

---

# BRIDGING THE GAP

## EVALUATION OF THE DOMESTIC VIOLENCE AND MENTAL HEALTH PILOT PROJECT

JOAN HARRISON SUPPORT SERVICES FOR WOMEN

Dr Lesley Laing and Cherie Toivonen

Faculty of Education and Social Work

University of Sydney

February 2010

# TABLE OF CONTENTS

<b>Executive Summary</b> .....	<b>2</b>
<b>The Evaluation</b> .....	<b>7</b>
Background.....	7
Research design.....	10
<b>Findings: work with clients</b> .....	<b>12</b>
Complex and challenging situations .....	12
Client demographics.....	13
<b>Findings: building collaboration</b> .....	<b>20</b>
<b>Findings: clients speak</b> .....	<b>24</b>
<b>Findings: Service providers</b> .....	<b>31</b>
Setting the scene: barriers for women.....	31
Impact of the DV&MH position.....	33
<b>Discussion &amp; Conclusions</b> .....	<b>42</b>
Outcomes for women.....	42
Outcomes that enhanced cross sector collaboration .....	43
<b>Appendices</b> .....	<b>44</b>
References.....	47

---

# EXECUTIVE SUMMARY

## Background

Domestic violence has profound impacts on women's mental health. Effective responses to women experiencing both domestic violence and mental ill health require the coordinated expertise of both the mental health and women's domestic violence sectors. Yet the very different histories, philosophies and organisational cultures of these two service sectors present formidable challenges to the development of effective working relationships and the sharing of different bodies of expertise (Gondolf, 1998). The Australian Research Council funded *Towards Better Practice* (TBP) research project (2005-2007) investigated how collaboration between domestic violence and mental health services could be enhanced in order to provide a more effective response to women who experience both domestic violence and mental illness/mental health concerns. Liverpool/Fairfield was one of the geographical areas that participated in the TBP research.

The Domestic Violence and Mental Health (DV&MH) position was established by Joan Harrison Support Services for Women as a pilot project in 2008. It was a direct response to findings from the *Towards Better Practice* (TBP) research project. Joan Harrison Support Services for Women was one of several specialist domestic violence services that participated actively in the Liverpool/Fairfield TBP steering committee that was established to develop and trial local collaborative initiatives.

The DV&MH service works with women who have experienced both domestic violence and mental illness/health concerns. The DV&MH worker provides ongoing case work, counselling, advocacy and generalist support to these women. The DV&MH worker also provides a community development, training and education service to service providers working across the Liverpool area. Extending cross sector collaboration is a core focus of the position.

A key finding of the TBP research was that, in the absence of collaboration across the domestic violence and mental health sectors, interventions fail to address the complex interaction of domestic violence and mental health issues, often leaving women in unsafe situations where their mental health issues are exacerbated. The following example demonstrates the role of the DV&MH service in bridging the gap between service sectors:

*An immigrant woman and mother of 3 children was experiencing domestic violence from her ex-partner. She had few relatives living in Australia and spoke limited English. Her partner had socially isolated her, for example by preventing her from attending English classes. After being abused by her ex-partner one night this young woman made some superficial cuts to her arm and was taken to Liverpool Hospital by the police. She was scheduled (i.e. held for involuntary treatment). Initially, the health professionals there assessed her only on the basis of information provided by*

*her ex-partner. However, the involvement of the DV&MH worker facilitated a more accurate assessment that included the context of abuse that had led her to self-harm.*

## **Methodology**

The aims of the evaluation were:

*To identify:*

- The demographic characteristics, domestic violence experiences and mental health issues of the service clients;
- Referral sources;
- The range and scope of activities of the position in direct client work; and
- The range and scope of activities of the position in facilitating and strengthening cross sector collaboration

*To explore:*

- the experiences of women clients of the assistance offered by the service;
- the perceptions of service providers in both the mental health and domestic violence sectors about the contribution of the service to the strengthening of the collaborative work that had begun in the earlier action research project.

Because this is a new service, both qualitative and quantitative data were collected from multiple sources to try to capture an holistic picture of this innovative, developing service. Data sources were:

- Semi-structured, in-depth interviews with clients of the service
- Semi-structured, in-depth interviews with service providers
- Case file audit
- Case studies
- Audit of engagement with service providers
- Service provider telephone snapshot

The in-depth interviews were coded and analysed using the qualitative data analysis package NVIVO. The data collected in the case file audit was also coded and the quantitative data analysis package SPSS was used to analyse the data.

### **Outcomes for women**

- The DV&MH service provides practical support, therapeutic interventions and advocacy for a vulnerable group of women with complex needs who, almost certainly in the past, would have “fallen through the gaps” of service provision between the mental health and domestic violence service sectors.
- The service has connected with hard to reach clients – women experiencing complex domestic violence and mental health concerns, younger women, Aboriginal women, and women from a culturally and linguistically diverse backgrounds.
- The DV&MH service has created connections with the mental health sector which has allowed identification and easy referral of women in a mental health setting who were experiencing domestic violence. Often, the detected violence had been the underlying cause of the mental health concern or illness. By addressing the violence, the mental health concerns were often alleviated.
- The impact of the work of the service on women’s mental health and their journey away from domestic violence is profound. All of the women interviewed had left the domestic violence and all reported an improvement in their mental health.
- The holistic and feminist approach of the DV&MH worker allowed a connection and trusting relationship to develop between the DV&MH worker and her clients. This in turn led to improved outcomes for the women as they listened to and trusted advice the DV&MH worker provided them with.
- Women’s experiences of violence and mental ill-health were listened to and validated by the worker which also enhanced the trusting relationship. Often women had never had this type of validation from a service provider which went a long way to improve their self-esteem, confidence, and health and well-being.
- The service model provided the type of assistance that women interviewed in the original TBP research identified as essential. It is also consistent with best practice identified in international research (Stenius & Veysey, 2005).

### **Outcomes that enhanced cross sector collaboration**

- The expertise of the DV/MH worker is highly regarded by service providers in both sectors and the consultation offered is both accessible and highly valued;
- The activities of the DV&MH worker have improved mental health service providers’ understanding of the impact of domestic violence on women’s mental health; their ability to identify underlying domestic violence in clients of mental health services; and promoted better practice with women who experience the complex interaction of both issues.

- In addition to direct work with women, improving collaborative initiatives across sectors has remained a central aspect of the DV/MH role through training, networking and consultation.
- In summary, the DV&MH role has proved an effective way to “bridge the gap” between the mental health and domestic violence sectors in the Liverpool area through a combination of collaborative initiatives and direct practice.
- The model of service is consistent with evidence-based practice with co-occurring mental health and domestic violence: i.e. it is an example of integrated, “trauma informed” service provision (Markoff, Finkelstein, Kammerer, Kreiner, & Prost, 2005). It is an innovative model of service provision that can inform service delivery across the health system, beyond the Liverpool area.

---

# THE EVALUATION

## BACKGROUND

### **Domestic Violence and Women's Mental Health**

There is a vast body of evidence of the harmful effects of domestic violence on women's physical and mental health (e.g. Campbell, et al., 2002; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Roberts, Lawrence, & Williams, 1998; Taft, 2003). The first study to estimate the health impact of domestic violence on women using the 'burden of disease' methodology, found that domestic violence is: "... responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking." (VicHealth, 2004, p. 8) Mental health impacts were found to contribute 73 per cent of this disease burden (Vos, et al., 2006).

Golding's (1999) meta analysis of 40 studies of the prevalence of mental ill health among women with a history of intimate partner violence found that: "Victims of domestic violence are more likely to have symptoms of depression, anxiety and post-traumatic stress disorder, to attempt suicide, and to misuse alcohol or other substances than women not experiencing domestic violence." (Golding, 1999)

The World Health Organisation (Krug, et al., 2002) notes that women who experience abuse have far more contact with the health system over their lifetime than non-victims. For women experiencing mental health concerns/illness, mental health services are often the point of contact with the health and welfare system where abuse can be disclosed. However, failure by mental health services to respond appropriately to domestic violence, either by discounting the violence, or by misdiagnosis and inappropriate treatment, can place a woman at risk of ongoing and escalating violence and compromised mental health.

Data collected under the National Supported Accommodation Assistance Program (SAAP) identifies domestic violence as the most common reason for women with children accessing SAAP services, such as women's refuges (Edwards, 2004). Many of these women also experience serious mental health concerns. For example, Mertin & Mohr (2000) found that 45 per cent of women leaving refuges in Adelaide met the criteria for diagnosis of post-traumatic stress disorder. However, women's domestic violence services often do not

have the expertise or resources to deal with chronic mental health issues, and as a result, they are not always able to provide accommodation to women with a mental illness who are escaping domestic violence (Chung, Kennedy, O'Brien, Wendt, & Cody, 2000). This can increase the risk of homelessness and consequent deterioration in physical and mental health for these women (Astbury & Cabral, 2000).

Effective responses to women experiencing both domestic violence and mental ill health require the coordinated expertise of both the mental health and women's domestic violence sectors. Yet the very different histories, philosophies and organisational cultures of these two service sectors present formidable challenges to the development of effective working relationships and the sharing of different bodies of expertise (Gondolf, 1998).

## THE DV&MH SERVICE

The Domestic Violence and Mental Health (DV&MH) position was established by Joan Harrison Support Services for Women as a pilot project in 2008. It was a direct response to findings from the Australian Research Council funded research project: *Towards Better Practice* (TBP). This research project investigated how collaboration between domestic violence and mental health services could be enhanced in order to provide a more effective response to women who experience both domestic violence and mental illness/mental health concerns. Joan Harrison Support Services for Women was one of several specialist domestic violence services that participated actively in the Liverpool/Fairfield TBP steering committee that was established to develop and trial local collaborative initiatives.

The Liverpool/Fairfield TBP steering committee developed a number of successful collaborative initiatives during 2006/7, including:

- Launch of a formal service agreement between the two sectors;
- Active involvement in promoting domestic violence routine screening training for mental health workers;
- Development of a training package for domestic violence and mental health workers across South West Sydney and an ongoing series of regular training seminars.

The Domestic Violence and Mental Health position is an important strategy to continue and extend the collaborative practices initiated under TBP. Funding was received for two years from the NSW Department of Premier and Cabinet. The DV&MH position works closely with TBP steering committee which continues to meet monthly to plan and review the collaborative activities. A highly experienced domestic violence worker who had been part of



the earlier TBP project was recruited to the position, enabling the service to begin where the TBP research left off, sustaining and building on the progress already made.

The DV&MH service works with women who have experienced both domestic violence and mental illness/health concerns. The DV&MH worker provides ongoing case work, counselling, advocacy and generalist support to these women. The DV&MH worker also provides a community development, training and education service to service providers working across the Liverpool area. Extending cross sector collaboration is a core focus of the position.

A key finding of the TBP research was that, in the absence of collaboration across the domestic violence and mental health sectors, interventions fail to address the complex interaction of domestic violence and mental health issues, often leaving women in unsafe situations where their mental health issues are exacerbated. The following example demonstrates the role of the DV&MH service in bridging the gap between service sectors:

*An immigrant woman and mother of 3 children was experiencing domestic violence from her ex-partner. She had few relatives living in Australia and spoke limited English. Her partner had socially isolated her, for example by preventing her from attending English classes. After being abused by her ex-partner one night this young woman made some superficial cuts to her arm and was taken to Liverpool Hospital by the police. She was scheduled (i.e. held for involuntary treatment). Initially, the health professionals there assessed her only on the basis of information provided by her ex-partner. However, the involvement of the DV&MH worker facilitated a more accurate assessment that included the context of abuse that had led her to self-harm.*

## THE EVALUATION TEAM

Dr Lesley Laing, one of the three Chief Investigators in the *Towards Better Practice* research during 2006-2009 undertook this evaluation. Cherie Toivonen, Senior Research Officer on the original TBP research undertook this role in this evaluation.

## RESEARCH DESIGN

### THE AIMS OF THE EVALUATION WERE:

#### *To identify:*

- The demographic characteristics, domestic violence experiences and mental health issues of the service clients;
- Referral sources;
- The range and scope of activities of the position in direct client work; and
- The range and scope of activities of the position in facilitating and strengthening cross sector collaboration

#### *To explore:*

- the experiences of women clients of the assistance offered by the service;
- the perceptions of service providers in both the mental health and domestic violence sectors about the contribution of the service to the strengthening of the collaborative work that had begun in the earlier action research project.

Because this is a new service, both qualitative and quantitative data were collected from multiple sources to try to capture an holistic picture of this innovative, developing service. Data sources were:

- Semi-structured, in-depth interviews with clients of the service

Consistent with the feminist orientation of the service, the evaluators wished to include the voices of the women clients in the evaluation but had to balance this desire with the potential risks that participating in a research could re-traumatise this vulnerable group. For this reason, consistent with the approval for the study given by the University of Sydney Human Ethics Research Committee, invitations were only extended to clients of the service whose health and safety would not be jeopardised by their participation in the judgement of the DV&MH worker. Although this provides a potential source of bias in the findings, this approach struck a balance between ethical considerations in dealing with a vulnerable client group and providing the opportunity for some of the women to participate in the evaluation. The women who were invited to participate in an interview were a) safe from violence and abuse, b) mentally well enough to discuss their experiences. The interview guide is provided at Appendix 3.

- Semi-structured, in-depth interviews with service providers

Workers from both the mental health and domestic violence sectors in Liverpool were invited to take part in an interview. Participants included service managers, outreach workers, educators, social workers and caseworkers from both government and non-government services. The interview schedule was based on previous Australian research into collaborative responses to domestic violence and is included as an appendix to this report.

- Case file audit

A quantitative audit of the case files of all the clients seen by the service for the period August 2008 to January 2010 was undertaken to identify demographic characteristics, referral sources, domestic violence and mental health issues and the nature and scope of interventions.

- Case studies

A number of case studies were collated in consultation with the worker in order provide an understanding of the complex nature of the work .

- Audit of engagement with service providers

Discussions were held with the DV&MH worker about the types of collaborative work undertaken with local service providers. The worker's 6 and 12 monthly reports were also used to ascertain the nature and extent of engagement with outside services. Data was collected in relation to: consultancy work, inter-agency meetings attended and training provided to services in both Liverpool and wider Sydney.

- Service provider telephone snapshot

The DV&MH worker kept a record of all phone calls she received from other service providers (all over 5 minutes in length) during the month of October, 2009. She recorded; the length of the phone call, reason for call and subsequent outcomes/follow up required. The snapshot added to information about work with other service providers (emails were not recorded).

## DATA ANALYSIS

The in-depth interviews were coded and analysed using the qualitative data analysis package NVIVO. The data collected in the case file audit was also coded and the quantitative data analysis package SPSS was used to analyse the data.

---

## FINDINGS: WORK WITH CLIENTS

### COMPLEX AND CHALLENGING SITUATIONS

The following case examples highlight the complex and challenging nature of this work which clearly requires a worker with experience and expertise in both domestic violence and mental health intervention:

*A young Aboriginal woman was forced to flee two states due to severe domestic violence and was then subjected to further domestic violence. This young woman had been hospitalised for five months interstate due to the severity of the physical injuries which still affected her. She was depressed, anxious, had suicidal thoughts, and was experiencing great grief and loss, as she was separated from her children who were in the care of extended family. She had also had numerous hospitalisations within the mental health system.*

A woman from an African country was dealing with the impacts of severe domestic violence from her partner. This was compounded for her by significant trauma that she experienced whilst in Africa and as a refugee, including multiple rapes and assaults, and the loss of her children. She was understandably severely depressed, had suicidal thoughts and a deep sense of hopelessness.

*A young woman was experiencing severe domestic violence from a much older male. Part of his abusive methods included controlling her with illegal drugs. This young woman was also dealing with the impacts of growing up in domestic violence and had experienced child sexual assault. She had received multiple mental health diagnoses including depression, paranoia, anxiety and schizophrenia and had been hospitalised on a number of occasions. The involvement of the DV&MH worker provided understanding of the context of life-long abuse that was contributing to her health presentations.*

## CLIENT DEMOGRAPHICS

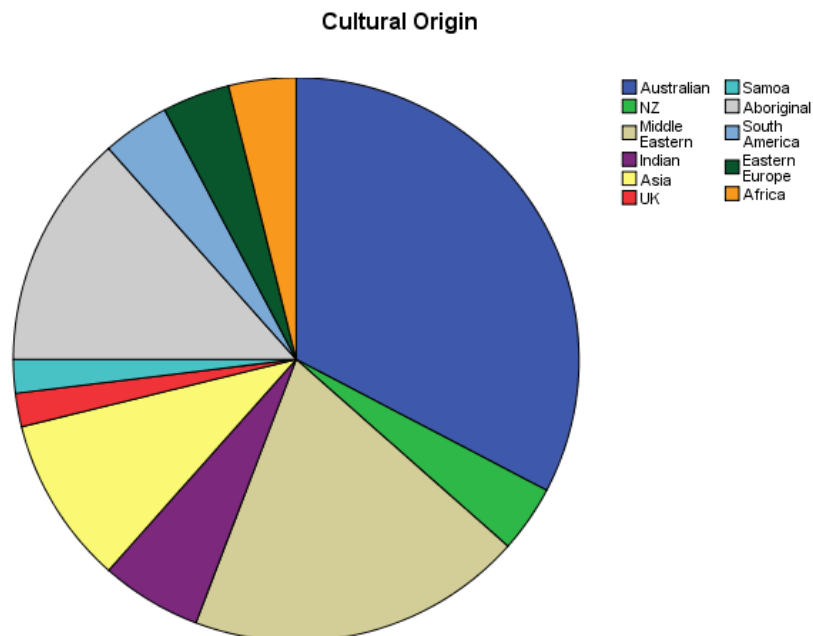
The following data was identified from the audit of the case files of 52 clients of the DV&MH service.

### Age

The women ranged in age from 18-61 years. Most of the women seen by the service were younger, falling in the age range of 18-30 years (35%), followed by those in the 31-40 age bracket (33%), then 41-50 years (18%) and finally 51-61 years (14%). ***This is a different pattern to referrals to the JHSS domestic violence outreach service, who are typically older. The new MH&DV service appears to be identifying younger women, i.e. reaching women at an earlier stage.***

### Cultural Origin

The women who used the service came from varied cultural backgrounds. Graph 1 below illustrates this diversity:



The largest cultural groups represented were Anglo-Australian (33%), Middle Eastern countries (19%), and significantly, Aboriginal and Torres Strait Islander women (14%).

## Children

Both women who had children (69%) and women without children (31 %) used the DV&MH service. Of those women who had children, 31% (16 women) did not have one or more of their children living with them. The reasons included DoCS involvement, the woman was in mental health care, extended family were looking after them or the children were now independent.

## The domestic violence women experienced

All of the clients had experienced multiple, overlapping forms of domestic violence. For the purpose of the audit, the violence women experienced was coded as: psychological/emotional, social isolation, financial, physical, severe physical (i.e. resulting in serious injury and hospitalisation) and sexual. As table 1 shows, 94% of clients of the service had experienced psychological and emotional abuse; 44% had experienced social isolation; 46% had experienced physical abuse; 36% had experienced financial abuse; 27% experienced severe physical abuse; and 21% had experienced sexual abuse.

**Types of Domestic Violence**

		Responses		
		Number of women	Percent of women	Percent of Cases
DV	Psychological/emotional	49	35.0%	94.2%
	Social isolation	23	16.4%	44.2%
	Financial	19	13.6%	36.5%
	Physical	24	17.1%	46.2%
	Severe physical	14	10.0%	26.9%
	Sexual	11	7.9%	21.2%
	Total	140	100.0%	269.2%

(Totals are greater than 100% due to multiple forms of co-occurring violence)

**ADVO Status**

35% of the women had an existing or had previous Apprehended Domestic Violence Orders (ADVO)s. Despite the severe abuse experienced, 65% of the women had no ADVO in place.

**Women’s mental health concerns/illness**

As in the case with the type of domestic violence experienced, the clients had also experienced more than one form of mental health concern or diagnosed mental illness in their lives. These mental health issues/diagnoses are outlined table 2 below.

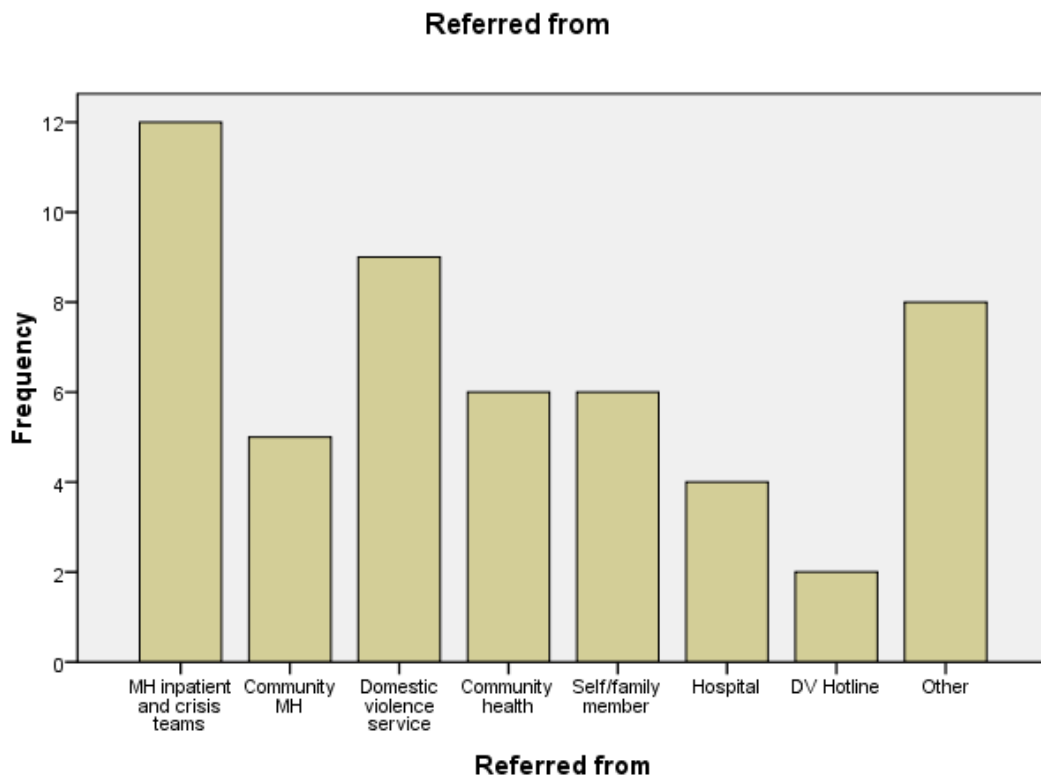
**Mental Health Issues/Diagnoses**

		Responses		
		Number of women	Percent of women	Percent of Cases
MentalHealth Concern/illness	PTSD	8	7.8%	15.4%
	Depression	36	35.3%	69.2%
	Schizophrenia	2	2.0%	3.8%
	Misdiagnosed mental illness	3	2.9%	5.8%
	Anxiety	23	22.5%	44.2%
	Suicidal Ideation/suicide attempt	20	19.6%	38.5%
	Dissociation	3	2.9%	5.8%
	Phobia	3	2.9%	5.8%
	Diagnosed bi-polar	3	2.9%	5.8%
	Personality disorder	1	1.0%	1.9%
	Total	102	100.0%	196.2%

Clients were most likely to experience depression (35% of clients seen), then anxiety (23%) and have suicidal ideation or attempt suicide (20%). Most women experienced these symptoms along with others such as PTSD, phobias, bi-polar etc.

### Referral points

The clients had been referred to the DV&MH service by a range of services in the area as shown in graph 2 below. ***The strength of the collaborative approach is seen in the large proportion of clients referred by mental health and health services.***



### The range of activities of the role

In order to provide a picture of the scope of activities in the role of the DV&MH worker, occasions of service were recorded for a one month time period (October 2009) and were categorised as: advocacy, crisis and practical counselling, practical support, brokerage, court support, referrals, collaboration with another service, and connecting with community. These were then broken down further to ascertain the length of time spent on each occasion of service. These groupings included: brief, mid-level and long occasions of service.

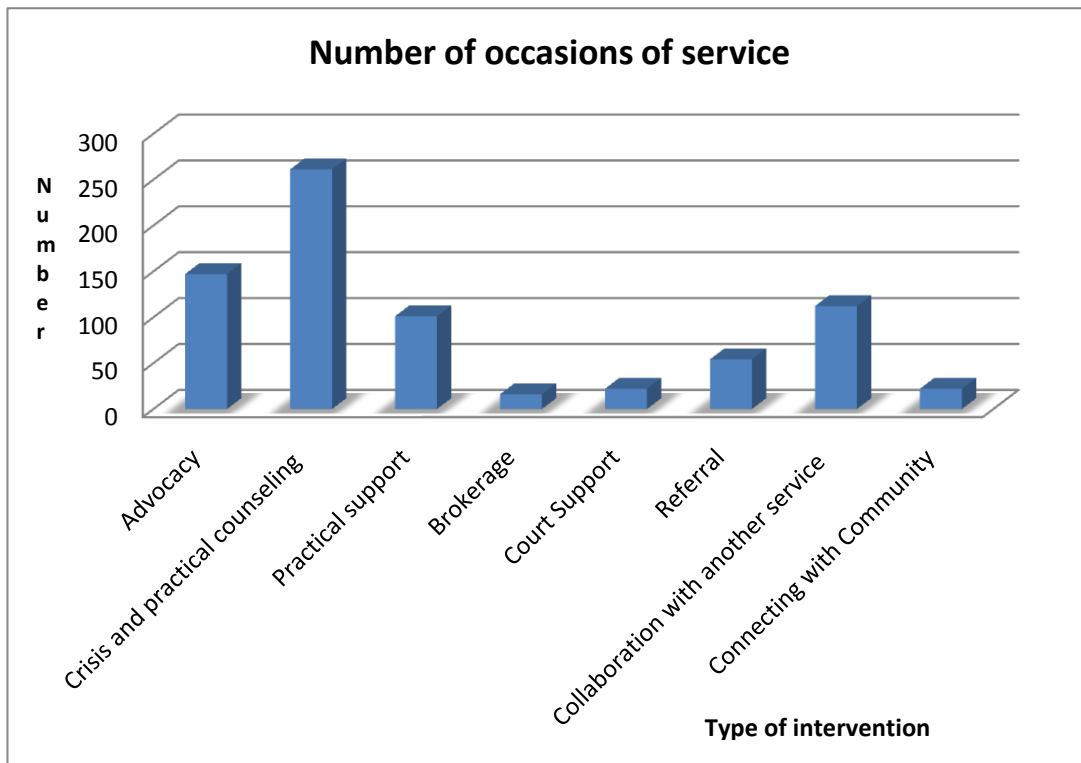
This identified the scope of the role which involves a wide range of interventions including:



- Responding directly to inpatient mental health units for crisis counselling, case conferences, and referrals;
- Facilitating the process and supporting women through mental health assessments with crisis mental health teams;
- Home visits;
- Follow-up of referrals from the crisis mental health team;
- Jointly supporting women with other mental health services (other than the crisis teams);
- Court support and advocacy with the police and magistrates when women are taking out ADVOs against their partners;
- Advocacy and support in relocating women to appropriate housing;
- Crisis and ongoing counselling;
- Making referrals to: various refuges, Liverpool Women's Health Centre (GP, groups, counselling, nurses, naturopath, massage etc), Liverpool Women's Resource Centre, mental health teams, PHAMS (personal helpers and mentors scheme for people with a mental illness), Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), counsellors and solicitors.

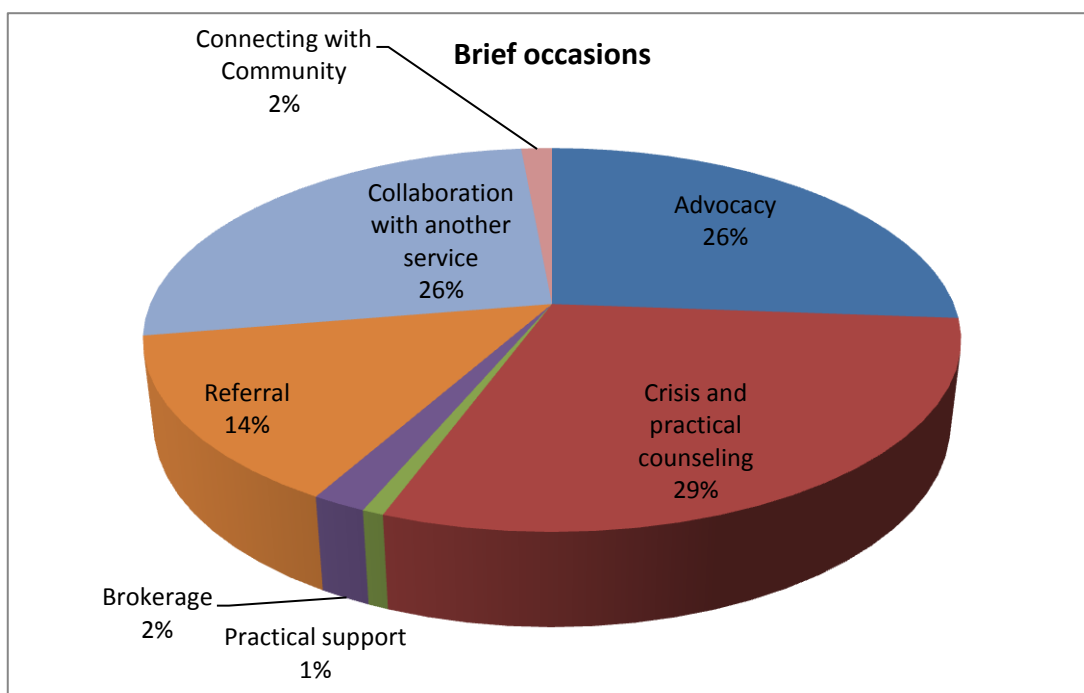
Full details of the audit are outlined in table 3 at Appendix 1.

Graphs 3, 4, 5 and 6 below provide some details on the scope of the work:

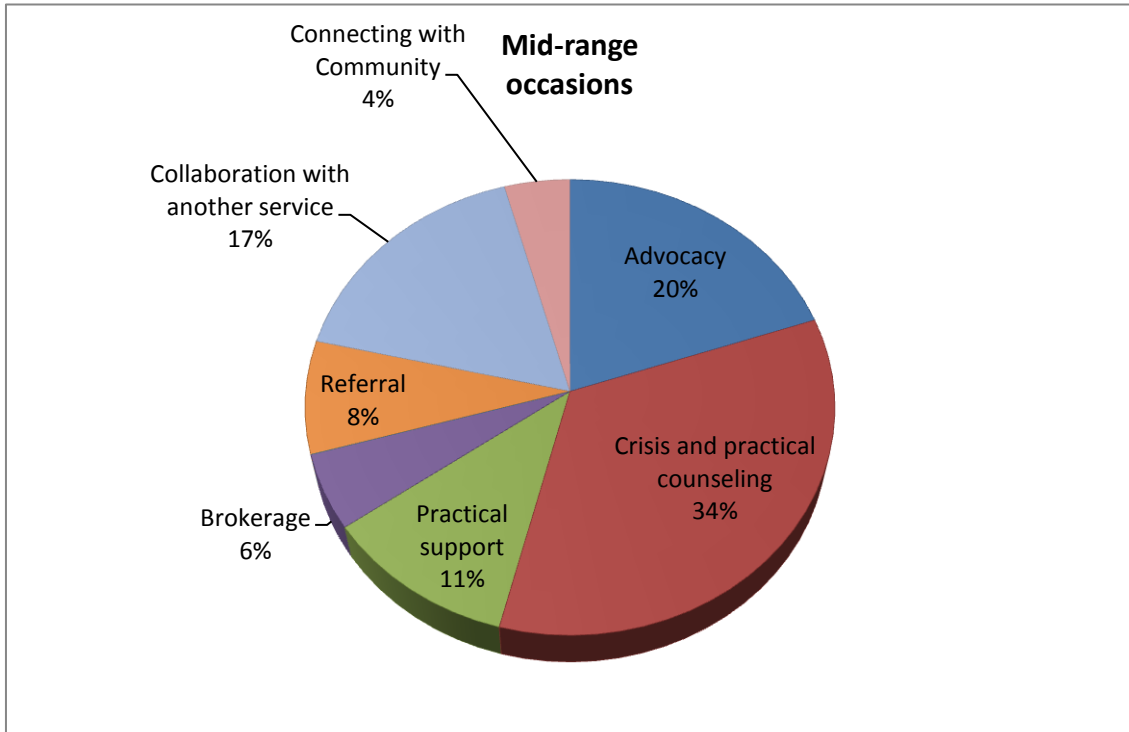


Above - Graph 3: Number and types of interventions from the service

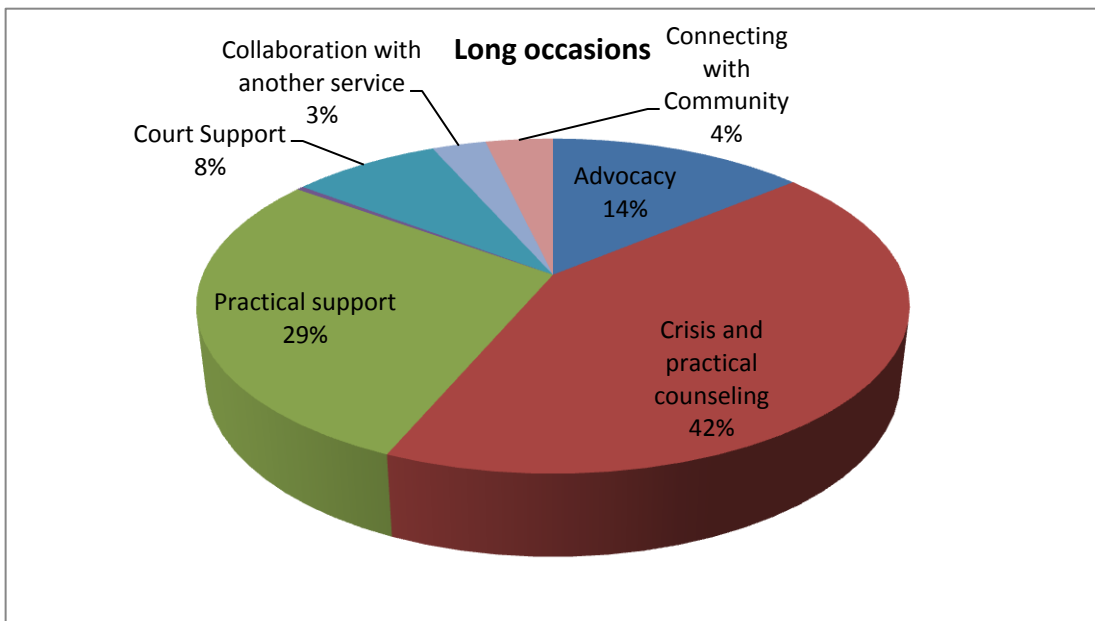
Graph 4: The types of "brief" interventions



**Graph 5 : The types of “mid-range” interventions**



**Graph 6: The types of “long” interventions**



---

# FINDINGS: BUILDING COLLABORATION

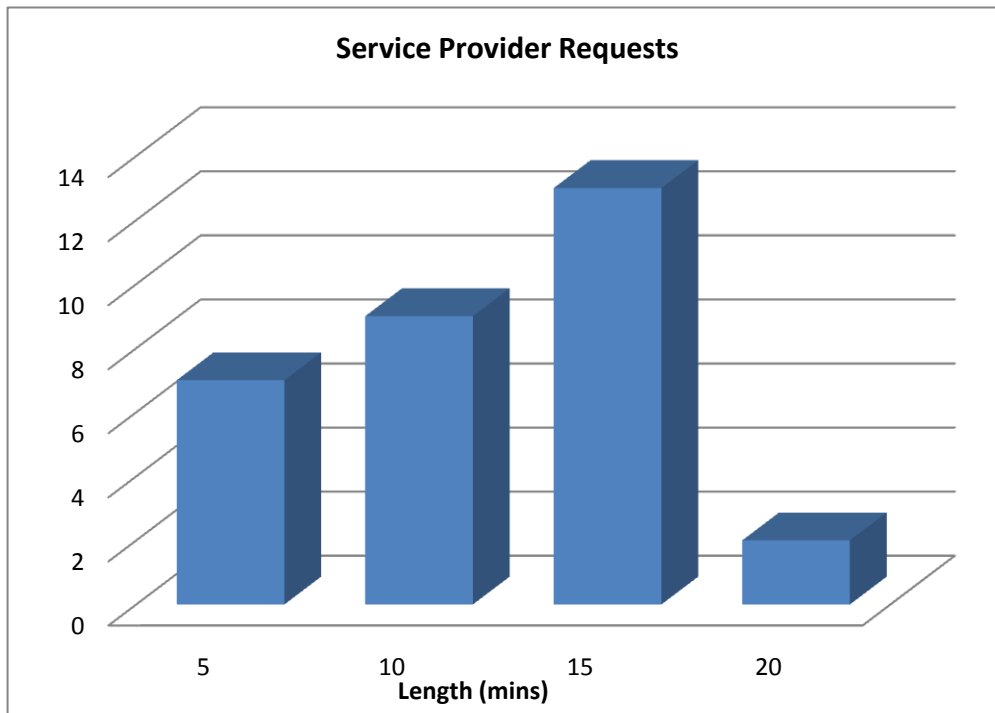
## CONSULTANCY

The DV&MH worker provides specialist consultancy to other service providers in the area over the phone, via email, through training sessions, and through networking at meetings and other inter-agencies. Service providers have contacted the DV&MH service in a consultancy capacity, requiring information and advice about:

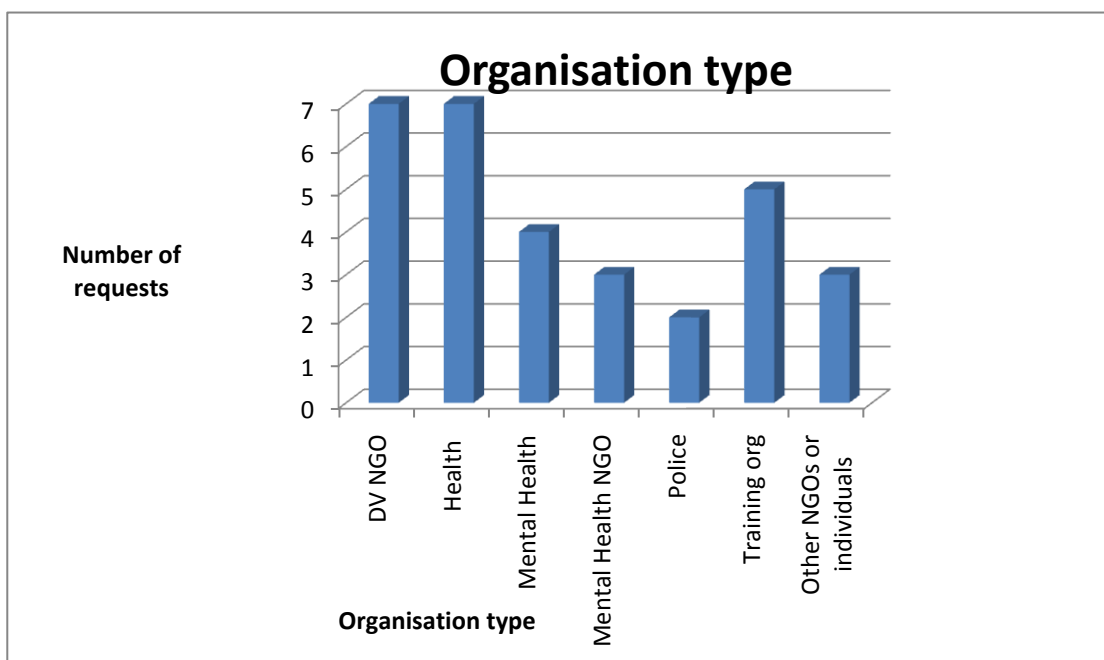
- legal procedures such as ADVOs;
- what to do in situations if the woman is experiencing mental health issues such as threatening self harm;
- how to facilitate women's access to refuges and other accommodation;
- how to advocate for women trying to negotiate the system;
- the links between domestic violence and mental health issues; and
- practice with women experiencing both mental health concerns and domestic violence.

Requests from service providers to the DV&MH worker during the month of October 2009 were captured in the phone snapshot to provide an example of the type of requests that the DV&MH worker assists with.

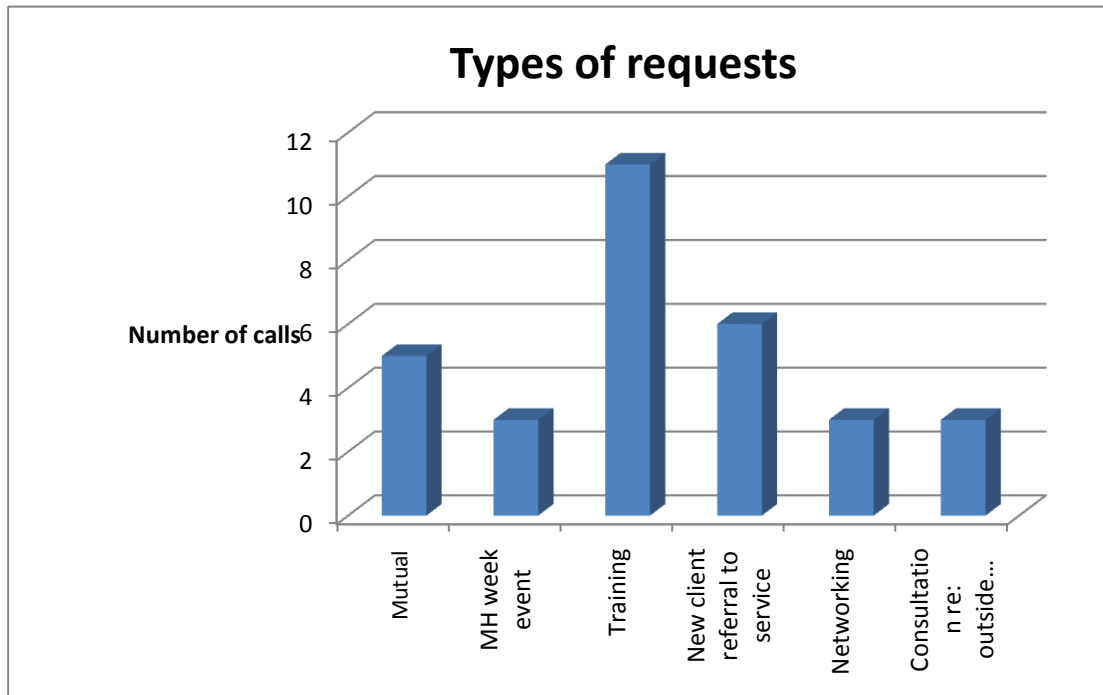
**Graph 7: The number & length of calls requesting service - October 2009**



**Graph 8: The number of phone requests made by the type of organization**



**Graph 9: Number & type of consultation requested**



## TRAINING

Training and information sessions which focus on the link between domestic violence and mental health and how the DV&MH service can assist both women and service providers continue to be a core activity of the service. Formal training sessions have included:

- A presentation for a consumer group at NEAMI (non-government mental health organisation). Approximately 20 people attended and the information presented included: healthy relationships, the impacts of an abusive relationship on mental health (compared to a healthy relationship), and self care.
- An In-service for the Psychiatric Emergency Critical Care (PECC) team about the service. 6 staff attended.
- Presentation at the Education Centre Against Violence, Domestic Violence Screening Forum. Approximately 100 workers were in attendance.
- Presentation to Catholic Care staff about the service and Domestic Violence and Mental Health. Approximately 50 workers were in attendance.

- Panellist at the Education Centre Against Violence Certificate IV training for 18 Aboriginal Health workers from across NSW.
- In-service to 20 Liverpool Hospital social work staff about the service.
- Key organizer and MC of the *Towards Better Practice Domestic Violence and Mental Health training forum*.
- Trainer at the Domestic Violence Screening “train the trainer” sessions and subsequent training sessions for mental health staff.

Training in its planning stages includes:

- The second *Towards Better Practice Domestic Violence and Mental Health training forum*.
- The Green Valley / Liverpool Domestic Violence Service, Liverpool / Fairfield Court Advocacy Service *Liverpool Police Domestic Violence Training* for local police.
- An in-service for staff at the Transcultural Mental Health Centre.

## PARTICIPATION ON COMMITTEES

The DV&MH worker also participates in local committees and interagency forums. These include:

- Member of the Liverpool Domestic Violence Liaison Committee which meets monthly (a network of local services to discuss and work together on domestic violence issues);
- Member and key organiser of the local ‘Towards Better Practice’ committee which meets fortnightly (local mental health and domestic violence workers working on initiatives to see these two sectors working better together); and
- Member of the Memorandum of Understanding Committee (MOU), a committee which meets bi-monthly made up of local mental health workers and the police to discuss common issues.

---

## FINDINGS: CLIENTS SPEAK

Seven clients of the service were interviewed. All were overwhelmingly positive about their experiences with the DV&MH worker. As noted earlier, this is not a random sample but provides an opportunity for some of those most vitally affected by the service, to provide input into the evaluation.

### **“Hard to put into words” ... an overwhelmingly positive experience**

It was difficult for some of the women to describe the particular aspects of the service that were the most helpful to them; rather they described the service and the worker on the whole as “just brilliant” and “on a rating of one to ten I would give Lynne a ten”. Some of the comments from women include:

*And what they did for me was – I can’t describe it. I can’t describe it. They say things are very, very bad – abusive, mentally abusive relationship. They were like knights in shining armour coming to the rescue so to speak. (Client 3)*

*They’ve just been – they saved my life ... I don’t know where I’d be if it hadn’t have been for Lynne and Jerry. Honestly. I really do not know. I’d hate to think actually. (Client 4)*

*I just can’t fault it. I really can’t ...The enormity of their task of what they actually do go above and beyond and I just think – to me that’s overwhelming but I just want people to realise that what they do is just brilliant. Like I can’t even put it into words. I don’t think words could suffice the greatness of what they actually do. And the service that they provide. (Client 1).*

### **Building trust ... making a different connection**

For the women, the *manner* in which the DV&MH worker engaged with them was as important as the types of assistance they received. Her approach encouraged trust and open communication. The women didn’t feel as though the worker was the



expert and they were the “poor victim” who needed help. Rather, they described experiencing an open and equal relationship with the worker. These responses are important as this is a client group which is often difficult to engage because of the abuses of power they have experienced, both in their relationships and in their interactions with service providers. This approach to women reflects the feminist philosophy informing the practice.

*She was really great. She was fun to talk to. She is – She’s like someone I can trust and talk to openly, even though I don’t know her so well, she’s just – she’s just welcomed me so well – she’s very open – open-minded person and I was able to communicate with her because I’m usually I’m not comfortable with people because ... for 10 years I’ve been abused. So I don’t feel comfortable talking to people and she made me feel welcome and talk to her openly and communicate what my problem was to her. (Client 4)*

Because of this connection, the women were more inclined to take on the information about domestic violence and its impact on mental health as they trusted the worker and were in a position to hear what she was telling them. They compared this to other experiences of seeking help, for example:

*She’s been my solid foundation where I never had one. And I know that I can comfort completely and that she’s got my best interests at heart ... with her I found a good bond between us and she was really open and, you know, talking about things and helping me. Yeah, come to the conclusions of that with my depression and anxiety and wot not, just how to deal with it. (Client 1)*

### **“Being listened to” ... the importance of validation**

Linked to the approach described above, the women described the power of the DV&MH worker really *listening* to them and *validating* past experiences. Being listened to, their experiences validated and believed, enabled the women to move along in their journey away from violence and forward in their recovery from mental illness/health concerns. They compared this experience of validation to previous experiences where health and other professionals didn’t believe or trust what the women had told them.

*Well, definitely the support and the listening and the caring and understanding and that that I was given. And, you know, I sort of felt a – like she was my friend, you know. I didn't feel like she was a professional person, if you know what I mean. Like she involved with me, as a professional person, but didn't – had a lot of compassion and a lot of understanding – not, you know, everything's black and white sort of thing. And she was helpful as she could possibly be (Client 2)*

*Often times you're lost for words. Often times you can't express the way you feel. You can't even tap into your feelings or your emotions. I have a history of post traumatic stress disorder. And I am numb a lot of the time. I don't feel very much at all. And having someone like Lynne who was just prepared to listen and reassure and at the same time affirm your position – it was very good ... And I know that I just felt assured and validated. (Client 6)*

### **An holistic approach – active, multi level advocacy**

The women commonly described the DV&MH worker as doing “everything” for them. The DV&MH worker acted as a guide and advocate for women as they negotiated the complex health and welfare system. This active involvement was crucial at a time when women were required to access and deal with complicated sectors such as the legal system, health, and government agencies. The women appreciated that the worker was able to assist them with a whole range of issues such as: finding accommodation, liaising with their mental health worker so things didn't fall through the gaps or get missed, the practical aspects of leaving an abusive partner (assisting with moving furniture, finding furniture for new accommodation, helping with pets), providing information about domestic violence (the cycle of violence, the impacts of violence on mental health), providing counselling, assisting with dealing with drug and alcohol issues, assistance with ADVOs, providing information about and referral to other appropriate services providers (for example to: victims compensation, solicitors, women's health, support groups).

*She's helped me out with a lot of things – like I had to move house and wot not. She was really excellent in helping me do that ... She helped me to settle in to my new*

*house and that. Yeah, I was, you know, I was ill for a while and she'd come in and see me and talk to me and that and she brought me some food sometimes and that. So she was really helpful. And it was good just to have that company there and someone to talk to, you know, and help you understand, you know, when I go through depression and wot not. It's been really good (Client 2)*

*Everything like from – like whatever difficulties I have emotionally and psychologically in doing, she helps with me. Because I have a medical condition and therefore she, as a result of my emotional breakdown, like experiences that like severe experiences that have occurred in my life. And so therefore the results of that have caused me in great depths of pain – like physical pain, emotional pain and psychological pain. And so therefore like she helps me and that – like we touch base on what needs to be improved and what still needs to be improved and what's currently improving. (Client 7)*

This model of service delivery – active, woman-centred advocacy – is required to engage, support and empower this client group. It is doubtful if other models (e.g. such as brokerage and referral) would offer sufficient intensity to assist the women to make such profound changes in their lives.

*So she – to be honest with you, I was just stuck surrounded in a large home with all this stuff and all these problems and myself being bashed and nightmares and everything. Just somebody coming to my life and just take it one step at a time and eventually, you know, like have me out of there and have me the refuge and have my stuff put in storage. You know, they arranged all that. Lynne. You know, that's a pretty big thing ... I just, even like today, I still stay in contact with them and go over to the Centre and that, you know, they're just a big part of my life that I'll never forget. You could never forget it. (Client 5)*

#### **Flexibility and availability – whatever needs to be done**

Women were impressed by the fact that the DV&MH worker was mostly available to them when they needed her and she had flexible arrangements about when and how she could

connect with clients. This was important to women who had experienced trauma and often needed support outside of scheduled visits/sessions.

*But yeah, I think anytime I need to talk to her, I can call her. She said 'anytime you need to talk to me'. 'Anything's wrong, just call me and I'll help talk to you and that'. So this is great (Client 2)*

*It's more like – like say I'm entitled to maybe 10 sessions with her – and they're over, she doesn't say 'I can't see you again' because from the start the relationship didn't start like that. It wasn't based on sessions. It was more based on a personal strength and stability and wellbeing (Client 7)*

### **Life-changing outcomes for women**

Women described the impacts of seeing the DV&MH worker as *life changing*. Women experienced changes on practical, emotional, and general health and well-being levels. All of the women interviewed had left the violence and the perpetrator and many reported improvements in their mental health. They attributed these changes to the DV&MH worker's understanding of mental illness/health concerns and the connection with domestic violence, and her ability to work with both issues.

*[My situation is] ... a lot, lot better. I think more so because I'm not using drugs. That helps. It just helps. I don't know, build my confidence, my self esteem – build – open my eyes up to what was going on with the domestic violence so helped me heal that and so then when I do get into violence – you know, situations or, you know, verbal situations, I know when to pull out and when to say things and when not to say things. Whereas before I was just like shout and say whatever I needed to say. And that sort of whatever. (Client 2)*

*Yes I am [away from the violence now] ... Oh definitely. Definitely [seeing Lynne helped]. She's saying, building me up and telling me – speaking to me, like clear and sensibly about things, without my emotions being involved and using rational and clear thinking (Client 1)*

Women also described feeling stronger, having the ability to cope with daily life which had at times in the past been difficult. Women also described now *understanding the link* between the abuse they had experienced and their mental and general health. They described having a clearer understanding of the cycle of violence and strategies in how to move away from the violence. Women described overcoming the lasting impacts of living with abuse, and moving forward in their life's journey.

*It just felt like I was – the whole world – I was on my – I was just one person against everything else, you know. I just felt so alone, and sometimes I would cry in the bathroom and since she came, she helped me feel stronger and know that 'look, you're in Australia, there's no need for all this and you need to like come out of it and relax and because now everything is going to be ok. Everything can only get better' ... she helped me feel different, like she helped me feel like I'm a woman. I should be respected. I shouldn't be abused and I should be able to a free woman because in Australia I am a free woman and I can do whatever I want to do, instead of being under someone else's control constantly. (Client 4)*

*And from where I've come from when I met Lynne to where I am now, I can honestly say that I've realised that things that meant the most to me, and I've got them here with me now, and I'm in a two bedroom Housing Commission unit. I've had to sacrifice a lot but I think I had to do that no matter which way I would have went, but it was the way – how it was done is what mattered because the way she helped me everything that they've done for me. It's been a – you know, all of them there – Lynne, the whole lot. They've just been – they saved my life. (Client 5)*

*I'm in like a stronger like mind frame, where that's concerned – where I'm not going to move because I'm thinking 'well why should I – if I move now, and if he finds me again, I'm going to be moving forever aren't I? ... And that's the one thing that sort of – you know, this time I am in control. You know what I mean? (Client 5)*

In addition, some women described practical changes such as now having their own place to live or going back to tertiary study.

### **Continuation of the service**

All women felt the position was vital and that they wouldn't have gotten to the point in life (feeling well and away from violence) without the DV&MH worker. All wanted the position to stay in the area to help other women in the future. None identified any negative aspects of the service and struggled to think of any improvements to suggest. One woman suggested that the service add a support group run for women who had experienced both violence and mental health concerns/illness.

*It needs to happen. I don't know how to stress that more. I strongly - it needs to happen. There needs to be more funding. The position needs to be kept and nurtured. And valued. I know that the clients value the service – but it needs to be valued by those who do the funding as well ... There would be more suicide attempts. There would be more suicide within the community than what there already is. There would be people taking up beds at hospitals. That really, all they need is someone to listen to them and get encouragement and support. (Client 6)*

*Well I definitely think the service should – it should be kept going because it's invaluable. It is totally invaluable. The people like myself and 100s of other women because without them what would we do? Like if I didn't have them to help me the way that they helped me, I don't know where I'd be now ... I want the service to continue, not just for myself but for other women and I just want people to understand the enormity of the parts they perform beyond what their role actually are. Like I don't think in job description is says 'rescue women from [country town] with a truck and helpers'. You know what I mean? (Client 1)*

---

## FINDINGS: SERVICE PROVIDERS

### SETTING THE SCENE: BARRIERS FACED BY WOMEN WHO EXPERIENCE BOTH DOMESTIC VIOLENCE AND MENTAL HEALTH CONCERNS/ILLNESS

Practitioners from both sectors identified the following barriers facing women who experienced domestic violence and mental health issues.

#### **The mental health concern/illness is the focus – the domestic violence is ignored**

Confirming a finding of the *Towards Better Practice* research, service providers said that the mental illness/health concern was invariably the main focus of intervention by not only mental health workers but by others such as police, DoCS and other non-government organisations. The domestic violence tends to be ignored as well as the impact on women's mental health.

*But once someone has a "mental health issue" then all the rest of their experience becomes secondary. So no one asks about the DV no one I guess acknowledges the impacts of the DV. They become focused on say let's fix the depression or this woman has "borderline personality disorder" so we need to do this, this and this. The DV gets lost there... (Domestic Violence Worker).*

*So unless it (the DV) is glaringly obvious it may not be explored with that person especially if they are acutely unwell (Mental Health Worker).*

*The domestic violence may not be touched on at all by mental health services which is fairly significant in terms of what happens next for her, in terms of being re-traumatised, in terms of her recovery from the mental health issue, in terms of any potential to move through the domestic violence is hugely inhibited (Domestic Violence Worker).*

### **Mental health concerns/illness used as a weapon or further form of control by the perpetrator**

Where the perpetrator uses the illness as a weapon against the woman, the abuse and control over the woman and children are exacerbated.

*He brought her in here not because she was ill but because her husband wanted to take the kids off her and the only way he could do that was by somehow getting her to take on that sick role (Mental Health Worker).*

### **Women with a mental health concern/illness are reluctant to use services**

Either through past negative experiences, stigma and judgements which were made about them previously or through fear of losing their children, practitioners described that women were often afraid to approach services for help. This often resulted in their mental health concern or illness becoming more severe or it left them in unsafe situations as they continued to stay with the abusive partner.

*Women who have been diagnosed with mental illness over time become reluctant to approach services. Particularly women who have children. They become afraid of being hospitalised again or seen as crazy, afraid of DoCS involvement, afraid of a whole range of things which means they are less likely to seek help (Domestic Violence Worker).*

### **Violence is hidden and difficult to identify**

The mental health practitioners described the difficulties they experienced in identifying domestic violence as an underlying cause of a woman's mental health concern/illness. A woman's response to trauma and abuse can often appear as symptoms of mental illness which is more easily framed within a medical model.

*I think one of the biggest issues we have is just trying to separate what is mental illness and what is a normal*



*reaction for the person being beaten up by the husband  
(Mental Health Worker).*

### **The issues are complex**

All workers acknowledged that women who experienced domestic violence and mental health concern/illness, often faced a number of other issues which made their lives incredibly difficult and complex. Women whom the practitioners talked about often also dealt with drug and alcohol, child protection, housing, and other health issues. This often meant that women had to deal with a number of different services who mostly worked in silos.

*They have got issues around their own psychological ill health, often physical ill health. Let's not forget that the two come together. So if you are not feeling well, you are not eating or sleeping properly. The body goes down. They have got social issues around housing, finances, children, grief, safety, physical injuries. So it is a whole multitude of issues (Domestic Violence Worker).*

## **THE IMPACT OF THE DOMESTIC VIOLENCE MENTAL HEALTH (DV&MH) POSITION**

All but one of the practitioners who were interviewed were overwhelmingly positive about the new position and the enormous impact that it has so far had on: service delivery for women experiencing domestic violence and mental health concerns/illness, improving understanding about the link between violence and mental health, improving collaboration between the two sectors, and bridging the gap so that women are less likely to fall between the two service sectors. The following describes the most significant impacts of the position.

### **Increased understanding of the impact of domestic violence on mental health and how to respond to women who have experienced both**

Because of the DVMH position, many workers across the two sectors (mental health and domestic violence), as well as a number of NGOs and government organisations (including the police, Centrelink and various community service providers) have developed an understanding of the impact of domestic violence on a woman's mental health and in turn are able to work more effectively with these women. One of the major issues that

practitioners described for these women was that the domestic violence often went unrecognised and the mental health concerns/illness were the only focus of intervention – never really addressing the underlying cause of the illness for women. Through training, education, and informal advice to service providers, the DVMH position has begun to shift the current thinking around these issues. This in turn has led to better outcomes for women.

*Because everything is so pathologised in here, having someone come in from the outside to say you know perhaps this girl has not got a disorder but she is having a normal reaction to the circumstances ... she (DVMH worker) makes it more balanced as well and having someone who specialises in domestic violence rather than psychiatry at least you have that balance there (Mental Health Worker).*

*It is massive and I have actually been surprised– I had a woman who presented here with high level anxiety and a number of issues that clearly were to a certain extent mental health issues that had been around a long time. When I spoke to someone at the hospital and told her there were mental health issues but she was also living with violence, they seemed to be able to hear that whereas often in the past they haven't been able to hear that (Domestic Violence Worker).*

*... I think people are ... getting a better understanding, that like not just saying there is this mentally unwell woman living in domestic violence but you know those things come together. The mental health is impacted, greatly affected because of the violence (Domestic Violence Worker).*

### **A conduit between the two disparate sectors**

Many workers saw the DVMH worker as a conduit between the two very distinct and often separate service sectors. The two sectors had in the past had very limited communication, understanding of how each system worked in a practical sense, and of the philosophical understanding from which they approached their client intervention (TBP research, 2009). The DVMH worker was seen as someone who bridged that gap, providing information and

advice to both sectors about the other. This also had a positive impact for women who had in the past tried to negotiate the two systems themselves.

*I see Lynne's role as the bridge between mental health and domestic violence - she's the face. And that way, you know, we've asked her to support them for clients who have domestic violence issues and mental health issues. And they're there to support when it's a mental health issue but there's some domestic violence in there too. So we can support them and they can support us. And Lynne is like the bridge between the two (Mental Health Worker).*

*The connections that Lynne has made in there (mental health service) and the fact that she is visible within that unit, and visible within that sort of area of Health, makes it so much easier for us to pop in ... to have someone who knows someone, just makes 10 million times difference. And it's hard because now – at least we know now. Right, if I've got a problem with an area, then I can ring, you know, this person or this person or this person and say which area should I go to do? Who should I talk to about this? Now we have contacts because of this research and Lynne's role and she's making more and more contacts, we're able to actually contact these people as well. So if I've got a client with an issue, what do you think I should do? So that's probably our biggest – I have found the biggest difference... So before I wouldn't have even known where to go – where do I go? What do I do? You know, how do I complain about this person? And now it's easier. She's opened those doors for us (Domestic Violence Worker).*

### **Someone to call on**

As the connection between violence, abuse and mental health becomes clear and is acknowledged, practitioners are developing new practices as they attempt to address both these issues with women. Some workers described that they felt inadequate or didn't have the appropriate skills to work with women facing these issues. These workers saw the DVMH worker as someone to “call on”, someone who could provide advice and information, and

discuss appropriate ways of working with women. The DVMH worker also played an advocacy role within the context of both the mental health and domestic violence service sector.

*She has been a good source of information as well and I think she is somebody who, well she is almost like a lifeline out of this mental health facility (Mental Health Worker).*

*I try to do it (work with the domestic violence issues) but having Lynne there or somebody from that service, they can come in and support me to do my work and support the client. It is great for everybody (Mental Health Worker).*

*I feel that a lot of services who are experienced in domestic violence or mental health now feel it is someone they can call on. To stop that confusion. You know here is a worker that can help them with the situation. So they can be less likely to put someone in the mental health basket when there is domestic violence issues (Domestic Violence Worker).*

### **Improved collaboration between the sectors**

The DVMH position was developed from the *Towards Better Practice* research whose aim was to improve collaboration between the mental health and domestic violence sectors. It was anticipated that once the research team had completed their work in the local area, the TBP steering committee that developed as part of the action research, would continue with the efforts to improve collaboration. The difficulty with this was that the process needed a driver. The DVMH worker has filled that position and continues to support the steering committee and the collaborative efforts it works on.

*I think the project is having an influence and is a flow-on from the TBP research and what we were already doing with the committee ... often you get to the end of a piece of research and even if it has been a very active and proactive piece of research like this, it has got nowhere to go and so it was a really logical step to get a worker in that*

*position you know. We always wanted that and it happened. It was timely and a natural flow on. Here is the stuff we have been talking about, here is the stuff we have been working on. Now we are going to take it to the next step. We will have a worker on the ground and see how it goes and it has been going very well and I think it has had a really positive impact. We have done all this work, all this groundwork and I think having had the research and the establishment of the steering committee over a long period of time has been good grounding for it. I think it kept that core group of people together and there is an interest there. I guess it has created something very workable. Her role is pivotal (Domestic Violence Worker).*

### **Improving education and training**

Practitioners discussed the importance and the effectiveness of the training that the DVMH position delivers. Picking up on training that began with the TBP steering committee, the DVMH worker placed training and providing information high on her agenda. Not only did she co-ordinate a number of information and education sessions with mental health staff, she also attended a number of interagency forums and meetings with service providers outside of the two sectors. Most notably, the training with police around responding to women who experience mental health concerns and domestic violence was seen as an outstanding achievement.

*Well the feedback has been really positive about all the training. We have had a lot of people who want to attend it. We have had great enquiries about it. So I think people are valuing it and seeing it as important. I think we could almost make the role just go out there and do training. I think that would fill up a full-time position, just the training. So it has been very positive. A very positive response to it which means people are getting something out of it, they are wanting more of it (Domestic Violence Worker).*

Practitioners also described the informal information and advice that the DVMH worker provided around particular clients as vital.

*I ask her what she does and how she does it. Just tapping into her experience and asking her what she goes through in her job so that I know (Mental Health Worker).*

*So that reduces the fear... Because people are frightened about mental health and they are frightened. I think they are frightened that they will do something wrong, that they will go around a little bit because I think people think if they say the wrong thing they could adversely affect her mental health and have a terrible outcome. But if they know there are actually real and practical things you can do and ways to work with women and you have a better understanding of mental health and some of the behaviours that go with that, it makes a better way of working, well working with that person much more possible when there is that clarity around it (Domestic Violence Worker).*

### **Improving service delivery for women experiencing domestic violence and mental illness**

Service providers recognised that in the past women who experienced domestic violence and mental health concern/illness often fell through the gaps of service provision, particularly when the domestic violence went unrecognised. Through education and training, working collaboratively with services, and providing a link between the two service sectors, the DVMH position has begun to address this service delivery gap.

*It is, until we had it (the position) I think we didn't realise how necessary it was you know what I mean. Having her around and having that service around I think it has made a big difference to the health and mental health of our clients. So it is great to have her around (Mental Health Worker).*

*I think there are very positive and significant impacts for women experienced domestic violence and mental health issues not being more marginalised. I know at least 2*

*situations that I have been involved with on the periphery where Lynne has been able to advocate for someone to ensure that the violence was dealt with. To the mental health service and the police. On both occasions and I have seen that directly. Indirectly I think it is a hugely important position and continues to be (Domestic Violence Worker).*

### **The model of intervention**

The way in which the DVMH worker responded to women was highly praised by the practitioners interviewed. There were a number of features of the way that the DVMH worker engaged with women that resulted in positive and often longstanding changes around both the domestic violence and the woman's mental health.

### ***A holistic approach***

*I really think enormous (positive impacts for women) and for me I think a lot of it is to do with the fact that she is focusing on that holistic model. This is not about seeing a woman once a week for an hour. It is far greater than that. It is about really helping and supporting that woman get from a to b and she is not going to be able to do that without that support (Domestic Violence Worker).*

### ***Flexibility***

*They ask them (the women) what they really needed. And what sort of support they can link and then they did the counselling work, the experience – because sometimes they don't want to talk about it ... she feels like at anytime she can go. Lynne's very flexible. She can ring up and Lynne will arrange an opportunity – you can an option to chose where you can go – like you can come to the office or she can come to you or see outside – it's really, really good. (NGO worker)*

### **Individual casework**

*We have had, for example a fairly complex client who was in the refuge. She left and returned to the perpetrator and the caseworker from the refuge organised for Lynne to do follow up casework with her. Within a week she actually left him again. She was re-housed and she has no intentions, I don't think, to return. So they are the results that you can just tick off (Domestic Violence Worker).*

### **Advocacy**

*We had a couple of case conferences just in regards to accommodation and in terms of discharge – who would be following her up, what they would be doing and Lynne was pivotal in that because she was the only one who specialised in domestic violence. So having her come around and provide education and just continual support of the person and keeping them in the loop of what is happening (Mental Health Worker).*

*Her being here consistently presents, well the patient that we had recently and Lynne worked with another worker ...and Lynne went with the client to the magistrate just as a support person. And I think having the presence there, particularly a woman, makes it easier for the patient to go through the experience (Mental Health Worker).*

### **Working from a feminist framework – listening to and respecting women**

*Women feeling that they are respected and that you accept them as women – not a case, not a number or a client – as women. Good feminist framework (Domestic Violence Worker).*

*I think that, for women, just having us being able to actually to just even get in there (to the mental health*



*system) to be able to be heard. And support women in what's going on and be able to provide a different perspective for workers, has been unbelievable for the women that we've helped. Made a big difference. Definitely. Because otherwise, you know, nothing changes for them (Domestic Violence Worker).*

### **The expertise and compassion of the incumbent**

All of the practitioners we interviewed had the utmost respect and admiration for Lynne Jennings who holds the DV/MH position. All commented on her compassion, commitment to ending violence against women and her clients, her relaxed manner (which made it easy to contact her and ask her questions), her strength in working between two disparate systems, her energy, and the fact that she really cares for the women she works with.

*She would be involved consistently and in my experience she has been really consistent with what she has been doing. She has been really supportive, whenever she has a chance she comes in and visits patients as well and just I guess keeping me updated as well if there are any upcoming projects and services as well (Mental Health Worker).*

*That we know her that she is keen and passionate about what she is doing and that she is informative and knowledgeable (Mental Health Worker).*

*That she is accessible. That we know her that she is keen and passionate about what she is doing and that she is informative and knowledgeable (Mental health worker).*

The location of the DV/MH position within a well established domestic violence service and the recruitment to the position of a very experienced and skilled practitioner has firmly established this new position which is highly valued by both the mental health and domestic violence sectors, and whose influence has impacted other agencies, such as the police.

---

# DISCUSSION & CONCLUSIONS

## OUTCOMES FOR WOMEN

- The DV&MH service provides practical support, therapeutic interventions and advocacy for a vulnerable group of women with complex needs who, almost certainly in the past, would have “fallen through the gaps” of service provision between the mental health and domestic violence service sectors.
- The service has connected with hard to reach clients – women experiencing complex domestic violence and mental health concerns, younger women, Aboriginal women, and women from a culturally and linguistically diverse backgrounds.
- The DV&MH service has created connections with the mental health sector which has allowed identification and easy referral of women in a mental health setting who were experiencing domestic violence. Often, the detected violence had been the underlying cause of the mental health concern or illness. By addressing the violence, the mental health concerns were often alleviated.
- The impact of the work of the service on women’s mental health and their journey away from domestic violence is profound. All of the women interviewed had left the domestic violence and all reported an improvement in their mental health.
- The holistic and feminist approach of the DV&MH worker allowed a connection and trusting relationship to develop between the DV&MH worker and her clients. This in turn led to improved outcomes for the women as they listened to and trusted advice the DV&MH worker provided them with.
- Women’s experiences of violence and mental ill-health were listened to and validated by the worker which also enhanced the trusting relationship. Often women had never had this type of validation from a service provider which went a long way to improve their self-esteem, confidence, and health and well-being.
- The service model provided the type of assistance that women interviewed in the original TBP research identified as essential. It is also consistent with best practice identified in international research (Stenius & Veysey, 2005).

## OUTCOMES THAT ENHANCED CROSS SECTOR COLLABORATION

- The expertise of the DV/MH worker is highly regarded by service providers in both sectors and the consultation offered is both accessible and highly valued;
- The activities of the DV&MH worker have improved mental health service providers' understanding of the impact of domestic violence on women's mental health; their ability to identify underlying domestic violence in clients of mental health services; and promoted better practice with women who experience the complex interaction of both issues.
- In addition to direct work with women, improving collaborative initiatives across sectors has remained a central aspect of the DV/MH role through training, networking and consultation.
- In summary, the DV&MH role has proved an effective way to "bridge the gap" between the mental health and domestic violence sectors in the Liverpool area through a combination of collaborative initiatives and direct practice.
- The model of service is consistent with evidence-based practice with co-occurring mental health and domestic violence: it is an example of integrated, "trauma informed" service provision (Markoff, et al., 2005). It is an innovative model of service provision that can inform service delivery across the health system, beyond the Liverpool area.

---

# APPENDIX 1

Table 3: **Number and type of occasions of service.**

	<b>Brief occasion of service (up to 15 mins) eg quick phone call</b>	<b>Mid-level occasion of service (up to an hour)</b>	<b>Long occasion of service (over an hour with the client – up to three hours)</b>	<b>Total</b>
<b>Advocacy</b>	72	37	38	147
<b>Crisis and practical counselling</b>	81	64	116	261
<b>Practical support</b>	2	21	78	101
<b>Brokerage</b>	5	10	1	16
<b>Court Support</b>	0	0	22	22
<b>Referral</b>	39	15	0	54
<b>Collaboration with another service (eg: information exchange)</b>	72	32	8	112
<b>Connecting with Community</b>	4	8	10	22
<b>Total</b>	275	187	273	735

---

## APPENDIX 2

### KEY INFORMANT INTERVIEW QUESTION SCHEDULE

- Can you tell me about the nature of contact that you have, if any, with women who have experienced domestic violence and mental health concerns/illness?
- From your perspective, what are the main problems or issues you and/or your agency/department face in dealing with women who have experienced both domestic violence and mental illness/health concerns? Why is that?
- How did you first hear about the domestic violence and mental health service at JHSSW?
- What is your understanding of why the domestic violence and mental health service was put in place and what it is aiming to do?
- What, if any, *expectations* do you have about what the DV/MH Service will achieve? Why is that?
- What impact, if any, has the DV/MH service had on the service response to women experiencing domestic violence and mental health concerns/illness?
- Have you seen any positive or significant outcomes or changes for these women?
- What impact, if any, do you think the DV/MH Service has had on *interagency* collaboration and cooperation?
- What impact, if any, do you think the service has had on education and training around domestic violence and mental health issues?
- What aspects of the program seem to be progressing or working particularly well? Why is that?
- What aspects seem to be progressing more slowly or working less well? Why is that?
- What suggestions do you have as to how this should be addressed in the short-term? In the longer term?
- Finally, are there any other comments/suggestions you would like to make in relation to the DV/MH Service or its development to date?

Note: These questions have been developed, based on the evaluation of the ACT Family Violence Intervention Project (Keys Young, 2000, pp. 90-91).

---

## APPENDIX 3

### INTERVIEW GUIDE: WOMEN

#### PREAMBLE

Thank you for agreeing to be interviewed today. As you know, I am interested in hearing about your experiences of the domestic violence/mental health worker here at Joan Harrison Support Services for Women (JHSSW). There are no right or wrong answers in this — it's all about what *you* think or feel. However, if you do not want to answer some of the questions I ask you, that's fine — just let me know. From time to time I'll check with you about how you are finding the interview.

1. Can you tell me about how you came to be in contact with the JHSSW Domestic Violence and Mental Health worker? And about what kind of involvement you have had with the service? (Explore how the participant was informed about the service, referral processes, type and length of contact)
2. What was it like for you approaching the service for the first time? Did you have any particular hopes or fears about what would happen when you made contact? How did these go?
3. What, if anything, was helpful about the contact you had with the service?
4. What, if anything, could have gone better or been more helpful to you about your contact with the service?
5. Did the service refer you to any other agencies/people? How did that work out (for each agency) for you?
6. I don't need to know in a great amount of detail, just as much as you are comfortable discussing, can you tell me about how your situation of domestic violence is now, compared to when you first had contact with the service?
7. Likewise, are you able to tell me how your mental health is compared to when you first had contact with the service?
8. Now a few questions about your living situation. Are you still with your partner/husband etc? Do you have children living with you? How old are they?
9. Finally are there any other comments you would like to make about your experiences of the service?
10. How has it been for you today doing this interview?

Thank you very much for giving your time today.

## REFERENCES

- Astbury, J., & Cabral, M. (2000). Women's Mental Health: An Evidence Based Review Retrieved 16/07/2006, from [http://www.who.int/mental\\_health/media/en/67.pdf](http://www.who.int/mental_health/media/en/67.pdf)
- Campbell, J., Jones, A., S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., et al. (2002). Intimate Partner Violence and Physical Health Consequences. *Archives of Internal Medicine*, 162(10), 1157-1163.
- Chung, D., Kennedy, R., O'Brien, B., Wendt, S., & Cody, S. (2000). *Home safe home: the link between domestic and family violence and women's homelessness*. Canberra: Commonwealth of Australia.
- Edwards, R. (2004). *Staying home leaving violence: promoting choices for women leaving abusive partners*. Sydney: Australian Domestic and Family Violence Clearinghouse
- Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: a meta analysis. *Journal of Family Violence*, 14(2), 99-132.
- Gondolf, E. W. (1998). *Assessing Woman Battering in Mental Health Services*. Thousand Oaks, California: Sage Publications.
- Keys Young (2000). *Evaluation of ACT Interagency Family Violence Intervention Program: Final Report*. Canberra, ACT ACT Department of Justice and Community Safety.
- Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A., & Lozano, R. (2002). *World report on violence and health*. Geneva: World Health Organization.
- Markoff, L. S., Finkelstein, N., Kammerer, N., Kreiner, P., & Prost, C. A. (2005). Relational Systems Model: Implementing a Model of Change in Integrating Services for Women with Substance Abuse and Mental Health Disorders and Histories of Trauma. *Journal of Behavioral Health Services & Research*, 32(2), 227-240.
- Mertin, P., & Mohr, P. (2000). Incidence and Correlates of Posttraumatic Stress Disorder in Australian Victims of Domestic Violence. *Journal of Family Violence*, 15(4), 411-422.
- Roberts, G. L., Lawrence, J. M., & Williams, G. M. (1998). The impact of domestic violence on women's mental health. *Australian and New Zealand Journal of Public Health*, 22(7), 796-801.
- Stenius, V. M. K., & Veysey, B. M. (2005). "It's the Little Things" Women, Trauma, and Strategies for Healing. *Journal of Interpersonal Violence*, 20(10), 1155-1174.
- Taft, A. (2003). Promoting Women's Mental Health: The challenges of intimate/domestic violence against women. *Issues Paper* Retrieved 19 October, 2006, from [http://www.austdvclearinghouse.unsw.edu.au/PDF%20files/Issues\\_Paper\\_8.pdf](http://www.austdvclearinghouse.unsw.edu.au/PDF%20files/Issues_Paper_8.pdf)
- VicHealth (2004). *The health costs of violence: measuring the burden of disease caused by intimate partner violence: a summary of findings*. Carlton South, Melbourne: Victorian Health Promotion Foundation.
- Vos, T., Astbury, J., Piers, L. S., Magnus, A., Heenan, M., Stanley, L., et al. (2006). Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. *Bulletin of the World Health Organisation*, 84(9), 739-744.