestic and family violence, justice and child protection sectors.** Violence against women, including intimate partner violence (IPV) and sexual assault, is associated with a range of short- and long-term physical and mental health consequences (Ayre, Lum On, Webster, & Moon, 2016). Studies show that violence against women may be associated with mental health consequences that often persist well into the life course, including long after the violence has stopped (Ayre et al., 2016; Moulding, Franzway, Wendt, Zufferey, & Chung, 2020). In addition, recent research centred upon fear showed that divorced/separated women reported a higher likelihood of fear of their partner than married women—from fourfold to eightfold higher—highlighting longer term mental health impacts of IPV (Signorelli et al., 2020).

At the population level, partner violence has been shown to be a major contributor to disease burden (the impact of illness, disability and premature death) among women aged 25–44 years (Australian Institute of Health and Welfare [AIHW], 2019). The largest proportion of the IPV burden in Australian women aged 18 years and over was due to mental health conditions (Webster, 2016). These include depressive disorders and anxiety disorders, which together were estimated to account for around 70 percent of disease burden (Webster, 2016). Women experience higher rates of depression/anxiety than men (Ussher, 2011). There are correlations between mental health conditions (including depression) and violence:

- One Australian study that examined 1257 female patients visiting general practitioners found that women experiencing depression were 5.8 times more

likely to have experienced physical, emotional or sexual violence than women who were not depressed (Hegarty, Gunn, Chondros, & Small, 2004).

- Another study of 658 Australian women who had a self-reported history of IPV found that just over half of the women (52%) reported receiving a diagnosis of mental illness. Of the women, 43 percent were diagnosed during a period when IPV was being perpetrated, and 44 percent were diagnosed after leaving the relationship. Only 13 percent of the women reported having a diagnosis of mental illness prior to the IPV occurring (Moulding et al., 2020).

For women aged 15 years and over, anxiety disorders made the largest contribution to the disease burden due to child abuse and neglect (39%), followed by suicide and self-inflicted injuries (34%) and depressive disorders (27%) (AIHW, 2019).

There are gendered differences between the violence experienced by women and the violence experienced by men. Violence against women is more likely to involve abusive and controlling behaviours designed to intimidate, belittle and control the victim (Webster et al., 2018). Violence against women is more likely to be repeated, with a majority of women reporting IPV also experiencing repeated violence (Webster et al., 2018). Women who have experienced one type of gendered violence often experience other types of gendered violence in their lifetime. In Australia, one quarter of women subjected to gendered violence report at least three different forms of interpersonal victimisation in their lifetime, including child sexual abuse, domestic violence, sexual assault and stalking (Cox, 2016; Rees et al., 2011). While it is difficult to get an accurate figure on the number of children in Australia who have experienced child abuse, approximately 2.5 million Australian adults (13%) report having experienced abuse during their childhood (ABS, 2019). Women who experienced childhood abuse were nearly three times more likely to experience partner violence than those who had not been abused as children (ABS, 2017).

Exposure to multiple, repeated forms of interpersonal victimisation, along with the resulting traumatic health problems and psychosocial challenges, is called complex trauma (Salter et al., 2020). ANROWS research shows that women with experiences of complex trauma are a significant but overlooked group of victims and survivors of gender-based violence in Australia (Salter et al., 2020). This cohort of women have interlinked health and safety needs. Poor health and unmet need can increase the risk of further victimisation, and ongoing victimisation can compound trauma-related mental illness (Salter, 2017).

## Purpose

This paper provides a synthesis of evidence on violence against women and mental health, examining the way that mental health intersects with trauma, complex trauma, disability, coercive control, access to justice and parenting. This paper is not intended to be a comprehensive literature review—it focuses on existing ANROWS research and other research, while also drawing on recent grey literature for further supporting evidence.

## Audience

This synthesis is designed for policymakers and practitioners engaging with women affected by violence, including domestic violence and sexual violence, who are also experiencing mental health impacts; and/ or who are developing policy and practice frameworks responsive to violence against women and mental health.

# FAST FACTS

The largest proportion of the intimate partner violence burden in Australian women aged 18 years and over was due to mental health conditions, including depressive disorders and anxiety disorders, which together were estimated to account for around 70 percent of disease burden (Webster, 2016).

In a study of 654 women, almost three quarters (70%) indicated good psychological wellbeing before IPV, 90 percent reported poor psychological wellbeing during violence, and 65 percent reported poor psychological wellbeing afterward. Of the women reporting poor mental health after IPV, 16 percent continued to struggle five or more years later (Moulding et al., 2020).

Raising mental health in Family Court matters is gendered, with it given as the "reason limiting child contact with mothers in 30 percent of such cases, but only in 2 percent of cases limiting fathers" (McInnes, 2013 as cited in Death, Ferguson, & Burgess, 2019, p. 7).

# KEY ISSUES

## Summary

- For women experiencing violence, mental health problems can overlap with trauma, complex trauma and disability, making simple diagnoses and treatment difficult.

- Mental ill health can be a compounding factor, a barrier, an outcome and a tool used by perpetrators of violence against women.

- Access to justice can be impacted at the intersection of mental health and violence against women, because the criminal justice system is not designed to accommodate trauma.

- Women with mental health concerns who have been subjected to gender-based violence can be harmed by institutions tasked with helping them.

- The co-occurrence of violence against women and mental health concerns can have parenting impacts, damaging the mother–child relationship and impacting the child's mental health.

- The complexity of the intersection of violence against women and mental health often requires collaboration between mental health, sexual violence, domestic and family violence and other sectors to provide effective care.

# KEY ISSUES

## Mental health overlaps with trauma, complex trauma and disability

For women experiencing violence, mental health problems can overlap with trauma, complex trauma and disability, making simple diagnoses and treatment difficult. Research shows that women who are receiving mental health services for depression, anxiety and post-traumatic stress disorder (PTSD) are at higher risk of experiencing adult lifetime partner violence when compared to women who do not have these disorders (Trevillion et al., 2014). This research highlights that alongside diagnosing and treating psychiatric symptoms, mental health professionals should also explore underlying causes for mental illness, including violence (Trevillion et al., 2014). A failure to identify the psychosocial impact of abuse (emotional abuse) may result in the internalisation of distress, reinforce feelings of self-blame, prolong the person's contact with mental health services and increase their potential to remain in abusive relationships (Trevillion et al., 2014). There is a need for women with experiences of gender-based violence, including child sexual assault, to make sense of their past and present experiences, which underpin their mental and social difficulties (Warner, 2009). From a practice perspective, failing to identify the psychosocial impact of abuse can lead to treatment resistance; therapeutic nihilism; ongoing victimisation from abusers as well as therapy providers; adoption of the "sick role"; increased feelings of hopelessness, helplessness and guilt; increased use of medication, and the use of multiple medications; decreased functionality; increased unemployment; and social and financial stressors.

Research highlights the ways that trauma, disability and mental health concerns can intersect and add complexity to both appropriate diagnosis and treatment. This complexity points to the need to take a broader view that encompasses experiences and environments that might be contributing to the behaviours the person is exhibiting, and have led to particular mental health diagnoses (Campbell, Richter, Howard, & Cockburn, 2020). Diagnosis becomes particularly important when it is attached to accessing funds, including Medicare and the National Disability Insurance Scheme (NDIS); it may make the difference between women being able to access appropriate specialist trauma treatment versus experiencing trauma as a permanent disability (Salter et al., 2020).

Women with experiences of violence and resulting trauma may resist established medical models of mental illness. As one study participant explained:

> [My therapist] talks about mental illness, and I say to him all the time, "Don't ever use that." And he goes, "Why? It's what it is." And I said, "No, it's not." I said, "When you use the word illness, you're saying that I'm sick. I'm not sick. I have a set of symptoms as a result of what was done to me. I'm not sick." (Quoted in Salter et al., 2020, p. 55)

This rejection of a mental health framing of the impacts of violence against women is also highlighted in Webster (2016), with a study participant pointing out:

> As time went by, he became very controlling. He wanted to know where I had been, who with … he would listen to my phone calls, and read my

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> (Trevillion et al., 2014).

diary. Later, he hit me for the first time. I was so scared. I was shaking and couldn't believe it was happening to me. Hitting me became part of my life … I became so depressed. I didn't think life was worth living. I went to the doctor and he said I had a depressive disorder. I hated the word "disorder". It made me feel that I was going mad or was already crazy. (Quoted in Webster, 2016, p. 20)

While medical models can provide language to articulate experiences and impacts of trauma, women may also view them as pathologising and individualising (as deficit) reasonable responses to overwhelming situations (Salter et al., 2020).

Women can also have an ambivalent relationship toward mental health labels because they sit within widespread stigmatisation of distressed women as "hysterical", malingering or simply "mad", and dismiss their legitimate concerns by positioning them within a medical model (Ussher, 2011). This leaves women with experiences of violence and poor mental health as vulnerable to stigma and re-victimisation (Salter et al., 2020). As one study participant, who was (mis) diagnosed with borderline personality disorder, explains: "The connotations with being [labelled] manipulative and a liar are really re-traumatising" (quoted in Salter et al., 2020, p. 56). Stigmatising misdiagnoses, through the collection and sharing of medical histories, can also follow the woman around for a considerable period of time (Salter et al., 2020) and impact them in areas like equitable access to justice. Medical diagnoses often fail to highlight women's agency and resilience in coping with violence, which can be a big part of recovering from debilitating trauma (Salter et al., 2020; Ussher et al., 2020). The medicalisation of women's trauma can also lead to an overreliance on a pharmacological rationale for treatment (Ussher, 2010).

There is emerging evidence that trauma contributes to observable differences in brain function. Developmental trauma, for example from adverse childhood experiences, can cause impairment in a similar way to cognitive disability from chemical trauma, like foetal alcohol spectrum disorder (FASD), or physical trauma, like a traumatic brain injury (Campbell et al., 2020). A single issue service system that doesn't understand this connection, or recognise the impact of trauma, can fail women with experiences of complex trauma (Salter et al., 2020). Women with complex trauma who do not have access to appropriate trauma-informed mental health services and assessment often experience negative life impacts (Bevis, Atkinson, McCarthy, & Sweet, 2020).

The research *Kungas' trauma experiences and effects on behaviour in Central Australia* (Bevis et al., 2020) is centred upon the life experiences of Aboriginal women who were incarcerated for alleged violent offences in Central Australia. It found that almost all of the women in the study had endured violence by an intimate partner prior to entering prison, and had experiences consistent with a diagnosis of complex trauma (Bevis et al., 2020). By exploring the life events that led to their incarceration, the research demonstrates the critical need for services that can effectively respond to the trauma of women's lives and prevent future incarceration (Bevis et al., 2020). It reflects the need for continuity of care at all levels (i.e. an integrated service system), including the coordination of care for women who have undiagnosed permanent disability and complex trauma (Bevis et al., 2020; Salter et al., 2020).

## Mental health can be weaponised for coercive control

Mental ill health can be a compounding factor, a barrier, an outcome and a tool used by perpetrators of violence against women. Women experiencing mental health concerns do have associated vulnerabilities, including being among the groups least likely to be believed when reporting sexual assault (Kelly, 2010). This fact is not lost on perpetrators of violence, as one study participant explains:

> I've got schizophrenia; he uses that against me a lot . . . the people I did talk to about it, they wouldn't believe me because then when they would go speak to him about it he'd be like no, she's just had another episode or—so that's, it was always then put back onto me and my fault. (Quoted in Day, Casey, Gerace, Oster, & O'Kane, 2018, p. 55)

However, to treat mental health as a "risk factor" of violence against women ignores the complexity of the issue.

The research highlights the way that coercive control is uniquely tailored to the victim/survivor, and incorporates tactics that are developed by the aggressor over time through trial and error (Tarrant, Tolmie, & Giudice, 2019). Mental health can be weaponised by abusers using tactics that include gaslighting through using constantly shifting goalposts:

> Since the abuser's goal is domination, not achieving a particular end (such as a clean house), rules are continually being revised or reinterpreted, making it impossible for victims to satisfy their partner, leaving them in a state of chronic anxiety. (Stark as cited in Tarrant et al., 2019, p. 26)

The mental health impact of gaslighting on women experiencing violence is considerable. The effect of being heard can be seen in the way that interventions like partner contact in men's behaviour change programs (MBCPs) can result in improved mental health impacts for women, feelings of validation and increased self-confidence, even when the MBCP does not lead to change in the perpetrator's violent and controlling behaviour (Chung, Anderson, Green, & Vlais, 2020).

The evidence also emphasises the impact of intersectional inequity, meaning the larger the number and extent of inequities a particular victim/survivor experiences, the more scope a predominant aggressor has to control and coerce her, and the less likely she is to be able to access help and safety. Intersectional inequity also impacts the social and institutional responses that the victim/survivor will receive in response to her help-seeking (Tarrant et al., 2019). Women with histories of victimisation from multiple abusers who may also be dealing with compromised mental health or physical or intellectual disability alongside other structural inequities can be more vulnerable to the perpetrator's coercive control (Tarrant et al., 2019). This can include women with immigration issues, women experiencing poverty, people who are sexuality or gender diverse, geographically isolated women, women experiencing racism and/or women with cultural values that support a male partner's right to use violence and discourage help-seeking. Tarrant and colleagues (2019) propose that a social entrapment framework be used,

particularly in court settings, to integrate different evidence of disadvantage to better understand the actions of a person experiencing coercive control.[1]

## Mental health can act as a barrier to women with experiences of violence accessing justice

Access to justice can be impacted at the intersection of mental health and violence against women, because the criminal justice system is not designed to accommodate trauma. Successful criminal justice outcomes for women with experiences of complex trauma are rare (Salter et al., 2020). While all of the women interviewed for the Salter et al. study had experienced extensive victimisation, no woman reported that the full extent of her victimisation had been prosecuted in the criminal justice system (Salter et al., 2020). The research shows that the system is not designed to accommodate people who have been affected by trauma (Dudley; Hohl & Stanko; Jordan; Mayor's Office for Policing and Crime as cited in Salter et al., 2020). This was highlighted in an interview with a sexual assault service manager, who explained:

> I guess it's tricky because for someone with what you would think of as a complex post-traumatic stress presentation, they're not a "good witness", if I can use that term, because their presentation doesn't typically look like someone who's got it together and who's reliable, so that can be really tricky and may in fact impact on your ability to seek justice if that is what you're seeking. (Quoted in Salter et al., p. 102)

For trans women of colour from culturally and linguistically diverse (CALD) backgrounds the barriers to justice associated with mental illness are compounded by other forms of discrimination and stigma (Ussher et al., 2020). Trans women of colour who work as sex workers are less likely to report sexual violence to police when they work in a legislative framework that makes their work illegal or subject to complex licensing laws, or involves visa conditions that are difficult to understand or comply with (Ussher et al, 2020). Perpetrators of violence can be aware, and leverage, that women with intersecting marginalisation "are less likely to receive helpful responses from their community or those agencies that are charged with their protection" (Tarrant et al., 2019, p. 21). Perpetrators can exploit anxiety about working illegally, or in violation of visa conditions, to prevent women from reporting violence levelled against them.

Mental health can also be weaponised by perpetrators in Family Court matters and impact victim/survivor access to justice. Recent Australian research into family law cases shows that parental alienation, a phenomenon which has been widely discredited in a clinical sense, continues to be raised by fathers as a defence to child sexual abuse allegations (Death et al., 2019). Raising parental alienation is a gendered phenomenon, with "mothers primarily being constructed as manipulative, mentally unwell, suffering from delusions, and ultimately harming their children with the intent of punishing the other parent" (Death et al., 2019, p. 2). McInnes (2013) found that the family law system does

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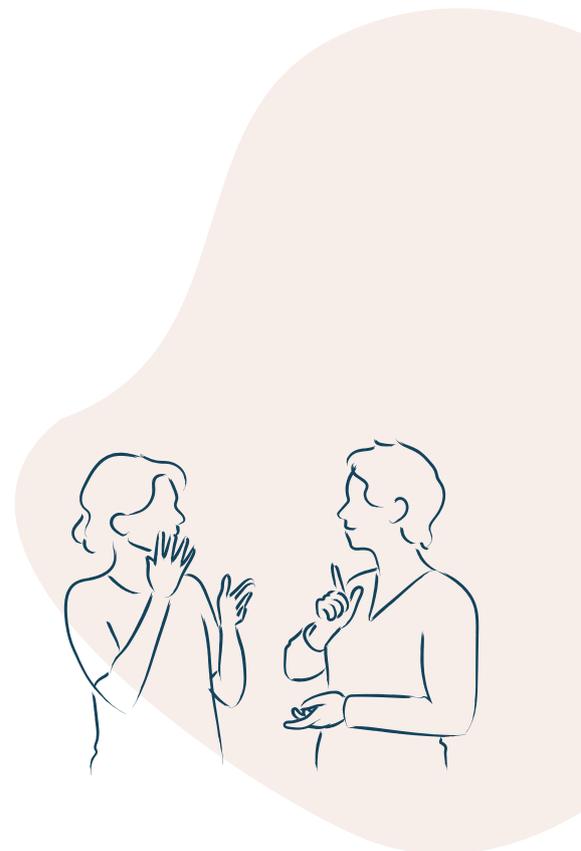
1   For a brief summary on the social entrapment framework proposed by Tarrant et al., see ANROWS (2019).

not respond as well as it should to child sexual abuse, and sometimes accepts perpetrator-generated narratives of mental illness to explain allegations, rather than recognising potential abuse. Raising mental health in Family Court matters is also gendered: it was given as the "reason limiting child contact with mothers in 30% of such cases, but only in 2% of cases limiting fathers", which does not align with general mental health prevalence (McInnes, 2013 as cited in Death et al., 2019, p. 7).

Being in court can exacerbate poor mental health, and provide abusers with increased opportunity for systems abuse. This can include perpetrators of violence using civil law processes to cross-examine women as self-represented litigants (Kaspiew et al., 2017).[2] Forthcoming ANROWS research led by Dr Jane Wangmann highlights that women can also suffer poor mental health as a result of self-representation (ANROWS, 2020b). This can be re-traumatising, particularly when the women are drawn into the court system through vexatious complaints and forced to represent themselves because they are unable to afford or qualify for alternative representation.

## Avoiding re-traumatising women with experiences of violence and poor mental health

Women with mental health concerns who have been subjected to gender-based violence can be harmed by institutions tasked with helping them. Women with experiences of violence and mental health impacts can have fraught interactions with police that can re-traumatise them as well as impact their access to justice. Salter and colleagues (2020, p. 99) state:

> Women in our study consistently complained that law enforcement could not identify, and did not understand, their traumatised presentations, and described being dismissed by them as mentally ill or "crazy".

When police were called for mental health issues, like self-harm or suicidality, sometimes their actions were re-traumatising for the women. This was highlighted in an interview with a study participant, who explained:

> There was a cop each side, got me by the back. Handcuffed me. One was sitting on my tail bone, and I had another one like … his hand was on my hair, and I started screaming. I went into a flashback situation where I thought my father was on top of me. And they're saying, "Stop resisting, stop resisting …" and all this sort of shit. (Quoted in Salter et al., 2020, p. 100)

This research points to the benefits of police being trauma-informed and trained in de-escalation, treating women with experiences of violence as vulnerable people rather than criminals (Salter et al., 2020). Being further harmed by an institution that is meant to help can result in betrayal trauma for victims/ survivors, exacerbating the negative effects of trauma (Smith & Freyd, 2013 as cited in Salter et al., 2020). It can also result in the women being unlikely

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2   Amendments to the *Family Law Act 1975* (Cth) to provide protection to victims of family violence who are cross-examined as part of family law proceedings came into effect on 10 September, 2019. See http://www.familycourt.gov.au/wps/wcm/connect/fcoaweb/family-law-matters/ family-violence/fv-cross-exam/

to reach out to the police the next time they have self-harmed or feel suicidal, with catastrophic consequences (Salter et al., 2020).

Even in mental health units—places that are explicitly equipped to work with people experiencing poor mental health—institutional harm can occur for women with experiences of gender-based violence. This can effectively limit another avenue of vital assistance for women. Research led by Dr Juliet Watson (2020) highlights that the process of involuntary treatment can be traumatic and can lead to increased lateral violence. This occurs because normal coping strategies, like taking a walk or spending time alone, are often prohibited, leading to the woman using alternative strategies to cope that may include harming others (Watson, Maylea, Roberts, Hill, & McCallum, 2020). This research also points to practices such as restraint and seclusion, which can be experienced as gender-based violence, particularly when done by male staff members, triggering memories of sexual assault and compounding existing trauma for women who have experienced violence (Watson et al., 2020). Mental health inpatient facilities can themselves be sites of gender-based violence, as implied in the account provided by one study participant, below:

> I've survived a lot of trauma and assaults in the past and rapes in the past and it was like what they did was repeating the trauma of that because they tackled me to the ground, they pinned me on the ground and then they basically forced me into a room that I didn't want to be in with security guards who were threatening to sexually assault me and who were just standing over me and glaring at me and saying abusive things to me in the doorway. (Quoted in Watson et al., 2020, p. 45)

When gender-based violence does occur, trauma-informed care is not consistently embedded into institutional practices (Watson et al., 2020). For example, victims/survivors are not always allowed to control the response process to a sexual assault, with some policies requiring mandatory police reporting, even without the woman's consent, while other policies might either implicitly or explicitly deny access to police reporting (Watson et al., 2020). The lack of consistent, trauma-informed procedures can also mean that next-of-kin contact can be made with perpetrators of violence. This can include allowing perpetrators visiting rights or imparting private information about the woman's condition or care without permission, which can be re-traumatising or, in some situations, expose the woman to more violence (Watson et al., 2020).

## Parenting at the intersection of violence against women and mental health

The co-occurrence of violence against women and mental health concerns can have parenting impacts, damaging the mother–child relationship and impacting the child's mental health. ANROWS research highlights that the intersection of mental health and violence against women also impacts parenting. The report *Domestic and family violence and parenting: Mixed method insights into impact and support needs* (Kaspiew et al., 2017) points out that maternal mental health impacts from violence can affect children's mental health:

> Yvette described the effect on her baby's mental health as a result of

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> DFV [domestic and family violence] affecting her own state: "So [baby] was super insecure, and really, really needed closeness. But then, of course, my presence wasn't always calm either, 'cause I was having panic attacks that had started during the pregnancy." (p. 157)

This can mean that mothers, even after separation from violent ex-partners, need to simultaneously manage lasting impacts on their own mental health and impacts upon their children's mental health (Kaspiew et al., 2017). As one study participant explained:

> I have a lot of anxiety, a lot of anxiety, and that's hard to manage on a daily basis. I think the biggest challenge I've had since separating from [ex-partner] is trying to mask or hide my anxiety from them. That's been a particularly challenging parenting experience. Because I've—we've gone through the family court and there's times where he has to see them and I have to drop them to him; hiding my fears and anxiety from them is quite difficult as a mum to sort of be there and try and be supportive of them and this process, when internally I'm absolutely frightened for their lives and have so much anxiety I really panic. So as a mother that part of my relationship with them is quite difficult. (Quoted in Kaspiew et al., 2017, p. 158)

Children who live with domestic and family violence are more likely to have a range of health, development and social problems. They are also at higher risk of perpetrating or becoming a victim of violence, which perpetuates intergenerational cycles of violence (Campo, Kaspiew, Moore, & Tayton; Flood & Fergus; Holt, Buckley, & Whelan; Humphreys, Houghton, & Ellis; Kaspiew et al.; Richards; Stith et al. as cited in Webster et al., 2018). Salter and colleagues suggest that future instances of complex trauma may be addressed by investing in the prevention and reduction of the intergenerational impacts of child trauma (Salter et al., 2020).

Addressing mental health impacts of living with violence for children, particularly while experiencing maternal mental health impacts, can be difficult. Mothers can encounter a lack of services and response when seeking therapeutic assistance, particularly for older teenagers or young adults with mental health problems linked to exposure to violent and abusive behaviour (Kaspiew et al., 2017). It can be even more difficult when adolescents exposed to childhood trauma themselves begin to use violence, as the report *The PIPA project: Positive Interventions for Perpetrators of Adolescent violence in the home* points out. This research recommends an increased focus upon early intervention in childhood experience of trauma and violence (Campbell et al., 2020; Salter et al., 2020).

Kaspiew et al. (2017) also indicated that the poorer parental mental health was, the lower that both mothers and fathers reported their average level of satisfaction in their relationship with their children. Both this research and forthcoming ANROWS research led by Professor Cathy Humphreys emphasise that attention needs to be paid to the way the mother–child relationship is undermined by perpetrators of violence. Both studies evidence the importance of undertaking relationship-based reparation work (ANROWS, 2020a; Kaspiew et al., 2017). Humphreys et al. go on to point out that all organisations providing services to families experiencing conflict and violence have an important role

to play in supporting the mental health of parents, helping parents recover their parenting capacity, and supporting the restoration of parent–child relationships (ANROWS, 2020a).

# Collaboration is key at the intersection of mental health and violence against women

The complexity of the intersection of violence against women and mental health often requires collaboration between mental health, sexual violence, domestic and family violence and other sectors to provide effective care. Research shows that women (cisgender and trans)[3] commonly experience sexual violence (Ussher et al., 2020) and that there is a strong relationship between sexual violence and poor mental health (Quadara, 2015). The relationship is complex, often involving a past history of multiple traumas. Mental health and sexual violence services often see the same women; however there may be a lack of communication and cross-referrals between services (Quadara, 2015). Effective care and response requires collaboration between mental health and sexual violence services.

Trauma-informed care seeks to create safety for patients by understanding the effects of trauma (including past and present violence) and its close links to health and behaviour (Quadara, 2015). *Women's Input into a Trauma-informed systems model of care in Health settings (the WITH study)* produced a systems model of trauma-informed care outlining how services can optimally undertake trauma-informed care when both mental health problems and a history of sexual violence are present (Hegarty et al., 2017). This research demonstrates the need for a holistic service model for addressing complex needs of women who experience sexual violence in tandem with other structural oppression and marginalisation (Hegarty et al., 2017). Women interviewed for this study:

> emphasised the importance of being able to easily access appropriate ongoing trauma-informed services that share information, provide referrals, and support women in accessing help for their complex issues at all times, not only during crises. (Hegarty et al., 2017, p. 10)

The need for integrated, trauma-informed services was also highlighted in the report *"A deep wound under my heart": Constructions of complex trauma and implications for women's wellbeing and safety from violence* (Salter et al., 2020). The report emphasises the importance of embedding services addressing the intersection of violence against women and mental health within a broader network of services that foster mutual learning, partnerships and warm referrals where necessary (Salter et al., 2020).

The complexity of implementing an integrated approach is highlighted in a forthcoming research report, *Safe & Together Addressing ComplexitY for Children (STACY for Children)* led by Cathy Humphreys. Focused upon

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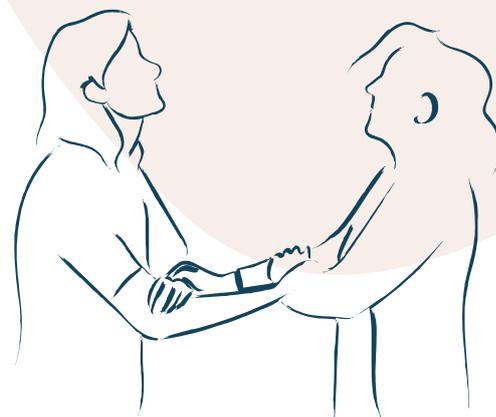
3   Cisgender describes people whose gender identity matches the sex that they were assigned at birth, while trans, (a contraction of transgender) is an umbrella term to describe people who have a gender identity that is different to the sex they were assigned at birth.

intersections between domestic and family violence, mental health and substance misuse, this research shows how one of those issues effectively shapes the contours of the other issue(s) within services. For example, mental health may be treated as the primary issue by mental health service providers while the perpetrator's violence is ignored or considered a symptom (ANROWS, 2020a). Differing focuses between services can make effective cross-sector collaboration hard to achieve. This results in women with experiences of complex trauma having to understand and navigate the (formal and informal) rules governing each service system they require, often simultaneously, while they are in crisis (Salter et al., 2020).

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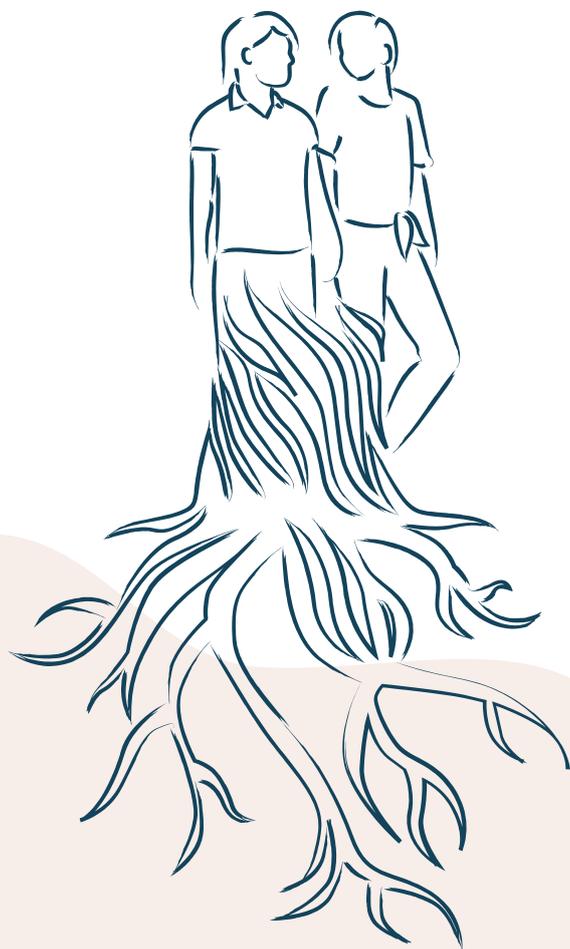
# KEY RECOMMENDATIONS

The following recommendations have been collated from the research discussed in this synthesis to provide guidance for policymakers, practice designers, program managers and practitioners working where violence against women and mental health intersect.

# For policy

## *Reduce violence and improve/nuance diagnosis*

- Focus on reducing intimate partner violence—this is likely to have a large impact on the overall disease burden among women through improvements to mental health, particularly for women aged 18–44 years (who are most likely to have children) (Ayre et al., 2016).

- Conduct community-wide, multi-faceted sexual violence prevention activities to encourage cultural change across all communities, promoting respect for gender, sexuality and cultural diversity, with zero tolerance for sexual violence for all women (Ussher et al., 2020).

- Reduce instances of future complex trauma by an investment in preventing and reducing the intergenerational impact of childhood trauma via pre- and post-natal care and screening for abuse and violence; trauma-informed parental and family support programs; and early intervention for trauma-exposed boys and girls (Salter et al., 2020).

- Increase the screening of and treatment for women entering the legal system with mental health concerns, complex trauma, FASD and brain injuries, with flow-through therapeutic care from prison to services on the outside (Bevis et al., 2020).

- Extend evidence-based models of care by creating Medicare Benefits Schedule (MBS) item numbers for trauma and complex trauma to measure the true cost of violence against women as frequent users of the health system (Salter et al., 2020).

## *Consistently provide trauma-informed care*

- Make a whole-of-government commitment to the implementation and coordination of trauma-informed practice across sectors. This should include:
  - the identification and prioritisation of women with experiences of complex trauma within public policy and service frameworks

  - a properly resourced audit to identify barriers to service cooperation for women with experiences of complex trauma, with participation from service consumers
  - embedding trauma-informed care within a holistic wellbeing framework that integrates mental, physical and psychosocial wellbeing
  - sustained and long-term funding for specialist trauma programs and services (Salter et al., 2020).

- Develop and implement non-traumatising models of involuntary mental health care (Salter et al., 2020).

- Base consent and information-sharing processes in mental health inpatient facilities on an understanding of domestic and family violence (Watson et al. 2020).

- Resource research to inform policymakers that incorporates women's voices about care they receive when they experience mental health issues and sexual violence (Hegarty et al., 2017).

- Improve access to comprehensive treatment for complex trauma under current policy arrangements, including Medicare and the NDIS, to minimise short-term and disjointed interventions and treatment (Salter et al., 2020).[4]

## *Support parenting*

- Recognise the impact of violence against women on parenting capacity, in particular that mothers may be experiencing compromised parenting capacity, as part of population-level preventative measures. Resource support for recovery in parenting capacity of mothers where domestic and family violence has occurred or is occurring (Kaspiew et al., 2017).

- Recognise that children and adolescents may have been directly or indirectly affected by domestic and family violence, and that measures to address resultant emotional, social and educational challenges may be needed, as well

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4   When improving these pathways, attention should also be paid to women from diverse populations, and/or those still experiencing violence, who may face barriers or disclosure risks when accessing services through Medicare and the NDIS, making them unlikely to do so (see Ussher et al., 2020; Vaughan et al., 2016).

as support for restoration of the parent–child relationship (ANROWS, 2020a; Campbell et al., 2020; Kaspiew et al., 2017).

- Resource partner contact so that women have ongoing access to support, as this has a positive benefit to their mental health, irrespective of a perpetrator's attendance at a men's behavioural change program (MBCP) and after program completion (Chung et al., 2020).

- Ensure that senior managers in mental health, alcohol and other drugs, and domestic and family violence organisations proactively develop policies for their staff that facilitate conversations about the role of their clients as mothers and fathers, and how to increase the visibility of children (ANROWS, 2020a).

## *Enable better access to justice*

- Promote partnership models where police attend mental health incidents alongside allied health professionals (Salter et al., 2020).

- Implement a social entrapment framework in criminal justice settings (Tarrant et al., 2019).

- Attend to safety issues and bring a "family violence lens" to the conduct of family law proceedings, in response to the high number of family law cases involving family violence allegations and self-representation. Legislative and policy responses need to contend with self-represented litigants' diversity and their complex needs, with the safety for victims/survivors of violence being paramount (ANROWS, 2020b).

- Recognise the vulnerability and needs of trans women who are sex workers when addressing sexual violence, including violence prevention, police response and support for women. As a first step, fully decriminalise sex work in every Australian state and territory (Ussher et al., 2020).

# For practice

## *Reduce violence and improve/nuance diagnosis*

- Implement better screening and health coordination within the prison context, including screening for complex trauma, other mental health conditions, FASD and brain injuries (Bevis et al., 2020; Day et al., 2018).

- Initiate early intervention for children and teenagers, with culturally specific support to help young people through exposure to traumatic incidents, IPV and assault (Bevis et al., 2020; Campbell et al., 2020).

- Increase focus on the importance of recognising adolescents who use violence in the home and its complexities—including the potential presence of trauma and undiagnosed disability—within mainstream family violence sectors (Campbell et al., 2020).

## *Consistently provide trauma-informed care*

- Implement a systems response (sufficient time, confidential space, strong leadership) that supports practitioners to deliver trauma-informed care. Women who experience sexual violence and mental health problems often present to multiple services seeking holistic women-centred care, where they are listened to and connected across services in an integrated way. Managers and practitioners need to work on building relationships across teams and services and structuring systems to integrate and coordinate care (Hegarty et al., 2017).

- Position partner contact programs as an important and appropriate response to women where their current or former partner is in an MBCP (Chung et al., 2020).

- Recognise that the practice of restraint can be experienced as gender-based violence, understand the potential for re-traumatisation during restraint and take action to mitigate the possibility of re-traumatisation if restraint must be used (Watson et al., 2020).

- Ensure that mental health inpatient staff do not perpetrate gender-based violence; have an understanding of gendered and complex trauma; provide trauma-informed responses regardless of whether clients have disclosed past experiences of gender-based violence; address the past trauma experiences that underlie current mental distress; and limit the re-traumatisation which can occur in mental health services (Watson et al., 2020).

- Recognise the resilience and agency of women in response to gender-based violence and mental health concerns (Salter et al., 2020; Ussher et al., 2020).

## *Support parenting*

- Provide long-term therapeutic assistance to women and their children who may be experiencing physical and emotional consequences from domestic and family violence and abuse (Kaspiew et al., 2017).

- Provide referrals for mothers to programs and services that will support the restoration of parenting capacity from a perspective of understanding the dynamics of domestic and family violence, including programs that offer services to mothers and children together. Children may also need assistance separately (Kaspiew et al., 2017).

- Increase attention and focus given to strategies, programs and resources that recognise adults as parents and enhance visibility of their children in domestic and family violence, alcohol and other drugs, and mental health interventions (ANROWS, 2020a).

## *Enable better access to justice*

- Resource police properly to work in a trauma-informed way, including via the provision of appropriate training for dealing with people with experiences of complex trauma (Salter et al., 2020).

- Move to trauma-informed prosecution, involving continuity of contact and care in a case from a trusted individual, with careful handover from police to prosecution, and from lawyer to lawyer (Salter et al., 2020).

- Provide additional support for trans women of colour who have experienced sexual violence to report incidents of sexual violence to the police, and to navigate court processes (Ussher et al., 2020).

- Use a social entrapment framework to show how the coercive power of the abuser extends *beyond* the incidents during which they are acting violently, and to show how the *social response* to IPV worsens a victim's/survivor's entrapment (Tarrant et al., 2019)

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# Forthcoming research

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## Suggested citation

## ANROWS acknowledgement

## Acknowledgement of Country

ANROWS acknowledges the Traditional Owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present, and future, and we value Aboriginal and Torres Strait Islander histories, cultures, and knowledge. We are committed to standing and working with Aboriginal and Torres Strait Islander peoples, honouring the truths set out in the Warawarni-gu Guma Statement.

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