Abuse and mental health policy: a (dis) connection?

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Abstract

Family violence and sexual abuse are serious issues for people with mental illness. The literature on abuse and mental illness provides evidence about the prevalence of abuse in the lives of those with mental illness and the connection between abuse and the development of mental illness.

Mental health policy ought to direct mental health services as how to prevent (further) abuse, and how to ensure sensitive approaches to detecting and responding to the abuse histories of mental health clients.

This research project investigates the level of policy guidance on abuse for mental health services. The study followed a qualitative research framework, integrating the Australian Policy Cycle developed by Bridgman and Davis (Bridgman & Davis, 2004) as a framework for the investigation of mental health policy. Two studies were undertaken: Study one, conducted a document analysis of mental health policies, with the sample comprising all available mental health policy from both the Commonwealth and Victorian Governments, as well as specific policies on abuse for mental health services. Utilising content analysis, the researcher developed a coding system and analysed those policies that include references to 'abuse'. For Study two key stakeholders in NSW and Victoria were interviewed. The researcher developed two interview schedules in accordance with findings from Study one, which found different levels of policy in those two states.

The results of this research are consistent with the Australian Policy Cycle. The findings on drivers and barriers were consistent with the stages of 'agenda setting' and 'implementation' proposed by this approach.

The study found a lack of policy guidance for mental health services in Victoria. In contrast the NSW state government provided clear guidance and expectations of how to work with clients with abuse histories. Its marked lack of policy direction has left Victoria without a statewide strategy and out of step with international developments. Lack of policy guidance leaves it up to individual mental health services or individual staff to find ways to address abuse issues within mental health care provision.

The thesis concludes with a discussion of its limitations and makes suggestions for future studies which could focus on the impact of policy variations on consumers, and/or the degree of difference these variations have had on mental health clinical

care. To conduct a comprehensive analysis of success and failure of such policies, a thorough evaluation of the NSW experience could be undertaken.

The thesis concludes with recommendations about policy development and implementation needed in Victoria, if the Victorian state government were to seriously engage with addressing the abuse issues of those with mental illness. Building on the experience from NSW, Victoria could develop policy for mental health services that addresses both sexual assault and family violence in a coordinated way. The associated implementation process could be linked to existing training bodies; and the evaluation strategy could ascertain the level of change and quality of service delivered to those members of society often deemed as 'most vulnerable'.

Such coordination in order to prevent and remediate abuse would not only provide those with mental illness who have abuse histories with high quality support, but would facilitate the implementation of mental health care in accordance with a population health framework, and would include mental health promotion and prevention—as has been advocated throughout Australia and internationally.

Statement of authorship

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis for any other degree of diploma.

No other person's work has been used without due acknowledgement in the main text for the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

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Conference papers and publications arising from thesis

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Abuse and mental illness—changing perceptions, changing practice. The Mental Health Services Conference, Auckland, New Zealand 2008.

NAMHS partnership project (poster presentation). 3rd International congress on women's mental health, Melbourne, 2008.

Safety for women in psychiatric inpatient units. Workshop (co-) panellist. 3rd International congress on women's mental health, Melbourne, 2008.

Family Violence and Mental Illness. Advanced professional development series, DVIRC, Melbourne 2007. Co-facilitator.

Abuse and mental health policy: a (dis) connection? La Trobe University, Faculty of Health Sciences, Research Festival, 2007.

NAMHS partnership project. Western cluster conference, Melbourne, 2007.

Bringing it all together. Cross-sector partnerships addressing mental health and abuse issues. TheMHS Conference, Melbourne 2007.

NWMH sexual abuse policy and guidelines. Implications for clinical practice. Clinical forum, NAMHS, Melbourne 2007.

Sexual abuse and mental illness, implications for practice. NWMH sexual abuse policy & guidelines launch, Melbourne 2007.

Family violence and mental illness, Clinical forum, NAMHS, Melbourne 2007.

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NAMHS partnership project plan 2005–2008. Northern Area Mental Health Service, 2005.

Cross-sector collaborations. Considerations to working across mental health, family violence & sexual assault services. 5th Australian Women's Health Conference, Melbourne, 2005.

Abbreviations

ABS	Australian Bureau of Statistics
BPD	Borderline Personality Disorder
CASA	Centre Against Sexual Assault
CNC	Clinical nurse consultant
CSA	Child sexual abuse/assault
DV	Domestic violence
DVIRC	Domestic Violence Incest Resource Centre
ECAV	Education Centre Against Violence
FV	Family violence
GTA	Gestalt Therapy Australia
HREOC	Human Rights and Equal Opportunity Commission
IPV	Intimate Partner Violence
NAMHS	Northern Area Mental Health Service
NGO	Non-government organisation
NHMRC	National Health and Medical Research Council
NSW	New South Wales
NWMH	NorthWestern Mental Health
PND	Post Natal Depression
PTSD	Post Traumatic Stress Disorder
SA	Sexual abuse/assault
TheMHS Conference	The Mental Health Services Conference
UN	United Nations
VMIAC	Victorian Mental Illness Awareness Council
WA	Western Australia
WHO	World Health Organisation

Chapter 1: Introduction

While rates of abuse for both family violence and sexual abuse are high in the general population, prevalence rates within the population of those with a diagnosed mental illness are even higher. Even those who maintain a purely biological view of mental illness and its origins cannot but recognise that prevalence rates alone are indicative of a need to provide mental health services that at least demonstrate sensitivity about the impact of such abuse on someone's mental health and their life overall.

Mental health services in Australia and elsewhere are guided by policy provided by state and federal governments—which have a mandate to provide the best possible care for those with mental illness, according to the latest research evidence and best practice guidance. Mental health policy in Australia and the State of Victoria (where this research was conducted) is relatively new, with the first policies being developed in the early 1990s. Nevertheless, it could be expected that Australian states and the Commonwealth would address issues of abuse within their policies on mental health care in a coordinated way, as has occurred with other issues—thereby providing guidance for those managing mental health services and those providing mental health care to some of the most vulnerable members of society.

This thesis investigates the factors that influence the development of policy that aims to prevent and reduce the impact of violence and sexual abuse on mental illness. It focuses on the development of policy responses for mental health services in Victoria during the period 1992 to 2006. The development of national mental health policy began in 1992, following the Eisen-Wolfenden Report of 1988 to the federal government on mental health services policy (Meadows, Singh, & Grigg, 2007). Furthermore the UN Declaration on the Principles of Human Rights (United Nations, 1991) and the National Inquiry into Human Rights of People with Mental Illness undertaken in 1992 in Australia (Human Rights and Equal Opportunity Commission, 1993c) contributed towards the national mental health policy development. The present study seeks to explore the extent to which policy development for the prevention and reduction of the impact of violence and abuse on mental illness in Victoria is consistent with policy development and implementation in other jurisdictions. The analysis of policy, with a particular focus on 'agenda setting' and 'implementation' is based on the Australian Policy Cycle developed by Bridgman and Davis, a staged approach to conceptualising the steps involved in policy formation and operationalisation.

The rationale for this study is anchored in a number of factors; these include

- evidence about the prevalence rates of abuse within the lives of those diagnosed with mental illness
- evidence about the link between abuse and the development of mental health problems/illness
- evidence about the implications for those with abuse histories who access mental health services and for the mental health services they access
- the fact that governments direct mental health services about their service provision and service conceptualisation through policy
- the fact that an issue has to be identified as such and has to make it onto the policy agenda if policy is going to be developed
- the fact that mental health services are required to provide the best possible care for those most vulnerable members of the community who access public mental health care
- the fact that mental health policy in Australia and Australian states is based on a number of inquiries which have provided evidence about the needs of people with mental illness, including their human rights
- the move from custodial care to a community-based approach to mental health care
- the challenges and tensions that psychiatry experiences between its historical orientation of a medical approach to mental health care and the (more recent) move towards a 'bio-psycho-social' framework of mental health care .

Research studies over the past twenty years provide evidence about the prevalence of sexual abuse and family violence in the population of people with mental illness, as well as the link between abuse and mental illness. While the primary focus of research studies investigating this link between abuse and mental ill-health has been on childhood sexual abuse and the link to developing mental illness, some research has also been undertaken with those who experience psychotic disorders, as well as investigating the mental health impact of family violence.

People diagnosed with a mental illness—especially women—show higher rates of abuse histories than those of the general population, come into contact with mental health services earlier, and utilise psychiatric crisis services more frequently than those without such histories. Additionally, those who have experienced abuse during childhood are at greater risk of experiencing abuse during adulthood—compared to those without such an experience. Those with a diagnosed mental illness—and again especially women—are also more vulnerable to being (re-) abused. People with

mental illness who have a history of childhood and/or adulthood abuse constitute a *majority* rather than a *minority* of public mental health clients. This, in combination with the fact that those with mental illness have high levels of abuse histories; with the heightened vulnerability of those who have experienced childhood abuse; and with the heightened vulnerability of those diagnosed with a mental illness puts those with mental illness and a history of abuse at particularly high risk of revictimisation.

A number of developments relevant to the issue of abuse and mental illness have occurred concurrently. They include the move from custodial care to that of care within the community; and policy changes that broaden the approach to mental health care, increasingly focussing on the human rights of people with mental illness. Furthermore policies and legislative frameworks address abuse, including (child) sexual abuse and family violence in general.

Internationally, work has been undertaken to redress the mental health impact of abuse and to provide safe(r) environments to prevent such abuse occurring. Within Australia, however, it appears that policy development (and implementation) has not been coordinated either through the Commonwealth or state governments. To date there is a dearth of research into policy development and its implementation (including effectiveness in reducing the impact of violence and increasing safety) in this area for mental health services. This study aims to investigate the reasons for policy development and reasons for lack of policy development (and its implementation) in this area. Keeping all of these factors in mind, the broad research questions for this research project are the following:

◊ Are there differences in the extent to which abuse and violence issues are included in mental health policy in different Australian jurisdictions?

◊ What factors have enabled or hindered the development of policy guidelines for the prevention and remediation of violence and abuse for people with a mental illness?

◊ What factors have enabled or hindered the implementation of strategies to prevent and remediate violence and abuse for people with a mental illness?

To explore these questions and associated issues the ‘Australian Policy Cycle’ (Bridgman & Davis, 2004) is utilised as the framework—in particular the stages of agenda setting and implementation and for the development of the research questions. Notwithstanding the contested nature of policy, mental health services are guided by policies developed by—predominately—state governments and to a lesser degree by the Commonwealth.

In summary, this research project aims to investigate the level of policy development for the guidance of mental health services, and what has led to the different level of policy guidance in the area of sexual abuse and family violence in NSW as opposed to Victoria. The researcher hypothesises that a number of 'drivers' (people and/or issues) have contributed to setting the policy agenda in NSW; and a lack of drivers, or the existence of barriers to policy development, have prevented a greater degree of development of such policy in Victoria. It was furthermore suspected that implementation of policies varies between the two states, with NSW's data gathering on one of the policies, providing evidence about implementation throughout parts of the state. While in Victoria it appeared that little or no implementation of relevant policies has occurred. It was envisaged that knowledge gained through a comparison between those two states could contribute towards policy development and implementation in Victoria—in particular as this type of research has not been previously undertaken.

To undertake this study a qualitative research methodology was developed and two studies were undertaken. Initially the researcher undertook a literature review; a review of mental health services development in Australian and Victoria and the development of mental health policy. Having finalised these steps, a research methodology for study one, inclusive of data gathering and analysis methods was developed. To undertake study one, the researcher undertook a document analysis of mental health policy in Victoria and Australia, as well as policy documents of other Australian states which specifically attend to family/domestic violence or sexual abuse for mental health services. Following the findings of study one which demonstrates marked differences between NSW and Victoria, study two was developed, in order to answer the remaining research questions. A comparative study (undertaken in two parts) was conducted in study two. Key informants in NSW and Victoria were asked about their perceptions and knowledge of the development (or lack of) and implementation of such policies.

The thesis is divided into eight chapters, and these will be discussed briefly. This chapter provides an introduction to the area of research and an outline of the thesis.

Chapter 2, the literature review, provides a review of the terminology relevant to this thesis, spanning the areas of mental health/illness, domestic/family violence and sexual abuse. This is followed by an overview of the epidemiology of mental illness and abuse and more specifically abuse and mental illness. A section on the burden of disease arising from abuse provides information on the economic cost of violence, including the (mental) health costs of violence. The chapter then provides a

discussion of the sequelae of violence, focusing predominantly on the mental health impact of such violence. The main section of the literature review provides a review of research into the prevalence of abuse in the lives of people with mental illness, as well as studies that provide evidence about abuse being a causal or contributing factor for the development of different types of mental illness. The chapter concludes with a discussion of emerging issues and work undertaken internationally in this field.

A historical overview of mental health service provision in Australia and more specifically in Victoria from its beginnings in the 19th century into the 21st century is provided in Chapter 3. Changes described include a move from custodial care to care that is provided within the community. This chapter also provides an overview of mental health policy development by both the Commonwealth and Victorian Governments, which guide mental health services in Victoria.

Chapter 4 outlines the policy framework utilised for this thesis. The Australian Policy Cycle developed by Bridgman and Davis (Bridgman & Davis, 2004) provides a staged approach to the conceptualising of policy development, its implementation and evaluation. This cycle includes eight steps, beginning with 'identifying an issue', which then 'makes it onto the agenda' (agenda setting) and moves through other stages such as policy analysis, consultation and coordination towards implementation, and finally evaluation. The Australian Policy Cycle provides a useful framework for the two areas this research is particularly interested in: 'agenda setting' and policy 'implementation'.

Chapter 5 provides an overview of the research methodology. This study, with the overarching framework of the Australian Policy Cycle, follows a qualitative research design, aiming to gain answers from key informants on issues of policy development and implementation. The first study—a document analysis of mental health policy—is described. The rationale for developing two interview schedules, one for each state (NSW and Victoria) is then explained. The chapter includes notes on the researcher, which situate her within this area of work and research. An overview of data-gathering methods and data analysis of each study follows. While a document analysis was conducted for Study one, Study two followed steps of a thematic analysis in order to analyse the data from key informant interviews.

Chapter 6 describes Study one and its findings. It includes sections describing the sample; document analysis; and a discussion of both Commonwealth and Victorian State Government policies that include issues of abuse. The chapter provides an overview of specific policy on abuse for mental health services. The findings of Study one are summarised at the conclusion of this chapter.

Chapter 7 describes Study two and its findings. It includes a description of interviews undertaken with key informants in NSW and Victoria. The discussion provides an overview of the findings from NSW as well as Victoria. A separate section draws a comparison between the two states and describes the differences that have led to policy development and implementation in NSW and a lack of such policy development in Victoria.

Chapter 8 draws together the findings from Study one and Study two and links those findings back to the Australian Policy Cycle and the literature on abuse and mental illness (discussion of findings). As this research study is particularly interested in the steps of 'agenda setting' and 'implementation' of policy, the discussion of findings focuses on these two steps of the cycle. The chapter includes a section on the limitations of the study and future research possibilities. It furthermore provides the conclusion of this study, drawn from the literature review, policy study and key informant interviews, in reference to the Australian Policy Cycle and work undertaken internationally in this area.

Chapter 2: Literature review

Introduction

This chapter reviews research studies that have investigated the relationship between violence and mental health (illness). It concludes with an overview of pertinent issues that arise from the research. The chapter commences with clarification of terminology as it relates to the mental health, family/domestic violence and sexual abuse area, before moving on to discuss the epidemiology for all these fields and the combined areas of mental illness and sexual abuse/family violence. A brief overview of both the cost of violence to the overall economy and its health impact follows.

Methodology

The following search terms and combinations of these were used to search the CINAHL, Medline, Psychinfo, Informit, and Proquest (Health & Medical) databases: childhood abuse; childhood abuse, sexual; sexual abuse; family violence; domestic violence; rape; mental illness; mental disorder; psychiatric disorder; and post traumatic stress disorder. The search produced 2443 results, which were reduced to a smaller number after the researcher read through the abstracts, which revealed a focus on a number of related areas not relevant to this section of the literature review. Exclusion criteria include research focused on children and adolescents; research studies that focus on the description of program responses to violence; studies with small sample size (for example three participants); studies where the sole focus was on physical health or victims/survivors' health care utilisation; studies where the sole focus was on sexual functioning; and studies with samples taken from primary care only.

The remaining studies were categorised into their main foci. Group (1) relates to the experience of childhood sexual assault and group (2) relates to the experience of family violence and the respective impact on mental health. Research in group (1)—childhood sexual abuse—was further categorised into childhood sexual abuse and (a) effects on mental health general; (b) effects on developing depression; (c) connection to suicidality; (d) development of post traumatic stress disorder; (d) connection to eating disorders; (f) as underlying issue of developing personality disorders; (g) connection to psychotic disorders or symptoms. There were no such distinctions made for category (2)—family violence and impact on mental health—as

this type of research focuses on the mental health impact of family violence, with no clear subgroup emerging.

For the section on 'emerging issues' searches via the internet were undertaken to obtain information on international and national examples of responses of governments and organisations; however this search is limited, as the aim is to provide some examples (a snapshot) of international developments. This search is limited to documents available through internet-based searches of organisations, key words and government websites.

Terminology

Mental health/mental illness

Good mental health is fundamental to the wellbeing of individuals, their families, and the whole population. Conversely, mental health problems and mental illness are among the greatest causes of disability, diminished quality of life, and reduced productivity. (Australian Health Ministers, 2003, p. 4)

Following the World Health Organisation definition (WHO, 1999) the Australian Government defines mental health as "a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential" (Australian Health Ministers, 2003, p. 5).

The terms 'mental illness' and 'psychiatric disorder' are used interchangeably within the literature. "Mental Illness is a general term that refers to a group of illnesses, in the same way that heart disease refers to a group of illnesses affecting the heart" (Department of Human Services/Mental Health Branch, 2004, p. 1). Bloch and Singh define psychiatric disorder as "a psychological 'syndrome' (or pattern) that is associated with distress (unpleasant symptoms) or dysfunction (impairment in one or more important areas of functioning) or with an increased risk of death, pain or disability" (Bloch & Singh, 1997, p. 38). Mental illness refers to both psychotic illnesses (such as schizophrenia) and non-psychotic illnesses (such as depression or obsessive-compulsive disorder).

Mental Illnesses are categorised by the Diagnostic and Statistical Manual of Mental Disorder of which the most current edition is the DSM IV[1] (American Psychiatric Association, 2000). The broad categories are Psychotic Illnesses (Schizophrenia,

[1] Previous editions of the DSM include the DSM-III and the DSM-III-R. These will be referred to later in this thesis, as they are cited by earlier researchers.

Schizoaffective Disorder, Delusional Disorder); Mood Disorders (Major Depressive Disorder, Bipolar Disorder); Anxiety Disorders (Panic Attacks, Social Phobia, Obsessive-Compulsive Disorder, Post Traumatic Stress Disorder); and Personality Disorders (Borderline Personality Disorder, Narcissistic Personality Disorder, Antisocial Personality Disorder). Most people will at some stage during their life experience a 'mental health problem' due to a particular stressful event (such as the death of a person close to them) or other adverse life events—while fewer people develop a 'mental illness' during their life.

A number of different terms refer to people who have been diagnosed with a mental illness, with terminology having undergone changes over time. People used to be frequently referred to as 'patients'; in more recent times the word 'consumer' has been adopted by many and a 'consumer (advocacy) movement' has developed in Australia and overseas. In the literature these terms are used interchangeably: most often a person is referred to as a 'patient' during their stay in a psychiatric inpatient unit, or by medical doctors and psychiatrists; the term 'consumer' is frequently used to refer to people with a mental illness in general.

While the above definitions and the categorisation of mental illness reflect current thinking and discourse in psychiatry; terminology, attitude and treatment of mental illness has changed over time. In an attempt to make sense of 'mental disorder', societies have grappled with its conceptualisation over time. Mental disorder and its expression through 'bizarre' behaviour was once seen as an expression of demonic possession (Middle Ages). During the Enlightenment age (17th and 18th centuries) when rationality was the dominant conceptualisation of society, those with behaviour that seemed outside of such rationality were seen as behaving 'immorally' and hence needed to be treated through 'moral treatment' in order to be cured from their malaise (McDermott & Meadows, 2007). Moving forward to modern psychiatry, the categorisations described above are the result of a need to make meaning of mental disorder, it is also symptomatic of a move to the term 'mental illness', which is imbedded in a medical understanding of 'illness'. The move to classification systems and the terminology of 'mental illness' has, on the one hand, produced a relatively easy to follow categorisation of such illness, while also acting in a reductionist way (a shortcut). Language in modern psychiatry reflects this, at times people are referred to by their illness, such as 'the schizophrenic', rather than a person who has (suffers from) schizophrenia. Structuralist perspectives on mental illness provide alternatives to the view that mental illness is purely a medical (or genetic) condition, which can be treated with medicine only or predominately. The anti-psychiatrist movement for example, suggests that the power relationship between psychiatrist and patient

influence diagnosis (McDermott & Meadows, 2007). While others point out that "psychiatry is a speciality within medicine" (Rogers, 2005, p. 2) and the current model of psychiatry is dominated by such a medical approach to mental illness and its treatment. While many also propose that the 'bio-psycho-social' model ought to or indeed is the dominant paradigm from which mental illness and those suffering from such illness need to be approached, there are many from within as well as from outside psychiatry who critique psychiatry for its focus on a medical approach, rather than a more balanced approach to mental illness which would truly reflect equal focus on the 'bio', the 'psychological' and the 'social' aspect of such a paradigm (Read, Mosher, & Bentall, 2004). A true bio-psycho-social focus would incorporate social circumstances and "biographical nuances" (Rogers & Pilgrim, 2005, p. 4) rather than leaning towards the medical (bio) and to a lesser degree to the psycho-social aspects of illness and its treatment.

Abuse

Abuse is an overarching term which, for the purpose of this thesis, relates to abuse perpetrated or experienced by individuals towards another individual. While not limited to intimate relationships, this kind of abuse is predominately perpetrated by someone who is in an intimate relationship with the person they are afflicting the abuse upon (family/domestic violence, child abuse, sexual abuse). The exception to the 'intimate' nature of such abuse is sexual assault/abuse perpetrated by a stranger towards the individual, while this occurs less frequently than sexual abuse by and towards a known person, this type of abuse is also included in this definition.

Abuse can also be afflicted towards individuals outside of intimate relationships, such as treatment facilities (which will be discussed later) or the type of treatment provided to a person can be experienced as abuse or abusive. While reference is made at a later stage in this thesis to abuse occurring within psychiatric institutions towards individuals, the interest and focus of this study is on interpersonal abuse (violence) perpetrated by and individual towards an individual; while this may occur within institutional settings such as psychiatric inpatient units and hence is included in the review of studies in this thesis; abuse experienced by those with mental illness on a systemic level is not the focus of this thesis. The following sections provide an overview of the terminology relevant to this study to further elaborate and define 'abuse'.

Domestic/family violence

Domestic violence is defined as physical, sexual, or emotional/psychological violence directed toward men, women, children, or elders occurring in current or past familial or intimate relationships whether the individuals are cohabiting or not and including violence directed toward dating partners. (American Association of Colleges of Nursing, 1999, p. 19)

The literature provides an array of definitions of family or domestic violence, child sexual abuse, partner violence, assault and intimate partner violence. While sexual abuse is most likely to occur as part of family violence, it can also occur separate from family violence. It will be discussed in the next section.

Terminology in this area has undergone changes over the years. For example during the 1970s to 1990s the term 'domestic violence' was used in most English speaking countries, including Australia, for all violence perpetrated within the family; while more recently the term 'family violence' has gained in popularity. Both terms encompass the 'private' nature of abuse that generally occurs within the home, often unseen/unheard by broader society. It includes physical, sexual, financial, psychological, emotional and mental abuse, is generally directed at women and/or children, and is perpetrated predominantly by men. It includes threats to the person, a third person or property and usually includes enforced social isolation. The Victorian Women's Safety Strategy defines family violence as

> … violent, threatening coercive or controlling behaviour that occurs in current or past family, domestic or intimate relationships … This encompasses not only physical injury but direct or indirect threats, sexual assault, emotional and psychological torment, economic control, property damage, social isolation and behaviour which cause a person to live in fear. (Victorian Government, 2002, p. 20)

The term 'family violence' has been adopted more recently and is preferred by many, as it encompasses a broader range of victim-perpetrator relationships: for example it includes members of the extended family. The term family violence is inclusive of "abuse perpetrated within familial relationships, other than partner violence and abuse of children by parents (child abuse). Thus it includes, for example, violence by adolescents towards parents, or abuse of older family members by non-partner family members" (Laing, 2000, p. 2).

Intimate partner violence

Intimate partner violence, sometimes referred to as domestic violence, family violence or relationship violence, refers to violence occurring between people who are, or were formerly, in an intimate relationship. (VicHealth, 2004, p. 5)

Intimate partner violence involves the same type of violence as family violence. For the purpose of this thesis domestic violence and family violence are used interchangeably. When either term is used their meaning includes violence of a physical, sexual or emotional nature within the immediate or extended family or kinship group.

Sexual abuse/assault

Sexual assault includes acts of a sexual nature that are unwanted, unwelcome and uninvited. This includes acts of a sexual nature carried out against a person's will through the use of physical force, intimidation, coercion, or any attempt to do this. (Queensland Government, 2004, p. 2)

Terminology and definitions of sexual abuse/assault vary and can depend on the particular philosophy or context within which they have been developed; for example definitions used within the legal system are different from an 'experienced based' definition (Australian Bureau of Statistics, 2003). The Sexual Assault Information Development Framework, developed by the Australian Bureau of Statistics (ABS), provides an experienced-based definition, proposing that

> sexual assault may be located on a continuum of behaviours from sexual harassment to life-threatening rape. These behaviours may include lewdness, stalking, indecent assault, date rape, drug-assisted sexual assault, child sexual abuse, incest, exposure of a person to pornography, use of a person in pornography, and threats or attempts to sexually assault. (Australian Bureau of Statistics, 2003, p. 9)

New South Wales Health defines sexual assault as

> any action in which a person is forced, coerced or threatened into sexual acts against their will. The range of acts committed against a person who experiences sexual assault may include fondling, masturbation, fellatio, cunnilingus, and anal, oral or vaginal penetration by a penis, finger or foreign object. (New South Wales Health, 2004, p. 5)

Sexual assault/abuse can take a number of forms and can be perpetrated against children and adults.

While the focus of this thesis is on adults with a diagnosed mental illness and history of abuse (family violence and sexual abuse), there are a number of reasons why childhood abuse needs to also be taken into account. One such reason is the fact that childhood (sexual) abuse is prominent for people with mental illness; furthermore an experience of childhood (sexual) abuse increases the likelihood of being abused in adulthood; and childhood sexual abuse can be a contributing or indeed causal factor in developing mental illness. Taking these facts into account the next section provides a definition of child sexual abuse, and a section on child abuse is provided in the section on 'epidemiology'.

Child sexual abuse/assault

Notions of abuse … reside in a relational inequality that enables one person to 'use' another person for his or her own ends. Neither the presence of harmful effects, nor the child's consent to the activity, nor the level of their sexual knowledge is relevant in this definition. (Domestic Violence and Incest Resource Centre, 2003, p. 23)

A number of terms are used to talk about abuse of a sexual nature towards children: incest; rape; sexual abuse or assault. Adults involved in perpetrating such acts are generally referred to as paedophiles. Childhood sexual abuse or assault occurs during a child's life and is more likely to be perpetrated by a person known to the child, such as a family member.

> Child sexual assault occurs when someone uses a child or young person for their own sexual gratification …. the abuse might include fondling, sexual exhibitionism, intercourse, oral or anal sex, masturbation in front of a child, photographing nude children, child prostitution. (Domestic Violence and Incest Resource Centre, 2001, p. 23)

Definitions of child sexual abuse used by researchers vary greatly. Some distinguish between non-contact sexual abuse; sexual abuse without penetration; and sexual abuse involving penetration. Some do not clearly define the parameters of child sexual abuse. Other differences relate to the age at which a person is considered to still be a child, with the upper age limit varying from 15 to 18 years. Child sexual abuse is predominantly perpetrated by people known to the child, rather than by strangers—and often occurs within a broader context of child abuse and/or family violence.

The terms 'victim' and 'survivor' both refer to a person who has experienced sexual abuse/assault or family violence and are used interchangeably throughout the

literature. These terms are often used together, with ‘victim/survivor’ indicating the whole experience, rather than defining a person solely as ‘victim’ or ‘survivor’.

Terminology in the area of interpersonal violence has changed over time, as has public opinion and the opinion of professionals as to what constitutes violent or abusive behaviour. The women’s movement with its roots in the 1960s and 1970s made violence perpetrated within the family public by raising the issue and calling it ‘domestic violence’, this was a first attempt to put into the public sphere something that happened behind ‘closed doors’ and was previously not spoken about publicly.

Feminist analysis of interpersonal abuse provides the backdrop for much of the work undertaken since the 1960s in the area of violence and abuse. Feminist activists, writers and researchers provide the analysis and arguments to take a closer look at power imbalances between men and women and children; so much so that ‘violence against women’ has become a term often used to describe male violence against women and children as a short-hand term. While much violence and abuse is perpetrated by males against women and children, feminism falls short to provide explanatory models to issues such as mothers abusing their children or mothers not protecting their children from abuse, especially when the mother is not under threat herself (Domestic Violence and Incest Resource Centre, 2003). If the emphasis is solely on male violence against women and children, there is a risk that those experiencing violence/abuse by their mother are excluded from the public discussion of violence and hence also from research studies. Equally such “feminist framework may also lead … to overlook or minimise … offences against children perpetrated by women or against male children” (Domestic Violence and Incest Resource Centre, 2003, p. 67).

In summary, this thesis is concerned with mental illness and abuse—both sexual abuse and family violence—and more specifically with people who have a mental illness and who are or have been experiencing such abuse (violence).

Having introduced the most relevant terminology, the next section will provide an overview of the epidemiology of mental illness and violence, with a specific focus on people with mental illness.

Epidemiology

One in five Australians will experience a mental illness. (Commonwealth Mental Health Branch, 2005, p. 1)

Harvey, Meadows and Singh established that 'during 1997, 17.7 per cent of the adult[2] population suffered a mental disorder' (anxiety, affective or substance misuse), while "between 3 and 5 per 1000 adults were found to have a psychotic disorder for which they received treatment" (Harvey, Meadows, & Singh, 2001, p. 127). Marked differences can be observed between women and men and the type of diagnosis they receive. Australian data, reflecting international findings, show that women are more likely to be diagnosed with anxiety disorders, depression, post traumatic stress disorders and borderline personality disorders than men. Men are more likely to be diagnosed with substance use disorders and antisocial personality disorder than women (Bloch & Singh, 1997; Harvey et al., 2001).

… one in three [Australian] women experience[d] … physical violence since the age of 15. (Australian Bureau of Statistics, 2004a, p. 1)

In 1996 it was found that 1.1 million of Australian women who had been in a previous relationship had experienced violence from a partner (Australian Bureau of Statistics, 1996). In 2005 it was found that 19.1% (vs. 17.9% in 1996) of Australian women aged 18 and over had experienced sexual assault since the age of 15 (Office of Women's Policy, 2005a). The 2005 survey documents the difference between rates of violence amongst women and men, with women being three times as likely to experience sexual violence (Office of Women's Policy, 2005a, p. 2). Women who experienced violence from their current partner were more likely than men to have experienced both child abuse (21.9%) and child sexual abuse (26.5%). Similarly those who experienced sexual abuse by a current partner had experienced child abuse (27.7%) and sexual abuse during childhood (35.6%). Men who were experiencing current physical abuse by a partner reported lower rates for both types of abuse during childhood; with 17.8% having experienced child abuse and 10.4% sexual abuse during childhood. The issue of revictimisation of those who have experience childhood (sexual) abuse is not only a significant issue for the general population but also for those with a diagnosed mental illness, as will be discussed later.

… 34% of women reported having experienced some form of sexual abuse over their lifetime. (Mouzos & Makkai, 2004)

An Australian study by Easteal found that almost 60 per cent of the 2642 victim/survivors who responded to a national survey had experienced rape more than once in their lives; and that 13.1 per cent "reported that they had been sexually assaulted 'too many times to count' " (Easteal, 1994). One third of respondents had

[2] Adult refers to people 18 years and above.

experienced sexual abuse by a member of their family. More than half of the respondents (61.8 per cent) had experienced sexual assault before the age of 20; male respondents reported particularly high victimisation before the age of seventeen (70.1 per cent). Overall most victim/survivors were female (96.2 per cent); generally perpetrators where known to the victim/survivor, with only one fifth experiencing violence perpetrated by a stranger.

Reporting of sexual abuse is far lower than actual rates of abuse, with only 12 to 20 per cent of sexual assaults against women being reported (Australian Institute of Criminology, 2005).

Twenty-nine per cent of women who were surveyed reported that they had experienced physical and/or sexual violence before the age of 16 years. (Mouzos & Makkai, 2004, p. 85)

Children can be the target of violence within the family or they may witness violence towards their mother, siblings or other family members. Childhood sexual abuse is most often perpetrated within the family. Abuse of children also includes other forms of violence, such as physical, emotional and psychological abuse. Children are also impacted by family violence that is not directed towards them but their mother (Australian Bureau of Statistics, 1996, p. 8).

As with adult sexual abuse, the extent of childhood abuse is difficult to determine. The Australian component of the International Violence Against Women Survey (Mouzos & Makkai, 2004), includes reported as well as non-reported abuse; the researchers found that 29 per cent of those surveyed had experienced some form of abuse before the age of 16, “with almost one in five experiencing this abuse by parents” (Mouzos & Makkai, 2004, p. 4).

“Women who experienced abuse during childhood were one and a half times more likely to experience any violence in adulthood” (Mouzos & Makkai, 2004, p. 4). Having experienced childhood abuse increases the likelihood of revictimisation as adult (Australian Bureau of Statistics, 1996; Peleikis, Mykletun, & Dahl, 2002) Australian Bureau of Statistics, 1996; Peleikis, Mykletun, & Dahl, 2002) with some studies showing a 3.5 increase in likelihood of revictimisation as compared with those without such an experience (Read, Agar, Barker-Collo, & Davies, 2001, p. 369).

Data and gender considerations

Most incidents of sexual assault are not reported to police…four out of five (80%) adult female victims of sexual assault responded that they had not told police about the most recent incident. (Australian Bureau of Statistics, 2004b)

As mentioned previously, family violence and sexual abuse are underreported—both in Australia and worldwide—for a multitude of reasons (Australian Bureau of Statistics, 2004b; Victorian Government, 2002; WHO, 2002b); it is therefore necessary to peruse both criminal statistics (Australian Bureau of Statistics, 2004b) and population-based surveys, which include non-reported offences (Australian Bureau of Statistics, 2004a) (Australian Bureau of Statistics, 2005; Mouzos & Makkai, 2004). The ABS found that overall over 80% of violence against women is unreported (Australian Bureau of Statistics, 2004a); while Easteal (Easteal, 1994) found that only one in five female victim/survivors of sexual abuse had made a report to police.

"Women were more likely to have been sexually abused than men. Before the age of 15, 12 % ... of women had been sexually abused compared to 4.5% ... of men" (Australian Bureau of Statistics, 2005, p. 12). Women and children are the majority of victim/survivors of any form of interpersonal violence; and in the majority violence is perpetrated by men—with some exceptions, such as same-sex violence or female towards male violence.

In recent years, male victim/survivors of sexual assault are increasingly included in research, while earlier work tended to solely focus on women. One of the reasons for the initial exclusion is that for some time men were seen only as the perpetrators, rather than at times also being victims (Neame & Heenan, 2003).

Within family violence studies the focus still remains predominantly on women and children as victim/survivors and men as perpetrators of such violence; prevalence rates support this. Violence between same-sex partners and female to male violence has received much less focus and available data is unreliable, as few studies have been undertaken.

Having provided an overview of the prevalence of mental illness, family violence and sexual abuse, the next section provides a review of prevalence rates of abuse in the lives of people with mental illness.

Violence and mental illness

Numerous studies have found that sexual and physical abuse histories are common among women and girls who have been diagnosed with mental illnesses. (Morrow & Chappell, 1999, p. 33)

It is estimated that between 49% and 90% of women psychiatric inpatients have experienced abuse (sexual and/or family violence) at some stage in their life (Hawthorne, McKenzie, & Dawson, 1996; Morrow, 2002; Morrow & Chappell, 1999; Muenzenmaier, Meyer, Struening, & Ferber, 1993). Golding (Golding, 1999) found in a meta-analysis of research studies, that just under half (47.6%) of all abused women suffered from clinical depression compared with 10.2 to 21.3% in women in the general community.

Child abuse rates in the general Australian population of women lies just under 30% and one in six women state that they have experienced sexual abuse since the age of fifteen (Australian Bureau of Statistics, 2004a). In comparison, those with a diagnosed mental illness report higher rates of abuse. An Australian study found that 54% of such women report having experienced sexual assault as adults (and half of these post-diagnosis) and 39% childhood sexual and physical abuse (Hawthorne et al., 1996). Prevalence rates for males with mental illness are also higher: Read established that childhood abuse is twice as high in those with a diagnosed mental illness as compared to the general population (Read, 1997). Additionally it has been reported that those who have experienced abuse during childhood are more likely to be re-abused as adults (Hawthorne et al., 1996; Read et al., 2001); and high prevalence rates of child abuse for those diagnosed with mental illness, combined with heightened vulnerability due to mental illness, makes this population particularly vulnerable to being revictimised.

Among people with mental illness there is growing evidence that many men have also experienced childhood sexual assault. Even though men report lower rates of childhood physical as well as sexual abuse than female inpatients, there is evidence that male psychiatric inpatients have experienced childhood (sexual) abuse (Read, 1998). Read found that “prevalence rates for male inpatients are at least twice as high as rates for men in general, both in the United States and England” (Read, 1997, p. 449).

Variations in prevalence rates

Data on prevalence rates vary greatly; while a number of factors contribute to these differences, they predominantly relate to 'definitions', the 'setting' in which research is undertaken and 'population groups'. Definitions of sexual abuse/assault, child sexual abuse and family violence vary greatly between research studies. Prevalence rates also vary depending on the setting in which the research has been undertaken: for example psychiatric inpatient samples tend to show higher rates of lifetime experience of interpersonal violence than community mental health samples. A limited number of studies have focused on women with mental illness who experience family violence (Campbell, Kub, & Rose, 1996; Cascardi, O'Leary, & Schlee, 1999; Dienemann et al., 2000; May, Rakhlin, Katz, & Limandri, 2003; Moracco et al., 2004).

In summary, the prevalence of violence in the lives of those diagnosed with mental illness is significant. Prevalence rates of sexual abuse, childhood abuse and family violence within the population of those with a diagnosed mental illness are higher than the general population. A high percentage of women with mental illness have experienced violence and frequently more than one kind of violence; they are also more likely to have several experiences of such violence over their lifetime. Data for women varies according to the type of services they access, with those in acute mental health care showing higher rates (up to 90%) and those in community-based services—while lower—still showing significantly high rates of such experiences (49% upwards). While men are less likely to be exposed to violence by a partner (domestic violence), men with mental illness are more likely than those without such illness to have experienced childhood sexual abuse.

While an experience of abuse has a number of impacts on the individual, the impact of violence also carries many other costs—not only to the individual but also to society. While this thesis is primarily interested in the impact of abuse on mental health, it is also concerned to understand the 'burden of disease' and the associated economic and social costs of violence. This analysis is important as it provides a context for discussions of policy development in relation to violence and mental illness. The next section will provide an overview of the economic and health costs of violence.

Burden of disease

The total annual cost of domestic violence in 2002−03 is estimated to be $8.1billion. (Access Economics, 2004b, p. VII)

Violence against women is a major cause of pain and suffering in society. Not only are the acts abhorrent in themselves, but a large part of our economy exists because violence against women exists. (Day, 1995, p. 1)

A report by Access Economics provides comprehensive data on the cost of family violence in Australia (Access Economics, 2004a). "Pain, suffering and premature mortality are the biggest contributors to the overall costs" which are estimated at $8.1 billion; the remaining $4.6 billion relates mostly to "consumption costs[3], of which the largest component is lost household economies of scale" (p. VI). The Australian Commonwealth Office of the Status of Women (Commonwealth, 2004) documents that the total lifetime cost of domestic violence alone can be as high as $224,470 per victim[4].

The total health cost of family violence for female victims in Australia for 2002 to 2003 was estimated as $314 million ,with nearly half of this being for hospital costs ($145 million), closely followed by pharmaceutical treatments ($61 million); depression and physical injuries together comprising half of the overall costs (Access Economics, 2004a). For children the health impact is estimated at $17.0 million in 2002–03 and for perpetrators the figure is $43.4 million. "Victims are assumed to bear 20% of the costs for themselves and their children—$75.8 million in all in 2002–03", while "perpetrators bear 20% of their own health costs"; government (taxpayers) bear over two thirds of the costs ($265.8m) and the broader community bears 11.5% of total health costs ($44.8m)" (p. 35).

According to this study, nearly 18% of all female depression in Australia and 17% of all female anxiety disorders were associated with family violence; suicides associated with domestic violence are the next single largest cause towards the burden of disease.

A study undertaken by VicHealth in Victoria provides figures on the cost of intimate partner violence (IPV) for the Victorian health care system (VicHealth, 2004). IPV is the leading risk factor contributing to the disease burden in Victorian women; "…it contributes 9 per cent to the total disease burden"; and is the "leading contributor to death, disability and illness in Victorian women 15–44" (p.10). It was found that

[3] The definition of consumption-related costs includes short-term costs of property replacement and bad debts and long-term costs of lost economies of scale and household operation (Access Economics, 2004a, p. 5).
[4] The overall estimated costs include amongst others: pain, suffering and premature mortality, health, production−related, second generation, and administrative costs.

> the greatest proportion of the disease burden is associated with mental health problems (60 per cent). Suicide, drug use and risky levels of smoking and alcohol consumption are also significant contributors. (VicHealth, 2004)

A study undertaken in a hospital emergency department in Brisbane, Australia found that women who had experienced family violence by an intimate partner were nine times more likely to have harmed themselves or have thoughts of harming themselves compared to women who had not experienced intimate partner violence (Roberts, Lawrence, Williams, & Raphael, 1998).

In summary, aside from the impact on the individual who experiences violence, there is a cost associated with the health and in particular the mental health impact of violence, not only to the individual but to the community at large.

This section has provided an overview of the costs of violence, in particular the mental health costs. What follows is a discussion of research studies which provide evidence about the sequelae of abuse on general health and mental health.

Sequelae of violence

This section provides an overview of the impact and the causal relationship of violence to the development of mental illness. The impact of abuse, especially childhood (sexual) abuse can be profound and can persist long after such abuse has stopped. The initial part discusses the impact of childhood sexual abuse and the mental health impact; what follows, provides an overview of the mental health impact of family violence. The chapter concludes with a discussion of emerging issues within this field of research.

Victim/survivors of interpersonal violence are more likely to suffer from a number of health issues compared to those without such an experience, including chronic pain, such as, headaches, back pain, chronic pelvic pain, and reproductive health problems; and gynaecological problems (Astbury, 2002; Campbell, 2002; Coker et al., 2002; Gerlock, 1999; Morrow, 2002; Morrow & Chappell, 1999; WHO, 2002b). Astbury, like others, reports that “many of the most important health risk behaviours are increased following violence, these include higher rates of smoking, drinking alcohol and using other drugs” (Astbury, 2002, p. 411).

Childhood sexual abuse and mental health impact

Child sexual abuse is thought to involve a disruption of the core person, often eventuating in affect tolerance difficulties, painful perceptions of self, problems in

interpersonal relationships, and disrupted beliefs about oneself and the external world. (Neumann, 1994, p. 35)

Research studies aim to examine the connection between childhood sexual abuse and the development of a mental illness in adult life. Similarly to Neumann (Neumann, 1994), other researchers argue that an experience of childhood sexual assault constitutes a disruption of a child's sense of self, which can lead to difficulties in managing stressful situations and make the development of mental illness more likely (Herman, 1992; Molnar, Buka, & Kessler, 2001. 753).

An experience of childhood sexual abuse has been found to be related to higher incidence of suicide attempts (Briere & Jordan, 2004; Briere & Elliott, 1994; Campbell, 2002; Dinwiddie et al., 2000; Zlotnick, 2001; Golding, 1999; Paolucci, Genuis, & Violato, 2001; Read et al., 2001; Ullman & Brecklin, 2002); greater use of mental health services and earlier engagement with those services and an increase in admission into psychiatric inpatient units (Molnar, Buka et al., 2001; Zlotnick, 2001; Mullen, Martin, Anderson, Romans, & Herbison, 1993; Read, 1998; Read et al., 2001; Spataro, Mullen, Burgess, Wells, & Moss, 2004); as well as higher rates of mental illness in general (Briere & Elliott, 1994; Difede, Apfeldorf, Cloitre, Spielman, & Perry, 1997; Dinwiddie et al., 2000; Gold, Lucenko, Elhai, Swingle, & Sellers, 1999; Golding, 2002; Muenzenmaier et al., 1993; Neumann, 1994; Neumann, Houskamp, Pollock, & Briere, 1996; Paolucci et al., 2001; Spataro et al., 2004; Thompson et al., 2003).

This first section will discuss research investigating clinical samples: this kind of research generally aims to find out about the prevalence of sexual abuse, and investigates the causal relationship between the experience of sexual abuse and the development of a mental disorder.

Briere and Elliott (Briere & Elliott, 1994) review studies undertaken between the mid-80s and the mid-90s that seek to investigate the short and long-term impact of childhood sexual abuse. They categorise their findings about the impact of the abuse on mental health into post traumatic stress; cognitive distortions; emotional distress (including depression, anxiety and anger); impaired sense of self; avoidance (including dissociative phenomena, substance abuse and addiction, suicide, tension-reducing activities such as self-harm, indiscriminate sexual behaviour, bingeing & purging, and self-mutilation); and interpersonal difficulties. Briere and Elliott's study confirms that "adult sexual abuse survivors have been found to display more intrusive, avoidant, and arousal symptoms of PTSD than those not abused as children" (Briere & Elliott, 1994, p. 56). They furthermore found that survivors of childhood sexual abuse have an increased likelihood of "chronic self-perceptions of

helplessness and hopelessness, impaired trust, self-blame and low self-esteem” (Briere & Elliott, 1994, p. 56). According to their research, depression and anxiety are the most commonly reported symptoms in adults who have experienced childhood sexual assault.

A meta-analytic review of the long-term sequelae of childhood sexual abuse in women undertaken by Neumann, Houskamp, Pollock and Briere (Neumann et al., 1996), included 38 studies. Their study revealed similar categories of responses to trauma to those discussed by Briere and Elliott. This study found “a significant relationship between childhood sexual abuse and psychological distress and dysfunction in adult women (p. 10) and points out that “certain problems may be associated especially (although not necessarily uniquely) with a sexual abuse history, such as traumatic stress and revictimization” (p. 11).

Paolucci and colleagues also undertook a meta-analysis of research studies on the effect of childhood sexual abuse; they chose studies that focus on post traumatic stress disorder, depression and suicide among other factors. Their study also found a connection between childhood sexual assault and the development of post traumatic stress disorder, depression and suicide.

Thompson et al (Thompson et al., 2003) hypothesised that an experience of sexual abuse increases likelihood of psychopathology, that childhood sexual abuse victims are more likely to have a mental disorders and that women who experienced both, abuse during childhood and adulthood would be even more likely to have such disorder than those who had experienced one form of abuse only (i.e. abuse during childhood). To undertake their study they compare women who had experienced one of “four conditions: (1) childhood sexual abuse; (2) rape in adulthood; (3) childhood sexual abuse plus rape in adulthood; and (4) no sexual trauma” (p. 35). Their study found no significant difference between childhood sexual abuse (csa) and adulthood sexual abuse and psychopathology; they did however, find that “CSA + rape in adulthood was associated with the risk of substance dependence over experiencing a singular trauma” (p. 37). Lifetime mood disorder was twice that for all three groups that had experienced abuse (compared to non-abused); major depression and bipolar disorders were significantly higher in the ‘abused groups’; and post traumatic stress disorder was 6–7 times higher in the “three trauma groups” (p. 37) than in the control group.

Having provided an overview of studies that investigate the mental health impact of childhood sexual abuse in general, the next section will discuss in more detail specific

types of mental illness and behaviour (for example suicidality) in connection with childhood sexual abuse.

Depression/anxiety

Depression is the display of a despondent mood or the loss of interest or pleasure in nearly all activities; irritability; sadness; changes in appetite or weight, sleep psychomotor activity; decreased energy; feelings of worthlessness or guilt; and difficulty thinking, concentrating, or making decisions. (Paolucci et al., 2001, p. 22)

Depression and/or anxiety as sequelae of childhood sexual abuse in adults are the most commonly found reactions of victim/survivors. A great number of studies have found this correlation between the experience of childhood sexual abuse and (adulthood) depression, anxiety, post traumatic stress disorder and increased suicidality (Briere & Elliott, 1994; Campbell, 2002; Davidson, Hughes, George, & Blazer, 1996; Dinwiddie et al., 2000; Hall, Sachs, Rayens, & Lutenbacher, 1993; Muenzenmaier et al., 1993; Paolucci et al., 2001; Read et al., 2001; Ullman & Brecklin, 2002; Zlotnick, Mattia, & Zimmerman, 2001).

Difede, Apfeldorf, Cloitre, Spielman and Perry (Difede et al., 1997) compared mental health clients with and without histories of abuse and found that “among those who were abused, major depressive disorder was more common than schizophrenia …” (p. 523); no significant differences between women and men were noted. Muenzenmaier, Meyer, Struening and Ferber (Muenzenmaier et al., 1993) studied a sample of 78 women who were clients at a community mental health centre and found that 65% of women had experienced some type of abuse or neglect during childhood; and many women had multiple abuse experiences (45% sexual abuse, 51% physical abuse, 22% neglect). This study found higher levels of depression in women who had experienced abuse.

Most studies in the area of sexual abuse and mental health outcomes are retrospective in nature; one Victorian study takes a different approach. Spataro, Mullen, Burgess, Wells and Moss “followed up a large cohort of boys and girls examined by forensic physicians following allegations of sexual abuse, and ascertained the frequency with which they were subsequently treated in the public mental health services” (Spataro et al., 2004, p. 416). A sample of 1612 children included 1327 females and 285 males, 16 years and younger and born between 1950 and 1991; the forensic examination confirmed that the majority of children (78.3%) had experienced penetration. The cohort was then linked to the Victorian Psychiatric Case Register, which records all contacts with public mental health services in

Victoria. Of the sample 12.4% had made contact with a public mental health service (135 females and 65 males), while the comparison population recorded a much lower rate of contact (3.6%). The clinical sample showed higher numbers of diagnosis for major affective disorders, anxiety disorders and acute stress disorders, with personality disorders having the highest correlation. Females and males of the cohort had higher rates of psychiatric diagnosis than the control group. Individuals who had experienced childhood sexual abuse were four times as likely to receive treatment at a mental health service than those who had not experienced childhood sexual abuse (CSA), with major affective disorders, anxiety disorders, personality disorders and disorders of childhood ranking the highest; anxiety disorders and acute stress disorders were three times more likely to be recorded for both females and males. Individuals who had experienced CSA were almost five times more likely to be diagnosed with borderline personality disorder.

Suicidality

Suicidality consists of recurrent thoughts of death or suicidal ideation and plans, and attempts or gestures of self-harm with death as a possible end result. (Paolucci et al., 2001, p. 227)

Read, Agar, Barker-Collo, Davies and Moskowitz (Read et al., 2001) reviewed 200 files (114 women and 86 men) of people who were treated at a community mental health Centre in New Zealand. The most common diagnosis was depression (85); schizophrenia (28); substance abuse (20); bipolar (15); personality disorder (10); and anxiety disorder (9). Of the 200 consumers, 40 disclosed and 20 disclosed childhood physical abuse and this was noted in their case files. “This study supports the relationship between child abuse and suicidality in adulthood; it also supports previous findings that although childhood physical abuse is related to suicidality, CSA is even more strongly related” (p. 370). Read et al. tested for adult physical abuse and adult sexual abuse as other factors contributing to suicidality and found that the relationship between CSA and suicidality remained. They draw the conclusion that “what is particularly remarkable about the current study … is the finding that CSA was more predictive of current suicidality than a current diagnosis of depression” (p. 371).

Davidson, Hughes, George and Blazer (Davidson et al., 1996) also found a correlation between an experience of lifetime sexual assault and increased likelihood of suicide attempts in women (the male sample was too small to draw evidence from), even after testing for other adversities. Overall (female and male) “respondents with a history of sexual assault were 6 times more likely to report a suicide attempt”

(p. 553). They furthermore found greater risk for women who had experienced sexual assault before the age of 16.

Read's study of psychiatric inpatients also found childhood sexual and physical abuse being a predictor for suicidality, with higher rates for men than women (Read, 1998).

Post traumatic stress disorder (PTSD)

While it is clear that ordinary, healthy people may become entrapped in prolonged abusive situations, it is equally clear that after their escape they are no longer ordinary or healthy. (Herman, 1992, p. 116)

Post traumatic stress disorder (PTSD) was for some time mainly associated with soldiers returning from war or people who had been exposed to natural disasters or major traffic accidents. PTSD has been included in the Diagnostic Manual of the American Psychiatric Association (DSM III) since 1980 (American Psychiatric Association, 1980). More recent research has established that post traumatic symptoms and PTSD are also linked to traumatic events of an interpersonal nature, such as sexual abuse and family violence. Judith Herman, an American psychiatrist, points out that the definition in the DSM III for trauma, which puts trauma 'outside of human experience' is inaccurate; she argues that data on child and adult sexual abuse as well as family violence demonstrate that these experiences *are* part of human experience (J. Herman, 1992). Herman found that "traumatic events produce profound and lasting changes in physiological arousal, emotion, cognition, and memory. Moreover traumatic events may sever these normally integrated functions from one another …" (p. 34). She argues for a new diagnosis for people who have experienced prolonged trauma and suggests that "the persistent anxiety, phobias, and panic of survivors are not the same as ordinary anxiety disorders" (p. 118). She argues for a new diagnosis, that of 'complex post-traumatic stress disorder', because

> … the responses to trauma are best understood as a spectrum of conditions rather than as a single disorder. They range from a brief stress reaction that gets better by itself and never qualifies for a diagnosis, to classic or simple post-traumatic stress disorder, to the complex syndrome of prolonged, repeated trauma (p. 119).

A number of studies have found PTSD to be one of the responses to abuse. Briggs and Joyce (Briggs & Joyce, 1997) found that many women from a sample of 73 adult women (16 and older) who sought counselling for sexual abuse at a family health counselling centre showed symptoms of PTSD. They furthermore found that "… the

severity of PTSD symptoms correlated with the extent of general psychopathology …. of particular importance was that the severity of the PTSD symptoms was associated with the extent of child sexual abuse involving actual sexual intercourse" (p. 579). The association between intercourse and severity of PTSD remained significant after testing for other variables (such as general level of psychopathology); furthermore women who had experienced multiple episodes of violence which involved intercourse were significantly more likely to develop PTSD. Equally, other studies found higher rates of post traumatic stress disorder in victim/survivors of sexual assault. Gearon, Kaltman, Brown and Bellack (Gearon, Kaltman, Brown, & Bellack, 2003) who focus on a sample of women who have other mental illnesses (schizophrenia, schizoaffective disorder or drug/alcohol dependence), found that nearly half of the women also met criteria for PTSD (25 of 54) and that "childhood sexual abuse and physical abuse were significantly associated with current PTSD" (p. 526); revictimisation was also associated with PTSD symptoms. These findings are supported by a number of other studies which also found that people who have experienced childhood sexual abuse develop symptoms of PTSD (Arata, 1999; Golding, 1999; Leverich et al., 2002; Cascardi, 1999; Read, 1997; Roberts et al., 1998).

Eating disorders

We found that sexually abused patients had a more serious clinical presentation in terms of comorbid psychiatric symptoms, and were more likely to present with signs of personality disturbance, than patients without abuse. (Tobin & Griffing, 1996, p. 147)

Psychological reactions to trauma in childhood and adulthood vary between individuals. While certain forms of mental health problems or illnesses such as depression and anxiety are more common among victim/survivors, some researchers have also found a connection between abuse and eating disorders (Leonard, Steiger, & Kao, 2003; Leverich et al., 2002; Matsunga et al., 1999; Read, 1997; Redford, 2001; Tobin & Griffing, 1996).

"The prevalence of child sexual assault among those with eating disorders ranges from 20% to 85% …" (Everett & Gallop, 2001, p. 45). Everett and Gallop found that women psychiatric inpatients with histories of child sexual abuse "are 43% more likely to have a concomitant eating disorder" than those without such a history (Everett & Gallop, 2001, p. 45).

A study that compares 51 women diagnosed with bulimia with women who were 'normal' eaters found that the bulimic group had experienced higher rates of child sexual abuse (39.2%), child physical abuse (60.8%) and both types of abuse (12%); while the control group of non-bulimic women scored lower on all abuse types. Adult abuse experiences were also higher in women diagnosed with bulimia, with 19.6% reporting sexual abuse, 19.6% reporting physical abuse and 9.8% reporting both types of abuse; the control group showed lower rates of both sexual and physical abuse and none had experienced both types of abuse (Leonard et al., 2003). Leonard, Steiger and Kao found "a correspondence between the presence and severity of abuse and the severity of concurrent psychopathologic symptoms" (p. 388).

Matsunga et al. (Matsunga et al., 1999) also found a correlation between abuse and higher psychopathology in their study of 44 women diagnosed with bulimia. Those who had experienced sexual or physical abuse during child or adulthood (45%) showed a higher "drive for thinness, [and had a higher level of] body dissatisfaction" (p. 473), and they also showed significantly higher rates of lifetime PTSD and substance dependence than those without abuse experiences.

A study that includes people with bulimia as well as anorexia provides similar findings about the level of abuse experienced (40%) and a correlation between the experience of abuse and higher comorbid psychiatric symptoms such as anxiety, depression, phobia and paranoia; higher rates of depression in those with abuse experience than those without were also found (Tobin & Griffing, 1996). This study found that those with abuse experience also engaged in significantly more self-harming behaviour: of 40% who reported self-harm eighty per cent had experienced abuse.

Other studies that investigated mental health impact of abuse more generally—rather than solely focusing on eating disorders—have also found high rates of abuse in people diagnosed with eating disorders: for example Mullen, Martin, Anderson, Romans and Herbison (Mullen et al., 1993) found that people with a history of sexual abuse were three times as likely to develop an eating disorder than those without such an experience.

Borderline personality disorder

The high prevalence rates of child abuse among BPD patients is not surprising given that abuse affects personality development. (Everett & Gallop, 2001, p. 46)

Women receive a diagnosis of borderline personality disorder (BPD) at a much higher rate than men, while men tend to receive higher rates of antisocial and narcissistic personality disorders. Borderline personality disorder was not given much attention by researchers or psychiatry in general until the 1980s; rates of childhood sexual abuse "among people diagnosed with borderline personality disorder cluster around 71% for women, ranging from 45% to 86%" (Everett & Gallop, 2001, p. 47). Herman, Perry and van der Kolk compared people with a diagnosis of BPD with a clinical control group and found significantly higher rates of trauma (81%), "including physical abuse (71%), sexual abuse (68%) and witnessing serious domestic violence (62%)" (Herman, Perry, & van der Kolk, 1989, p. 490). They not only found higher rates of abuse among those diagnosed with BPD, but also earlier onset of abuse, often repeated over longer periods. These findings are echoed by other studies which also found earlier onset of abuse in those diagnosed with BPD (Heffernan & Cloitre, 2000; McLean & Gallop, 2003; Silk, Lee, Hill, & Lohr, 1995), along with higher lifetime victimisation, chronic abuse and a higher rate of intrafamilial (generally a parent) sexual abuse.

Silk, Lee, Hill and Lohr (Silk et al., 1995) also found a high prevalence of childhood sexual abuse among their sample of people with this diagnosis. Of 55 patients, forty-one reported some form of sexual abuse and of those, thirty-six (88%) were women. Severity of abuse is linked to higher symptomatology and parasuicide; abuse by a parent predicts an increase in symptoms, such as hopelessness and worthlessness; and prolonged or ongoing sexual abuse is linked to higher symptomatology. Silk, Lee, Hill and Lohr "suggest a relationship to repetitive and severe trauma, and, thus, to a form of posttraumatic stress disorder that has particular interpersonal manifestations" (p. 1063).

Psychotic symptoms and disorders

[Patients who had experienced childhood sexual abuse were] more likely to show psychotic symptoms, those symptoms appear at an earlier age than in nonabused patients. (Read, 1997, p. 40)

While the connection between sexual abuse and depression, anxiety, PTSD, suicidality, dissociation, eating disorders, substance dependency and physical health problems has received increasing attention, abuse and its potential influence or connection to psychosis has not been investigated to the same extent. There are few studies that try to understand if there is a link between abuse and psychosis. Read (Read, 1997) undertook a review of 15 studies and found that "approximately two-thirds of women inpatients report either physical or sexual childhood abuse (64% of

323 women)" and that "child sexual abuse was reported by half the women" (p. 448). Child physical abuse was reported by 44% of women; and twenty-nine per cent of women reported both physical and sexual abuse. Men reported similar rates of childhood physical abuse but lower rates of childhood sexual abuse. One study by Mullen, Martin, Anderson, Romans and Herbison (Mullen et al., 1993) found that 85% of women had been sexually abused before the age of 16. The studies Read examined also found that patients with a history of abuse showed more psychotic symptoms in general and that they "scored higher on measures of symptoms that are usually ... considered indicative of schizophrenia" (p. 450).

In a recent study of inpatients of a psychiatric hospital, Read, Agar, Argyle and Aderhold (Read, Agar, Argyle, & Aderhold, 2003) found that patients showed high prevalence rates of sexual and physical abuse experienced in both childhood and adulthood. They also found higher rates of hallucinations for those who had an experience of childhood abuse. This study relied on file notes taken by clinicians, which is a limitation. It has been documented elsewhere that prevalence rates are generally higher than medical records show, unless questions about abuse, both physical and sexual, are included in the assessment of clients (Read et al., 2001); Young, Read, & Barker-Collo, 2001; (Agar, Read, & Bush, 2002; Cavanagh, Read, & New, 2004; Young, Read, & Barker-Collo, 2001). This sample of 200 patients includes women and men; as well as adult and childhood sexual assault; and adult and childhood physical assault. Women score higher in all forms of abuse than men and the total sample. The researchers found a link between the severity of abuse and an increased likelihood of positive schizophrenic symptoms[5]. "Those subjected to CA [child abuse] were almost twice as likely (35%) than the non-abused patients (19%) to have two or more of the five 'characteristic symptoms' of schizophrenia, the number required for a DSM-IV diagnosis" (p. 14). Read et al. furthermore found that hearing voices among this sample, "was the most strongly related" (p. 15) to child abuse. A study undertaken by Ellason and Ross (Ellason & Ross, 1997) about an increase in psychotic symptoms for people who had experienced childhood abuse produced similar results.

Following this discussion of the impact of sexual assault on mental health, the next section provides an overview of research undertaken to investigate the mental health impact of family violence on victim/survivors.

[5] Positive symptoms include hallucinations (auditory, sensory and visual).

Family violence

Extent, severity, and type of abuse is associated with the intensity of PTSD. Severity refers to how life threatening the abuse is. The more life threatening the abuse is, the more traumatic the effect. (Jones, Highes, & Unterstaller, 2001, p. 100)

The effects of family violence (including physical, emotional, financial, and sexual abuse) can have many short and long-term effects on victim/survivors. As mentioned previously, the majority of violence is perpetrated by males towards women and children, hence the terms 'victim/survivor' and 'women' will be used interchangeably throughout this discussion. Studies have found that similarly to childhood abuse, an experience of family violence can result in depression (Briere, Woo, McRae, Foltz, & Sitzman, 1997; Campbell, 2002; Campbell et al., 1996; Cascardi, Mueser, DeGiralomo, & Murrin, 1996; Cascardi et al., 1999; Danielson, Moffitt, Caspi, & Silva, 1998; Golding, 1999; Mullen, Romans-Clarkson, Walton, & Herbison, 1988; Roberts et al., 1998); post traumatic stress disorder or symptoms (Briere & Jordan, 2004; Cascardi et al., 1999; Dienemann et al., 2000; Golding, 1999; Jones et al., 2001; Roberts et al., 1998; Taft, 2003); anxiety (Briere, 2001; Goodman, Johnson, Dutton, & Harris, 1997; Roberts et al., 1998); dissociation (Briere & Jordan, 2004); suicidality (Campbell, 2002; Cascardi et al., 1996; Golding, 1999; Goodman et al., 1997; Ullman & Brecklin, 2002); and drug or alcohol dependency/abuse (Briere & Jordan, 2004). Prevalence rates between studies vary: this relates to differences in definitions of family/domestic/intimate partner violence. Most studies define family violence as violence perpetrated by a man against a woman and/or child/ren; while others work with a narrower definition, for example of intimate partner violence. "An intimate partner is defined as a current or former spouse, common-law spouse, a cohabitating partner, a current or former boyfriend or girlfriend, and a current or former dating partner, and includes both heterosexual or homosexual partners" (Daniels, 2005, p. 45). Most researchers do not include female to male violence or same-sex partners within their studies. There is a small but growing body of work that seeks to find out about the prevalence of intimate partner violence in same-sex relationships; however there has been little research undertaken in this area. Unless explicitly stated, the studies examined for this review generally refer to violence perpetrated by men against women and/or children.

Numerous studies have found a correlation between "frequency, severity, chronicity, and recency of interpersonal victimization … with greater levels of psychopathological distress" (Briere & Jordan, 2004). Other studies have found that for some, symptoms may subside once the woman is safe (Campbell, Sullivan, & Davidson, 1995; May et

al., 2003; Tan, Basta, Sullivan, & Davidson, 1995; Warshaw & Barnes, 2003); while yet other studies document the long-term effects of prolonged violence (Briere & Jordan, 2004; Cascardi et al., 1999; Danielson et al., 1998; Dienemann et al., 2000; Golding, 1999; Moracco et al., 2004; Mullen et al., 1988; Roberts et al., 1998).

Warshaw and Barnes (Warshaw & Barnes, 2003) analysed 16 studies of women who had experienced family violence and accessed a domestic violence support service and found that the prevalence rate of depression ranged between 17% to 72%, with rates for PTSD ranging from 33% to 88%. Higher rates of distress are experienced by those accessing domestic/family violence services such as refuges. Other studies have confirmed these findings (Golding, 1999).

Cascardi, O'Leary and Schlee (Cascardi et al., 1999) undertook a study over four years with 92 women who were seeking "treatment for marital problems and who were physically victimized by the spouses" (p. 227). Nearly 30% of women in this sample met criteria for PTSD and 32% for major depression, with 17% meeting criteria for both disorders; furthermore a correlation was found between the frequency and the severity of the abuse and PTSD.

Golding (Golding, 1999) undertook a meta-analysis of studies that focus on the mental health impact of intimate partner violence, including studies in settings other than family violence services (such as emergency departments and psychiatric settings). She focuses on studies that investigate *physical* violence perpetrated within the context of family violence or intimate partner violence. She found a mean prevalence rate of 48% for depression and 64% for PTSD for those having experienced such violence. Alcohol and drug abuse dependency were higher in refuge residents than the in general population. Similarly to other studies, samples of domestic violence refuges show higher prevalence of depression.

Jones, Hughes and Unterstaller (Jones et al., 2001) reviewed 42 studies on PTSD and domestic violence, and point out that all studies used "samples of battered women who are … almost exclusively made up of women who came forward and sought help or shelter" (p. 101). They point out that these women may not be representative and that they may be "the most troubled of battered women, or they may be the healthiest of battered women, who have the most emotional resources to seek services" (p. 101). However, the findings of this review show that symptoms in women who have experienced family violence are consistent with PTSD. Findings are consistent across varying samples (refuges, hospitals, and community agencies) with 31%–84% of women experiencing PTSD; they further found that multiple victimisations (especially childhood sexual abuse and adult sexual abuse) increase

the likelihood of developing PTSD. The refuge population is at higher risk of developing PTSD; "estimates of victimization among the shelter population range from 40–84%" (p. 100); in addition to having experienced family violence, they are also homeless, which is likely to increase their distress. Furthermore they found that "suicide is a risk among domestic violence victims who exhibit PTSD symptoms" (p. 112) and substance abuse was also reported at higher rates in victimised women, with women who suffered both childhood and adulthood abuse, reporting "significantly more lifetime drug and alcohol dependence" (p. 112).

To investigate the prevalence of domestic violence in women with depression, Dienemann, Boyle, Baker, Resnick, Wiederhorn and Campbell (Dienemann et al., 2000) studied eighty-two women with a diagnosis of depression, who were either psychiatric inpatients or participated in a support group for people with depression. Of the 82 women, 61% reported a lifetime prevalence of domestic violence (this study includes same-sex violence) and 29.3% of lifetime prevalence of forced sex. This study found that the prevalence of domestic violence was approximately twice that of the general population and that "severity of abuse was significantly correlated to severity of depression" (p. 499).

To investigate the comorbidity of partner violence and psychiatric illness, Danielson, Moffitt, Caspi and Silva (Danielson et al., 1998) studied 1,037 participants (48% women, 52% men) in a 'Multidisciplinary Health and Development Study', since birth (1972–73). Using the 'Conflict Tactics Scales' to ascertain interpersonal violence experiences and the DSM-III-R classification system for mental disorders, they found that

> … over half of the women victimized by violence suffered a DSM-III-R disorder; they had significantly elevated rates of mood and eating disorders. Nearly two-thirds of the women victimized by severe[6] partner violence met criteria for one or more disorders and had significantly elevated rates of mood, eating, and substance disorders and symptoms of schizophrenia (p. 132).

An Australian longitudinal study focuses on women accessing an emergency department in a Brisbane hospital; with nearly half (48.4%) of 355 women who participated in a 'Women's Health Study' reporting lifetime intimate abuse (Roberts et al., 1998); and those

[6] Severe violence is defined as: "kick, bite, or hit with fist; hit with object; beat up; choked or strangled; threatened with knife or gun; use a knife or gun" (Danielson et al., 1998, p. 131)

> … who reported any form of lifetime intimate abuse received significantly more psychiatric diagnoses than those reporting no abuse, except that dysthymia[7] and somatization occurred least often in women reporting child abuse only. Women reporting both child abuse and adult abuse had the highest rates of all psychiatric disorders (p. 799).

Lifetime abuse resulted in higher prevalence of generalised anxiety, dysthymia, depression, phobias, current harmful alcohol consumption and drug dependence; with 48.5% of those reporting adult and child abuse showing lifetime PTSD and 30.6% of 'adult abuse only' showing lifetime PTSD.

A review of research by Briere and Jordan provides a summary of the understanding of the sequelae of experiencing interpersonal violence. They suggest, as others (J. Herman, 1992), that there is not one way that victim/survivors respond to violence but that responses involve "a number of different potential psychological symptoms or disorders" (p. 1261) and that similarities can be found whether the assault is of a sexual or physical nature, or whether it occurred in childhood or adulthood. They suggest that individual responses, retraumatisation and other social variables may influence the course of reaction for a female victim/survivor who is retraumatised in adulthood.

> Child abuse, for example, may produce symptoms that ultimately complicate or intensify a woman's response to an adult trauma, previous traumas may alter the intensity of her peritraumatic response to later traumas (p. 1261).

In summary, not only are revictimisation rates higher for those who have experienced abuse during childhood; the earlier experience of abuse can also exacerbate the experience of (re) victimisation during adulthood.

Revictimisation

People who have experienced childhood abuse (physical, sexual or otherwise) are more likely to be revictimised as an adults; additionally people with a mental illness are at higher risk of experiencing abuse. Both of these facts and the high level of abuse histories for those diagnosed with a mental illness constitute an even higher likelihood of re/victimisation for people who have a mental illness; and in particular for women with mental illness.

Briere and Jordan found that women who already have a mental illness or other psychological problems may be an easier target for interpersonal violence (Briere &

[7] Dysthymia is persistent, mild depression.

Jordan, 2004). They found that “women with chronic psychotic illness (e.g. schizophrenia) are easier prey for sexually or physically assaultive men” (p. 1257). Repeated victimisation is common for many women; Mouzos and Makkai (Mouzos & Makkai, 2004, p. 87) found that those women “who experienced abuse during childhood were one and a half times more likely to experience any violence in adulthood” and especially those women who have a mental illness (Banyard, Williams, & Siegel, 2002; Briere & Zaidi, 1989; Butzel et al., 2000; Gearon et al., 2003; Goodman et al., 1997; Goodman, Rosenberg, Mueser, & Drake, 1997; Jones et al., 2001; Kessler, Molnar, Feurer, & Appelbaum, 2001; Leonard et al., 2003; Muenzenmaier et al., 1993; Peleikis et al., 2002; Read et al., 2001; Roberts et al., 1998). Women with mental illness may also be an easier target because of their mental state, which may be associated with (for example) a lack of understanding about a potentially unsafe situation, while other factors include unsafe (living) environments. It has been found that mixed-gender facilities, including psychiatric wards, are places where revictimisation occurs frequently (Davidson, 1997; Graham, 1994; Victorian Women and Mental Health Network, 2008). Women often live in unsafe housing situations such as rooming houses, or are homeless and therefore are confronted with unsafe situations in order to have or keep housing. Women in family violence situations are particularly exposed to this dilemma, as separation often includes becoming homeless (Australian Institute of Health and Welfare, 2005; Chung, Kennedy, O'Brien, & Wendt, 2000). Similarly some women who, following abuse, turn to alcohol or drug use as a way of managing the experience (Briere & Jordan, 2004) and consequently become dependent on those, may live in unsafe circumstances; or drug use may impair their judgement about their own safety.

In summary, while in general those who have experienced childhood abuse are more likely to experience further abuse as adults, those (women) with mental illness are at even higher risk of revictimisation.

While the above discussed research studies all aim to show the connection between abuse and the development of mental illness there are some inherent issues that need attention. As discussed earlier, definitions of what constitutes abuse vary; furthermore the age-range for who is considered to be a child varies considerably; overall there is a strong emphasis on researching the impact of abuse on women’s mental health, while there is a lack of such studies which focus on men, or that investigate gender differences in the area of abuse and development of mental illness. The same gender disparity emerges when one looks at the type of illnesses that researchers have focussed on within this area of research. Women are more likely to suffer from depression, anxiety, eating disorders, Borderline Personality

Disorder than men, who tend to be diagnosed with Anti Social Personality Disorder more frequently than women; equally psychotic illnesses and the connection to abuse have not been investigated by researchers (with few exceptions, for example (Read, 1997) to the degree that other illnesses have, such as depression and the link to abuse. Most studies, with very few exceptions are retrospective in nature (for example see (Spataro et al., 2004), hence relying on individuals memory, which has been proven to show lower rates of abuse than actually has occurred, due to the fact that much abuse is 'blocked' by memory (Spataro et al., 2004). While many studies which show a correlation between childhood sexual/abuse and development of mental illness or mental health problems, there is a lack of research undertaken to investigate the effects of interpersonal violence perpetrated towards those with existing mental health problems/illness as well as a lack of research about those revictimised as adults who have a mental illness. While the impact of family violence on the individual is shown, there is a lack of investigation of such violence on those already suffering from mental illness. Concurrently there are divergent definitions used in studies which investigate the impact of family violence on mental health, some including only physical violence, while others use a broader and more commonly applied definition of violence and are inclusive of emotional, psychological and financial violence.

At the same time, those studies investigating a link between abuse and the development of mental health problems and indeed mental illness provide evidence about such a link and the need to not only take these experiences into account when providing mental health care but also to potentially question to usefulness of the medical model to 'treat' mental illness. If the development of mental illness is connected to childhood abuse experiences, for example, simply providing a drug to deal with anxiety or depression is unlikely to attend to the underlying issues associated with the long-term effects of abuse. This move away from a purely medical model has been promoted by many within and beyond psychiatry. The bio-genetic conceptualisation of mental illness has a strong focus on genetic predisposition and sees adverse life events as triggers to an "underlying genetic time bomb" (Read et al., 2004, p. 4). While the above discussed research studies which aim to show a connection between abuse and mental illness do not all claim that such an experience is the only factor for the development of mental illness, they provide evidence about the correlation between such trauma and the development of mental illness, no matter if the belief is that there is such a thing as a 'genetic time bomb' or not. This move away from a belief that mental illness is a purely genetic or medical condition proves to be in contradiction with the dominance of the medical model of psychiatry and its treatment of mental illness and people experiencing such

illness; while those who promote the bio-psycho-social model of psychiatry are likely to disagree that it (or they) gives preference to a medical approach to mental illness, critics express their dissatisfaction with the lack of balance to the 'bio' within the 'bio-psycho-social' approach and argue that there needs to be a move towards a more balanced approach that truly incorporates the 'social' dimension of such an approach (Read et al., 2004).

Conclusion

The literature review provides evidence about the level of abuse (family violence and sexual abuse) within the general population as well as those with mental illness. While prevalence rates are high in the general community, they are significantly higher in those who have a mental illness. A large body of research provides evidence about the connection between the experience of childhood sexual assault (CSA) and mental health problems as well as mental illness later in life. CSA has been linked with depression/anxiety, eating disorders, borderline personality disorders, post-traumatic stress disorder; and increased suicidality. It has also been documented that childhood sexual abuse can have an impact on the types of hallucinations and delusions of those with psychotic disorders. The mental health impacts of family violence include depression/anxiety and post traumatic stress symptoms or disorder as the most common responses; while dissociation and drug and/or alcohol dependency can also be a result of experiencing family violence.

The link between the severity, length, chronicity and recency of interpersonal victimisation and psychological distress has equally been established, with clear correlation between these factors and their mental health impact.

With some exceptions, abuse is directed towards women and children and is mostly perpetrated by males; overwhelmingly such abuse is perpetrated by a person known to the victim/survivor rather than a stranger. While studies tended to exclude males as victim/survivors and data is still scarce, more recent studies within the mental health context provide evidence about a relatively high level of childhood sexual abuse among those men diagnosed with mental illness.

Those who have experienced abuse during childhood are more likely to be revictimised during adulthood and this likelihood is increased for those with mental illness, who are particularly vulnerable to abuse. People with mental illness who have been abused tend to come into contact with mental health services earlier and more frequently and tend to use emergency and acute services more often than those with mental illness who have no abuse histories.

Recent studies provide evidence about the economic cost of violence (abuse) for the individual (both victim/survivors and perpetrators) as well as the Australian/Victorian community at large. The health cost of violence against women, for example, is estimated at $314 million for Australia; with mental health costs comprising over half of overall health costs.

In conclusion, numerous research studies provide insight into the connection between trauma—sexual abuse and/or family violence—and mental health impact. Psychiatry has traditionally had a biological focus for understanding (the development of) mental illness and treatment responses; more recently a shift towards a more inclusive view of mental illness and (therefore) treatment responses has begun to emerge internationally. This trend is discussed below.

Emerging issues

Internationally, the past decade has seen governments increasingly acknowledging the impact of abuse on mental health and also responding to this fact in a number of ways. Responses include formation of policy or guidelines by governments or professional bodies; in some instances the development of trauma informed mental health care; trauma (mental) health services; and attempts to improve safety within psychiatric inpatient units. This section provides an overview of some of the work undertaken in response to the knowledge of the link between abuse and mental health/illness and especially in relation to the need to protect those with mental illness from (further) abuse.

Countries such as Canada and the United Kingdom have developed national strategies to address women's mental health issues, including abuse. The Canadian strategy calls for the need for mental health services to develop "specific treatment/support protocols for women with present and past experiences of physical and/or sexual violence" (Morrow, 2003, p. 10). The Department of Health in the United Kingdom has developed a similar strategy (M. H. Department of Health, Health & Social Care Standards & Quality Group,, 2003b), which addresses issues of women's safety in mixed-gender wards. The UK government has more recently also published a national policy on violence and abuse for mental health services (Department of Health, 2008). New Zealand has developed a national strategy for health and mental health services to respond to interpersonal violence (Ministry of Health, 2001, p. 24). The USA has published guidelines on identifying and responding to domestic violence for health care including mental health settings (Family Violence Prevention Fund, 2004).

Common themes in all of these policies are the acknowledgment of a connection between abuse and mental health/illness; the need to prevent further abuse; locating the responsibility for inquiry and adequate responses within mental health services; and a mandate to support those entering mental health services who have experienced abuse.

Governments across the globe have also provided guidance about these issues via more practically orientated resource manuals, which generally outline practice principles, procedures, expectations and appropriate responses. Examples of these come from the USA (Department of Health, 2001) British Columbia (Morrow & Varcoe, 2000); Wales (National Assembly of Wales, 2001); and the state of New York (Office for the Prevention of Domestic Violence, 2000). While there are differences in the level of detail between those documents, they include guidance for mental/health care professionals, managers and organisations in responding to abuse (Department of Health, 2000; Morrow & Varcoe, 2000); and model policy statements and strategies/steps for implementation (Morrow & Varcoe, 2000). Routine assessment of domestic violence during the intake/assessment phase of mental/health care is proposed by most guidelines (National Advisory Council on Violence Against Women, 2001). Additionally, a number of governments focus on inter-agency or cross-sector collaboration (Department of Health Western Australia, 1998) Ministry of Health, 1998; (Department of Health Western Australia, 1999; Ministry of Health, 1998). To assist with the implementation process some governments have produced comprehensive resource and training manuals (Ganley, 1998; Warshaw & Ganley, 1998).

Some work towards increasing a trauma focus within mental health services, aiming to support the development and sustainability of “trauma-informed services that address the mental health needs of domestic violence survivors and their children” (Domestic Violence & Mental Health Policy Initiative, 2002). Similarly, other governments have provided guidance towards redeveloping mental health care into more trauma-focused care (Jennings, 2004). Yet others have chosen to set up specialist trauma centres, such as the Psychological Trauma Clinic at Los Angeles County and University of Southern California Medical Centre (Briere, 2002; Middleton & Higson, 2004).

Some Governments have also increasingly aimed at the prevention of abuse within psychiatric inpatient units through strategies and guidelines in order to increase safety (M. H. Department of Health, Health & Social Care Standards & Quality Group, 2003a, p. 35). Research studies have for some time provided insight into the level

and impact of such abuse (Jennings & Ralph, 1997)Graham, 1994; Quirk, Lelliott, & Seale, 2004).

The development of government responses includes the acknowledgment of a link between abuse and mental health impact and the need for government and mental health services to respond to this fact by making ‘abuse’ the core business of mental health services. Additionally it has been established that unless policies and guidelines are implemented together with skills development, those working in mental health services generally do not inquire about abuse histories (Irwin & Waugh, 2001; Read & Fraser, 1998b; Young et al., 2001; Agar et al., 2002; Cusack, Frueh, & Brady, 2004); at the same time mental health clients tend not to spontaneously disclose such an experience unless they are asked (Read & Fraser, 1998a).

In summary, governments around the world have begun to widen the conceptual framework of mental health services including paying attention to both the impact of abuse on mental health as well as prevention of (further) abuse from occurring within mental health care settings. This reconceptualisation of mental health care includes a move away from a solely biological (medical) focus as an explanatory model of mental illness, towards the inclusion of social factors—hence moving abuse into the core business of mental health services.

While internationally governments have moved to address abuse within the mental health services’ context, this is not the case in Australia. While some work has been undertaken by specific Australian State Governments, Australia lacks research investigating policies that address abuse and mental illness.

The next chapter provides a historical overview of the development of mental health services and policy in Australia.

Chapter 3: Mental health services and policy in Australia

Introduction

Madness, that is unreason, had to be put away, confined to another place and withheld form the gaze of society …. (Healy, 2003, p. 104)

This chapter provides an overview of the development of mental health services and policy in Australia and Victoria. It focuses on the progressive elaboration and application of a human rights framework for mental health policy. Concerns about physical and sexual abuse of people with a mental illness are set within this context. The chapter argues that concerns about the human rights of people with a mental illness have become increasingly significant as movements to establish civil and human rights more broadly have been successful.

Attitudes, language and perceptions shift with developments over time. From the early period of white settlement, Australian mental health policy underwent significant change and development. Initially there was a strong focus on custodial care of people who were mentally ill. People were locked away in asylums, partially for their own protection, but often because they were seen as dangerous or criminals. During this period there was poor understanding of the basis of mental illness and little in the way of treatment or rehabilitation. By current standards custodial incarceration was often cruel and inhumane (Lewis, 1988).

Subsequently and for most of the 20th century, policy for people with a mental illness shifted to a focus on care and treatment. Understanding of the environmental and biological basis of mental illness grew and a range of treatment methodologies and regimes were developed. In particular, new forms of pharmaceutical and psychological interventions evolved. Nevertheless, people with serious mental illness often continued to be isolated in large congregate residential care facilities in circumstances which would not be considered acceptable today (Lewis, 1988; Singh, 2007a).

It was not until the late 20th century that a strong focus on the rights of people with mental illness emerged—coinciding in developed countries and particularly the United States with a broader concern with civil and human rights for a range of disadvantaged and oppressed groups. This resulted in a concerted policy of deinstitutionalisation of congregate care facilities for people with serious mental illness and a move towards community-based care; and more recently the inclusion of a focus on recovery (Fossey, 2001).

Alongside these developments has been the articulation of a growing recognition of the rights of people with a mental illness to be safe from violence and abuse from others who may harm them. The early view of people with mental illness as dangerous and a threat to society did not include a concern for their safety. The move from a need for society to be protected from those with mental illness to a need to protect those with mental illness from abuse, neglect or human rights abuse (Human Rights and Equal Opportunity Commission, 1993c), reflects international changes. This shift towards the need for protection is expressed through rights-based frameworks and philosophies.

Internationally the move towards a focus on human rights began after the Second World War with the establishment of the United Nations (UN), and drawing on the UN Charter of 1945 on the Universal Declaration of Human Rights (Singh, 2007e). Concurrently with these events, international developments in the area of human rights include, among others, the civil rights movement in the USA (working towards abolishing racial discrimination against African-Americans) and the women's (feminist) movement (which includes the call for a life free from abuse and violence). The declaration of the Rights of Disabled Persons and the UN Declaration for the protection of persons with mental illness of 1991 are closely linked to the changing nature of state-based responses to people with mental illness.

Initially mental health services in Australia were not guided by national or state policies, but rather by leaders (within mental health services) who frequently came from overseas, and implemented changes on a state or sometimes local level. It was only during the early 1990s that Australia began to develop a national approach to mental health care (Singh, Benson, Weir, Rosen, & Ash, 2007). Changes reflected and were influenced by international developments. It has been within this context that mental health policies' inclusion and exclusion of issues has developed; and, as will be discussed later, this is also the case for issues of sexual abuse and family violence.

Along with the developments and changes in mental health services and the recognition of the rights of people with mental illness, community attitudes, laws and government approaches have also changed; and so has the language that reflects thinking and attitudes towards people with mental illness. While terms like 'lunatic', 'idiot', 'mental hygiene', 'lunacy', 'mental deficiency' and others were used during the eighteenth and into the nineteenth century, since the later part of the twentieth century those terms have no longer been in use. In this historical overview the terminology of the former time is reflected; however when such terms are used they

are accompanied by single quotation marks (with the exception of original quotes), to express respect towards people with mental illness.

The following section provides an overview of the way both the federal government of Australia and the state government of Victoria have responded to people with a mental illness, from 'pre-medical treatment era' responses to 'institutionalisation' and 'treatment in the community'.

Pre-medical treatment

Australia initially adopted a British approach to care for 'lunatics' and the 'insane' during the early years of white settlement; while at the same time "law, administration and systems of care were shaped by the colonial experience—at first by the penal character and autocratic government of the early settlement" (Lewis, 1988, p. 1). Criminality and 'insanity' were closely linked and initially all people deemed 'insane' were accommodated in jails; during the early 1800s 'criminals' and 'lunatics' were separated in the first asylums; however well into the 1880s people would continue to be admitted to asylums after having been arrested by police (Lewis, 1988). The 'insane' were seen as dangerous and therefore needing to be incarcerated. This philosophy of incarceration and protection of society from the 'insane' reflected a lack of concern about those who have a mental illness and their treatment and protection from (human rights) abuse.

Institutionalisation

The next phase of mental health services, mirroring international developments, was a move towards care for people with mental illness in separate institutions from those incarcerated for criminal activities; this development is characterised by the development of large institutions.

Australia's first asylum, Castle Hill, was opened in NSW in 1811; other Australian states followed and Victoria established the Yarra Bend asylum in 1848. This move of separation between the 'criminals' and the 'insane', saw the 'insane' treated within the same institutions as those deemed 'idiots' or 'retards' (people with an intellectual disability) and 'inebriates' (people with an alcohol dependency).

In Australia, the modern era of concern about segregation and institutionalisation has its formal beginnings in 1955 when Stoller and Arscott undertook an inquiry into the standards of mental health services. This provided the first national overview of the treatment of people with mental illness (Stoller & Arscott, 1955). Stoller and Arscott's inquiry found that Australia's standards of mental health care were "lower than those

existing in the United Kingdom, United States of America and Canada. They are lower in terms of beds, staffing, extramural activity and research. Yet standards overseas are by no means ideal" (Stoller & Arscott, 1955, p. 165). The positive changes towards improving mental health facilities that occurred in other countries after 1945 were not reflected in Australia. The inquiry's report included suggestions for a better coordinated mental health care system across Australia, proposing the establishment of a Federal Mental Health Division and the establishment of Mental Health Divisions within state health , which were to oversee the development of mental health services. Following this report, the financial relationship between the Commonwealth Government and the states changed to enable provision of services through a partnership approach between the Commonwealth Government and state governments.

Victoria followed the example of the United Kingdom closely, due to the employment of a British doctor, Ernest Jones (Mental Health Authority, 1968) who increased the number of hospitals and advocated as early as 1941 for a closer link between general hospitals and psychiatry (Lewis, 1988, p. 37). Following an inquiry which reviewed mental health services in Victoria, the first central authority for psychiatric services was established in 1952 under the British psychiatrist Cunningham Dax. Staff ratios began to increase with the injection of funds following the Mental Health Act of 1959 (Government Printer, 1963) and included employment of staff from all disciplines (nurses, psychiatrists, social workers, medical officers and psychologists).

Victoria was something of a leader in change among Australian states and it continued on this path with Cunningham Dax' suggestion for closer proximity between general and psychiatric hospitals (Dax, 1961). The 1950s and 1960s also saw the development of the first effective antipsychotic, antidepressant medication as well as the first tranquillizers (McDermott & Meadows, 2007). The development of these and other drugs, paved the way towards deinstitutionalisation, with the possibility of treating those with mental illness outside of institutions.

Concurrently to the development of these drugs, institutionalisation and segregation of people with mental illness from the general public were increasingly criticised. Movements of the 1960s and 1970s promoted human and civil rights of all citizens, including those with mental illness—at least in its intention.

Following these developments, the first Community Mental Health Centre in Melbourne was established in 1973 and by 1980 there were twelve in Victoria (Lewis, 1988); during 1982 services for mental illness and intellectual disability were separated; the Victorian Mental Illness Awareness Council (VMIAC)—a consumer

organisation—was established during the 1980s; and the Office of Psychiatric Services was established in the same year as the release of the Mental Health Act of 1986 (Office of Psychiatric Services, 199?). Along with these developments significant concerns were expressed about the quality of care provided in institutions; and people with mental illness and disabilities were progressively considered to have rights, including the right to be free from abuse and to be able to participate in everyday settings and activities. Institutionalisation still locked people away for long periods without much focus on the possibility of rehabilitation or any belief that people with mental illness could live in the community.

A number of consultations were undertaken into the lives of people with mental illness, such as the Eisen-Wolfenden report (1989) into the Commonwealth's involvement in mental health (Singh, 2007b); followed by the report of the first inquiry into human rights of people with mental illness, which was published in 1993 by the Human Rights and Equal Opportunity Commission (Human Rights and Equal Opportunity Commission, 1993c). The report of the Commission documents human rights abuses being perpetrated against people with mental illness within psychiatric institutions across Australia. Unfortunately the change from incarcerating those with mental illness in jails to placing them in institutions did little towards protecting them from abuse. The report includes accounts of harassment and assault of women within those institutions, perpetrated by staff, other patients and visitors. The notion of separating people with mental illness from society was also increasingly seen as a restriction—if not abuse of—a human right—that of freedom to live within the community. The move towards a rights-based philosophy included deinstitutionalisation had occurred internationally during the late 1960s and in the 1970s.

Treatment in the community

1992 represented an historic turning point for mental health policy and service delivery in Australia. Recognising the need for a unified, dedicated reform agenda, governments in Australia came together to endorse the principles and the plan for reform under a National Mental Health Strategy. (Australian Health Ministers, 2003, p. 3)

Foreshadowed by developments discussed above, the next phase in the development of psychiatry in Australia during the 1980s and 1990s, namely 'deinstitutionalisation', saw a move from the remaining large hospitals to community-based mental health services. This occurred at the same time as the need for national policy response and guidance for the provision of mental health services was

articulated (Singh & Fossey, 2007). These developments occurred as a response to a number of developments in Australia, the Eisen-Wolfenden report; the Royal Commission's report; submissions by the Royal and New Zealand College of Psychiatrists (RANZCP) and pressure by consumer groups all contributed towards a move towards the closing of large institutions, namely deinstitutionalisation.

Deinstitutionalisation emphasised, at least theoretically, the rights of people with mental illness to take part in community life; this led to the development of service mainstreaming and community integration. Institutions were seen as environments which by their very design could not provide residents with normal opportunities for participation in society. Throughout the 1990s across Australia mental health services were increasingly provided in the community. Developments in Victoria during this time parallel national developments; however it took most of the 1990s to close the last of the large institutions (Office of Psychiatric Services, 199?).

During the 1990s, driven by those policy directions, Victoria began to establish Area-Based Public Mental Health Services, comprising Crisis and Assessment Teams; Mobile Assessment and Treatment Teams; and Community Mental Health Clinics. Stand-alone psychiatric hospitals were closed down and psychiatric inpatient units were integrated into generalist hospitals (Singh, 2007c). During the 1990s mental health consumers, as well as carers and families of people with mental illness, became increasingly involved in service development and delivery. This move towards providing treatment and care within the community as much as possible is part of a move towards a rights-based framework and is a recognition of the need to provide mental health care in the least possible restrictive way.

Deinstitutionalisation and the development of community-based care are guided by policies in Australia and Victoria. The next section provides an overview of national and Victorian policy development that has guided clinical mental health service provision during the 1990s and into the twenty-first century.

Policy development: Australia[8]

The National Mental Health Strategy of 1992 provided the first national approach to mental health care in Australia. This was articulated through the National Mental Health Policy (Australian Health Ministers, 1992b); the National Mental Health Plan (Australian Health Ministers, 1992a); the Mental Health Statements of Rights and Responsibilities (Australian Health Ministers, 1991); and the Medicare Agreements,

[8] The key policy documents mentioned in this sub-section are summarised in table form in Appendix D (Commonwealth policies) and Appendix E (Victorian policies).

which provided funding for the reform agenda. The National Mental Health Policy outlines and supports new approaches to mental health care provision in Australia, including community-based care: it states three major aims, one of which is “to assure the rights of people with mental disorders” (Australian Health Ministers, 1992b, p. 11).

The Mental Health Statement of Rights and Responsibilities outlined the civil and human rights which underpin the National Mental Health Strategy (Australian Health Ministers, 1991); it included rights and responsibilities of carers, advocates, service providers, and consumers of mental health services.

The National Inquiry into the Human Rights of People with Mental Illness (Human Rights and Equal Opportunity Commission, 1993a, 1993b) echoed the need for a move towards a human rights approach to mental health care and the need for protection of people with mental illness. This inquiry constituted a major catalyst to the development of a national approach to mental health in Australia. The report provided anecdotal evidence about human right abuses within the Australian mental health system, which contradicted Australia’s position as signatory to the UN ‘Principles on the Rights of the Mentally Ill’ (United Nations, 1991).

The Second National Mental Health Plan (Australian Health Ministers, 1998), promoted a broadening in focus of mental health care to include those suffering from depression, based on findings of the World Health Organization which document that depression constitutes a major burden of disease worldwide (namely 11 per cent).

Two national policy documents, published in 1998 and 2000 under the Second National Mental Health Plan also provided a new focus—that of the inclusion of prevention and mental health promotion within mental health care (Australian Health Ministers, 1998). This policy framework adopted Mrazek and Haggerty’s concept of health promotion (Mrazek & Haggerty, 1994), spanning ‘prevention, early intervention, treatment and maintenance’.

While not strictly a policy document, a publication under the National Mental Health Strategy by Emeritus Professor Beverley Raphael further strengthens governments’ call for changes in mental health care in Australia (Raphael, 2000). Raphael suggests that it is vital to recognise “the *social factors* that contribute to health and ill health” (p. 3, italics in original). She suggests that the mental health system—with its focus on treatment rather than prevention and health promotion—stands in contradiction to a framework that encompasses a “full spectrum of interventions from prevention” (p. 3) to treatment and maintenance. Population health, according to Raphael

> … implies an understanding of the social system influencing health and their environments and institutions. It will include prevention directed to populations that are vulnerable. (Raphael, 2000, p. 8)

The Third National Mental Health Plan 2003−2008 (Australian Health Ministers, 2003) adopts a population health framework based

> … on the understanding that the influences on mental health occur in the events and settings of everyday life. It recognises that health and illness result from the complex interplay of biological, psychological, social, environmental and economic factors at all levels—individual, family, community, national and global (Australian Health Ministers, 2003, p. 9).

Furthermore the population health framework "recognises the importance of mental health issues across the life span, from infancy to old age and across diverse groups within the population" (p. 9) as well as those with complex needs.

Current Australian mental health policy at the time of writing this thesis identifies, for the first time, national safety priorities for mental health services (National Mental Health working group, 2005). The plan sees safety as an integral component of quality in mental health service provision and provides ten principles for "planning, developing and implementing safety activities and safety improvement processes in mental health services" (National Mental Health working group, 2005).

Reflecting international developments, Australia has also seen some changes in the relationship between mental health services: and consumers of mental health services; consumer-run advocacy groups and individuals increasingly provide advice and guidance to mental health services, are involved in determining their own treatment; and represent the 'consumer voice' on state and Commonwealth mental health advisory groups (Olsen & Epstein, 2001).

Policy development: Victoria

An injection of funding through the National Mental Health Plan contributed to changes in the Australian states and territories—including Victoria—during the early 1990s (Australian Health Ministers, 1992a). The move towards deinstitutionalisation was accompanied by policy which provided an outline for continuing reform to be undertaken in Victoria (Office of Psychiatric Services, 1992). The election of the Kennett Government saw the mainstreaming process temporarily put on hold as the department put its own 'stamp' onto the deinstitutionalisation process with the publication of further policy directions (Office of Psychiatric Services, 1992) and

promotion, for the first time, of a state-based strategy for the co-ordination of the mental health system in Victoria (Psychiatric Services Unit, 1993). State government policies provided further direction for the redevelopment of mental health services in Victoria (Psychiatric Services Division, 1994; Psychiatric Services Division, 1996); in accordance with these policies and the National Mental Health Plan the change from institutions to community-based mental health care was completed during 1996/97.

In 1997 the department published Victoria's (only) women's mental health policy, acknowledging that "women with mental illness are a key group of service users who will benefit from policy directions that require mental health services to continue to adapt current practice to more appropriately and adequately meet the needs of consumers" (Victorian Government Department of Human Services, 1997, p. iii).

A further policy document published by the Mental Health Branch in 2002 (Victorian Government Department of Human Services, 2002a) sets priorities for the years 2003 to 2007 for mental health services in Victoria. This policy is concerned with the increased demand for services and the increase in people with complex needs presenting at public mental health services.

Changes over time

People affected by mental illness are among the most vulnerable and disadvantaged in our community (Human Rights and Equal Opportunity Commission, 1993a. p. 1)

Mental health policy development on both a federal and state level has taken place against a backdrop of international developments. The 'Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care' (United Nations, 1991), adopted in both the National Mental Health Plan and Policy (Australian Health Ministers, 1992a, 1992b) provide guiding principles for the protection of people with mental illness. This shift towards recognising a need to protect people with mental illness from harm, including a protection from sexual exploitation by others, provides a strong message to policy makers about the level of vulnerability of many of those who suffer from mental illness. This message is strongly echoed by the Australian report on human rights abuses experienced by mentally ill people within the Australian mental health services context (Human Rights and Equal Opportunity Commission, 1993c). Reflecting international developments, trends in Australia throughout the 1990s show a move towards an increasingly evidence-based practice, a focus on prevention and early intervention, working within a population health model, a whole-of-life-span approach, and working within a health/mental health promotion framework. Policy changes and directions express

this need to ‘widen the gaze’ towards an inclusion of the broader context of people’s lives—in order to understand and (better) respond to those suffering from mental illness. Prevention includes the notion that risk as well as protective factors need to be known and that prevention is highly dependent on the identification of biological, environmental *and* psychological factors (Singh, 2007a). A recovery model has been adopted in mental health care: this is influenced by a population health model, takes a lifespan approach, and includes mental health prevention and early intervention. While a contested concept by some, those promoting recovery point out that recovery means “rebuilding a meaningful and valued life” (Repper & Perkins, 2003, p. 45). While adopted into current mental health care models, recovery is not necessarily understood the same way by all those involved in mental health care and treatment. A concept developed by those who have and are experiencing mental illness, requires a broader view of mental illness, its impact on the individual as well as the life events which go along with developing and being diagnosed with a mental illness. Those promoting recovery focussed mental health care also suggest that some of the concepts and impacts of the mental health system may need to be first better understood by mental health clinicians before they can truly grasp ‘recovery’ (Repper & Perkins, 2003). Experiences of people with mental illness of the treatment they receive (the kind and the way they are treated) is more likely beyond their control than undertaken in ‘partnership’ with them. The loss of power as part of the process of receiving a diagnosis and utilising mental health services are all issues that play a role in the recovery process. Regaining control, making meaning of experiences, re-establishing a sense of self are all factors contributing towards recovery. Concurrently recovery is “not the same *as cure*” (Repper & Perkins, 2003, p. 46, italics in original) however recovery can be conceptualised as “remaining symptoms and problems interfere less with a person’s life” (p. 46); representing an integration of experience into a person’s life. Those who interpret recovery as being cured from an illness, contest that recovery is possible for people with mental illness if their mental illness still prevails, while those arguing that “recovery is not an end-point but a continuing journey: people are not ‘recovered’, they are ‘recovering’; [furthermore] people are not recovering from illness, but recovering meaningful and valuable lives whether or not their problems can be eliminated” (Repper & Perkins, 2003, p. 59). If recovery is considered as part of current mental health practice, then issues arising as part of the development of mental illness, during the course of mental illness, need to be taken into account and given adequate focus in order to integrate them into the meaning making and search for a meaningful life for those living with mental illness and its effects.

The recovery model is, at least theoretically, inclusive of life before development of mental illness, life with mental illness as well as hope for a future in which the person with mental illness will be able to live as best as they can within society. It is not surprising then, that as part of this shift towards a 'whole of life approach' issues of sexual abuse and family violence have started to emerge in the lives of those with mental illness.

In summary, developments have seen a shift from incarceration alongside 'criminals', to institutionalisation and finally a move to community (re) integration of people with mental illness. Such changes are also characterised by a move towards and an adoption of several frameworks: consumer rights; a population health model; mental health prevention and early intervention; as well as recovery. These frameworks not only promote the inclusion of a whole-of-life approach, they also promote a broadening in conceptualisation and understanding of mental illness. One of the most significant shifts in this area has been the focus on human rights of those with mental illness, following international trends. This shift, which developed alongside of international human rights developments, is reflected in the consumer rights movement in Australia and attempts by those developing policy and providing mental health care to do so in a much more 'human way' as compared to earlier years. The shift from social exclusion (incarceration and institutionalisation) to social inclusion and community based care goes hand-in-hand with a shift towards a bio-psycho-social approach to understanding of mental illness and treatment options (Meadows, 2007). This shift to some degree includes recognition of the broader context of people's lives and the impact on later life of developments during childhood, adolescence and adulthood.

Australia followed international developments in the conceptualisation about how to treat those with mental illness by incorporating the development of the Universal Declaration of Human Rights by the UN in1945, publishing the Mental Health Statements of Rights and Responsibilities (Australian Health Ministers, 1991) and conducting its own National Inquiry into the Human Rights of People with Mental Illness (Human Rights and Equal Opportunity Commission, 1993a, 1993b). While deinstitutionalisation, treatment in the community, increased visibility of those with mental illness are all developments that have contributed towards greater 'integration' of people with mental illness into mainstream society, there is equally still much work to be done in order to truly achieve human rights for people with mental illness. While modern psychiatry promotes itself as operating within a framework that provides a 'bio-psycho-social' approach to mental illness, in reality the dominance of the 'bio-medical' approach still exists.

Rogers and Pilgrim (2005) suggest that "the *medicalization of psychological abnormality*" (p. 144, italics in original) has occurred through the focus on providing a medical response to those with mental illness. Criticism of this medical focus combined with coercive methods of imposing treatment on people was the focus of what became known as the 'anti-psychiatry' movement or the 'anti-psychiatrists' during the 1960s and 1970s. Those advocating that psychiatry asserts "coercive social control" (Rogers & Pilgrim, 2005, p. 130) challenged psychiatry about these and other 'methods' of treatment of people with mental illness. The anti-psychiatry movement challenged the notion of 'voluntary' treatment, when psychiatry has the power to impose, coerce and 'make' people do things or receive treatment against their will. Some forty years later these tensions between coercing people into treatment, being able to 'make' them comply (via the Mental Health Act) and at the same time promote consumer and carer involvement in consumers' treatment and options remains, often unchallenged.

Those questioning the coercive role of psychiatry point out that psychiatry regulates people's lives and that professionals "act as agents of the state" (Rogers & Pilgrim, 2005) and that power is located in the hands of professionals who dominate their clients at the behest of their state employer" (p. 131).

> Psychiatric treatment remains in a precarious state of legitimacy. This uncertainty is then amplified by the doubts about the effectiveness of both physical and psychological therapeutic approaches and the complaints that have accumulated about the iatrogenic effects of these treatments (Rogers & Pilgrim, 2005, p. 164).

Concurrently the focus on providing predominately medical care, as opposed to a mix of approaches provides its own challenges in a system that is generally spoken of as providing choices and involves consumers and carers in treatment planning. Rogers and Pilgrim (2005) suggest that "throughout medicine, therapeutic preferences are evident. Certain treatments may predominate, but they coexist with lesser-used alternatives" (p. 143). While the 'bio-psycho-social' approach of psychiatry may include so called 'alternative' treatments (such as 'talking therapies'), it is equally true that "the fact that psychiatric treatments are biased more towards drugs and ECT[9] is indeed a problem" (Rogers & Pilgrim, 2005, p. 143). People with mental illness do generally not get a choice in relation to if or indeed what type of medication they are prescribed, the decision about such matters usually lies with the psychiatrist or medical officer. Those utilising mental health services often describe services provided as "overwhelmingly limited to medication" (p. 143) rather than providing a

[9] ECT= Electric Convulsive Therapy

more balanced service which offers various treatment options and choice about such treatment. Rogers and Pilgrim suggest that this “strong bias towards drugs reflects bio-medical professional preferences at the expense of user choice” (p. 143). This inability of the mental health system to broaden its treatment options and provide choice about treatment types clearly stand in contrast to a system that values patients’ opinions, self-determination and truly reflects a focus on ‘human rights’.

The move from large institutions into more integrated services, which saw the move of psychiatric inpatient units into mainstream hospitals, has in reality only partially achieved a move towards greater human rights for those with mental illness.

> Although ‘community care’ may have ended incarceration in remote asylums, rejection and exclusion are as much a reality of life for people with mental health problems as they have ever been. Indeed those diagnosed with a significant mental illness are amongst the most excluded in society. (Sayce, 2000, p. 19)

Segregation of those with mental illness continues in ‘psychiatric wards’, which, while often situated within general hospitals, are still separate to mainstream wards. Community organisations wanting to set up housing or other support services for those with psychiatric disabilities are, to this day, at times confronted with hostility by those living in surrounding areas, displaying attitudes such as ‘they (people with a mental illness) are not welcomed in our neighbourhood’. Those with mental illness find it harder to gain and retain employment and are often confronted with the difficult decision ‘to tell or not to tell’ about their mental illness (Repper & Perkins, 2003; Rogers & Pilgrim, 2005; Sayce, 2000). Those able to hide their mental illness may choose to do so when applying for work or housing, in order to obtain what other citizens take for granted. Concurrently a hierarchy of oppression exists when it comes to types of mental illness, “the nature and intensity of discrimination varies by the diagnosis and visibility of mental health problems” (Sayce, 2000, p. 60). Admitting to someone that one has depression will receive less negative attention than admitting that someone suffers from schizophrenia or Borderline Personality Disorder. Displaying depressive symptoms generally attracts less negative attention than someone talking to themselves or the voices they hear.

At the same time as ‘human rights’ for people with mental illness are promoted, those with mental illness are still treated against their will and in a system that promotes medical intervention through the prescription of medication, often with little choice of treatment options. Those utilising mental health services suggest that “forced detention and treatment have damaged them” (Sayce, 2000, p. 65); most patients in

Victorian psychiatric inpatient units are there on an involuntary basis and are prescribed medication and treatment against their will (Humphries, 2008). While the promotion of human rights for people with mental illness has been, at least in theory, adopted by mental health services, states and territories in Australia, a discrepancy remains between people's rights (for example to refuse treatment) and control by government (through the mental health act). Those carrying out government's legislation can impose treatment and detain those deemed unable to make decisions for themselves. This discrepancy can provide a dilemma for those concerned with human rights for people with mental illness. While long-term incarceration is no longer acceptable, community based treatment orders are authorised against people's will; "they permit involuntary treatment in the community of some people with mental illness who are subject to an involuntary order" (Chief Psychiatrist, 2005, p. 1). Such treatment against one's will can be experienced as an extension of "having one's views invalidated [and this] also lies at the heart of being treated compulsorily or without properly informed consent" (Sayce, 2000, p. 65).

People with mental illness often report that they are frequently not believed, that their opinion is invalidated and that often they are not taken seriously (Sayce, 2000), while the general public holds many prejudices against those with mental illness, these experiences of being invalidated are echoed from within mental health services. To counteract the labelling of people with mental illness the consumer movement (individuals and organisations) have focussed on demystifying mental illness and associated behaviours. The disregard and disbelief has worst outcomes when people with mental illness report crimes perpetrated against them. The recent "Study on reported rapes in Victoria" (Heenan & Murray, 2006) provides evidence about the high percentage of complaints by those with mental illness not being followed through to court; one of the main reasons for this being that

> the most significant difference in cases involving victims with a psychiatric disability compared to the overall sample appears to be amongst Police members' views of the allegations. (…) members expressed some degree of disbelief in over 40 per cent of cases (compared to 20.6 per cent in the wider sample) and were confident that the allegations were false in 14.5 per cent of cases (compared to 9 per cent in the wider sample) (p. 34).

Even those members of the Victorian police specialised in responding to victims of sexual assault (SOCAU members) "indicated more negative views about the veracity of reports of rape victims with psychiatric disabilities" (30.6 % as compared to 9.9% in the overall sample) and were more inclined to state that they believed that the allegations were false (p. 34). The experience of not being believed, is unfortunately

not new to people with mental illness, however it has greater impact when those involved in statutory institutions perpetuate disbelief, with the impact potentially being much greater on the individual person. This disbelief stands in stark contrast to research which shows that those with mental illness are no more likely not to tell the truth than those without such illness, on the contrary generally sexual abuse is underreported (Read, Hammersley, & Rudegair, 2007; Spataro et al., 2004).

The above discussed issues pertaining to the lack of human rights of people with mental illness are in contrast to the Statements of Rights and Responsibilities (Australian Health Ministers, 1991) and the recommendations of the report of the National Inquiry into the Human Rights of People with Mental Illness (HEROC, 1993a, 1993b) and the report acknowledges that

> people affected by mental illness are among the most vulnerable and disadvantaged in our community. They suffer from widespread, systemic discrimination and are consistently denied the rights and services to which they are entitled.

The report, documenting widespread human rights abuse, makes numerous recommendations with a view to increase rights to ensure the dignity of people with mental illness. It appears that many of the recommendations are still not implemented some 15 years later. The frequent experience of consumers which documents a lack of their involvement in their treatment stands in contrast to the recommendation that "patients should he given an opportunity to express views and ask questions of the prescribing doctor". Equally, the lack of involvement of consumers in protecting their rights and a lack of avenues to persue complaints and grievances if they disagree with treatment is does not correlate with HEROC's recommendation that "controls and safeguards [are needed] to protect the rights of people with mental illness and [to] ensure that they receive appropriate care". The experience of many people with mental illness, who do not receive the care and concern they wish for, stands in contradiction to the UN Declaration of Human Rights also. While the UN promotes that "all persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person" (p. 43). The statement goes on to suggest that people with mental illness have a right for protection and protection from degrading treatment; it is undertandable that those receiving involuntary treatment or feel coerced into complying with treatment disagree that they are provided with the protection they wish and believe they ought to receive.

While the late 20th century within mental health care is characterised by deinstitutionalisation, community treatment and human rights for people with mental illness and much has been achieved in promoting increased respect and dignity for people with psychiatric disabilities, there is still much more to be achieved if human rights are to be reflected in everyday life for those members of the community diagnosed with mental illness.

At the same time, the focus on community-based treatment and care, and the integration of and focus on human rights and dignity, provide the backdrop against which issues of abuse in the lives of those with mental illness have increasingly been articulated. While a lack of focus on protecting those with mental illness from abuse prevailed during the time of institutional care, with deinstitutionalisation and the introduction of a human rights focus it is no longer acceptable that those with mental illness are not protected from abuse; therefore policy and service providers have a responsibility to ensure that people are indeed protected from such abuse.

Changes in mental health systems and policy include a move from the disparate system of earlier years to a more coordinated system resulting from national and state policies and developments since the early 1990s. These changes have occurred in the context of international developments which have seen a move towards a rights-based framework and treatment of those with mental illness, and recognition of the need to protect people with mental illness from harm. At the same time, while this need to protect has been recognised and some work has been done in Australian states to address the issue, there is an evident lack of research on exploring abuse of people with mental illness—as well as a lack of policies that aim to address such abuse in Victoria and Australia.

The next chapter provides an overview of the policy framework utilised for this thesis.

Chapter 4: Policy Framework

Introduction

'Policy' is a central concept in both the analysis and the practice of the way we are governed. It gives both observers and participants a handle on the process, a way of making sense of the complexity of governing. (Colebatch, 2002, p.1)

This Australian Policy Cycle (Bridgman & Davis, 2004) provides the overall approach to analysing policy for this thesis, with a particular focus on agenda setting and policy implementation and is discussed in this chapter, alongside of some of the criticisms of this approach.

Public policy has been described as being "concerned with how issues and problems come to be defined and constructed and how they are placed on the political and policy agenda" (Parsons, 1995, p. XV). Analysis of policy is concerned with 'why' and 'how' something comes to the attention of 'policy makers' as well as the steps involved in the development, implementation and evaluation of policy. An increasingly more popular framework used in Australia is the 'Australian Policy Cycle': this thesis is concerned with the phases of 'agenda setting' and 'implementation'. The Australian Policy Cycle is most compatible with the focus and questions of this thesis and hence was chosen as an approach to undertaking this closer investigation on mental health policy.

Prior to discussing the Australian Policy Cycle, the next section discusses some of the problematic nature of policy.

A variety of frameworks, theories and approaches to describe and analyse the policy process have been developed. These include pluralist-elitist approaches focusing on power and its distribution among elites and how this impacts on decision making about policies (Cobb & Elder, 1972); policy discourse approaches which "examine the policy process in terms of language and communication" (Parsons, 1995, p. 39); and Neo-Marxist approaches, utilising Marxist theory in understanding and analysing policy. The way policy making is approached does influence how one approaches and conceptualises policy, ones understanding (or focus on) how it is formed, why some issues make the agenda, while other do not, who is responsible for policy, who decides on policies and what the dynamics are that influence agenda setting.

Public policy is not a straight forward concept, with just one definition, equally understood by those involved in policy making and those responsible for its

implementation; in contrast, public policy is a much discussed concept, with varying definitions and explanations as to how and why policy is made and implemented. Colebatch (2002, p. 7) suggests that

> although (or perhaps because) the term [policy] is so widely used, it does not have a clear and unambiguous definition. 'Policy' may be used to mean a broad orientation (…), an indication of normal practice (…), a specific commitment (…) or a statement of values (…).

Bridgman and Davis (2004) suggest that there is a "multitude of meanings (…) [about policy], since policy is shorthand for everything from an analysis of past decisions to the imposition of current political thinking" (p. 3). Colebatch (2001) suggests that

> 'policy' is a way of labelling thoughts about the way the world is and the way it might be, and of justifying practices and organizational arrangements, and the participants in the governmental process seek to have their concerns and activities expressed as 'policy' (p. 8).

Policy is a term widely used to describe 'what' and 'how' things are done within a specific context (organisation, government). Some approaches to how policy decisions are made assume that an "articulate, conscious choice" (Colebatch, 2002, p. 15) is made to develop and implement specific policies, those contesting this sentiment, such as Colebatch, suggest that it is not always that clear to understand how a decision is made and suggests that a policy decision may have its "origin in practice: what can be done conveniently and systematically, what works, what is consistent with the expectations that others have of us" (p. 15). He also suggests that, while it is often assumed that policy decisions are made 'at the top' (of government, of a division within government or within an organisation) and then passed down the administrative line, this is not always so. He suggests that the policy process is far more complex than that and it is not always clear were or who made the decision; for example is it the minister who signs off on a policy; the senior bureaucrat who provided the analysis and argument for policy development or is it another division with government which suggested the need to address a particular issue via a new policy?

Colebatch suggests that the "dominant paradigm in discussion of policy, by both participants and observers, sees it as the exercise of authority to achieve collective purposes" (p. 49). This way of conceptualising policy assumes purposive action to get to a specific goal. This goal orientated way of understanding policy, promoted by Bridgman and Davis as well as other authors, assumes that organisations and governments are "set up to pursue goals, and that for governments, these goals are

the optimal improvement in the welfare of people" (Colebatch, 2002, p. 51). Contrary to this assumption, Colebatch suggests that goals are not always clear; that if they can be defined, they can be vague or ambiguous and lack in guiding what action needs to be taken. While others, including Bridgman and Davis, suggest that the policy process can be understood in a "sequence of stages in the development and pursuit of this goal, beginning with thought, moving through to action and ending with the solution" (Colebatch, p. 49), Colebatch suggests that the policy process is hardly ever this neat and observers cannot clearly follow these steps, rather that several of the steps either occur concurrently or indeed some do not occur at all (a critique of the policy cycle will be provided later on in this chapter also).

Yeatman (1998) similarly to others suggests that "the relationship of these stages [policy agenda, development, formulation, implementation, delivery, evaluation and monitoring] to one another is more complex than that of a linear-circular sequence of feedback loops as it is often conceived" (p. 16). She furthermore suggests, as does Colebatch, that the stages overlap and that the policy process is not such a straight forward process.

Yeatman further suggests that policy can be experienced by service providers who are responsible for its implementation within their organisations as a "set of parameters, requirements, constraints and regulations over which they have little control" (p. 27). Those with the job to implement the policy, however do not always see new policy as part of their 'core business', according to Yeatman, which makes for a potentially tense relationship to policy and those sections and individuals in government that are responsible for providing the policy message to those who need to implement it. Yeatman proposes that if one understands the "policy process [being] designed in terms of the executive model of policy, this service deliverer perception of the relationship of policy to their real work makes sense" (p. 28). Yeatman proposes that policy is not simply made by those within bureaucracy but is a complex interplay between a number of players, including activists, policy makers and others; however that in the above-described process of an executive style of policy making, those responsible for its implementation may not experience themselves as being part of the making policy.

The Australian Policy Cycle

The Australian Policy Cycle, developed by Bridgman and Davis (2004) outlines one way of conceptualising the cyclic nature of the development, implementation and evaluation of public policy. The researcher appreciates that while these steps are not necessarily applied in a linear way when policy is formed, or indeed that frequently

not all steps are followed through in the process of policy making, the cycle does provide one useful way to understand policy formation. It includes eight steps: the identification of an issue (agenda setting); policy analysis; identification of relevant policy instruments; consultation; coordination; decision; implementation; and finally evaluation. While the policy cycle has been criticised by some as being an oversimplified approach to policy which does not address issues of content, but rather, outlines the process of how policy is made (Everett, 2003), it provides a useful conceptual framework of the policy process. The Australian Policy Cycle is essentially a process-orientated framework. The authors point out that the cycle is an analytical or explanatory tool rather than representing an 'absolute' framework that is adhered to each time policy is developed. To conceptualise the development of policy in a cyclical or staged way is not an entirely new approach; a number of authors have previously provided similar concepts in order to think about policy in a systematic way (Hogwood & Gunn, 1983; Bridgman & Davis, 2004; Parsons, 1995). The next section discusses the eight steps with a particular focus on agenda setting (how and why issues make the policy agenda) and implementation of policy, which are of specific interest to this research; alternative conceptualisations and explanations of agenda setting and implementation are also be provided.

The initial step in the policy process is the identification of issues—agenda setting—which occurs when an issue is identified and makes it onto the policy agenda from amongst an array of potential issues government could attend to. The area of agenda setting concerns itself with questioning why certain issues make the agenda rather than others. Public policy development and implementation is complex: many factors contribute towards an issue 'making the agenda' while others do not. These 'issue drivers', according to Bridgman and Davis include both internal (within Government) and external drivers: internal drivers include financial drivers; the impact of monitoring policies in other jurisdictions; and those issues that need attention on a regular basis. External drivers include the media; legal shifts; and international developments. Some theorise that the reason why an issue makes it onto the agenda is strongly connected with the issue having 'mass appeal': the more people are impacted upon, the more likely an issue will be attended to. While interest groups may put considerable pressure on government to attend to a particular issue, it is most likely that there will be "influential elites either already in government or with access to decision makers" (p. 40) who are truly able to influence government or indeed are in a position to make decisions on what makes the policy agenda. In a way agenda setting is a complex inter-relationship between two or more of these drivers (H. Colebatch, 2006). There are processes within each step of the policy cycle that contribute to policy formation: for example for an issue to actually make the agenda it

first has to be clearly defined. The processes of agenda setting can involve finding initial agreement that there actually *is* a problem and if the problem is significant enough, agreement that something needs to be done about it. Bridgman and Davis suggest that policy makers prefer to know that there is the prospect of a solution to the issue/problem. Parsons suggests that "values, beliefs, ideologies, interests and bias all shape perception of reality" (Parsons, 1995 p. 88) and the same applies not only to those who bring an issue to government's attention but to government itself.

While the Australian Policy Cycle does not provide a rationale for why some issues make the agenda and others do not feature on the policy agenda, other perspectives provide a critical analysis of agenda setting. Parsons (1995) suggests that "the genesis of a policy involves the recognition of a problem. What counts as a problem and how a problem is defined depends upon the way in which policy makers seek to address an issue or an event" (p. 87). Agenda setting from a pluralist perspective suggests that "the definition of problems and the setting of policy agendas is essentially the outcome of a process of competition between different groups" (Parsons, 1995, p. 125). A pluralist view does not suggest that power is unequally distributed and therefore lacks analysis of the power-differential between those in a position to influence agenda setting and those that are not in such a position. Cobb and Elder (1972) suggest that agenda setting occurs due to a conflict between groups "over procedural matters relating to the distribution of positions or resources" (Cobb and Elder cited in Parsons, 1995, p. 127). They further suggest that issues are created through a number of means; either via "manufacturing of an issue by one or more of the contending parties who perceive an unfavourable bias in the distribution of positions or resources (p. 82); while another "form of issue creation can be traced to a person or group who manufacture an issue for their own gain"; yet another way that an issue may be created is through an unanticipated event (such as the outbreak of an illness and the need to develop a hand-washing policy); or, they suggest, an issue can be identified by "persons or groups who have no position or resources to gain for themselves" (p. 83), these are referred to as 'do-gooders'. Cobb and Elder suggest that an issue which has been identified by a concerned group gets expanded to a wider group of interested or concerned people to finally get attention by the general public. They argue that a number of other factors also determine if an issue makes it onto the policy agenda; and suggest that much of agenda setting is dealing with conflicts between groups. According to Cobb and Elder, factors which impact on agenda setting include the concreteness of an issue, they state that "issues are likely to be expanded to a larger public if they can be defined broadly to appeal to more subgroups within the populace" (p. 112). Furthermore, they suggest that "the more socially significant an issue is defined to be, the greater the likelihood that it will be

expanded to a larger public (p. 116). Temporal relevance, the longevity of an issue determines if an issue is likely to be expanded to a broader audience; and the more non-technical an issue is defined and hence easier understandable, the greater the likelihood that it will be of interest to a broader audience. Finally, Cobb and Elder suggest that the "more an issue is defined as lacking a clear precedent, the greater the chance it will be expanded to a larger population (p. 122). All of these factors interplay whether an issue does or does not gain attention from a broader audience, whether there is interest and support to become an item on the policy agenda.

In summary, there are many reasons why a particular issue makes it on to the policy agenda, while others are left off it—as mentioned, agenda setting is a complex interplay of many different factors. While there are many analytical frameworks for understanding agenda setting, the common question within all of these approaches is "how issues and problems come to be—or not to be (that is the question)—political or public things" (Parsons, 1995, p. 88).

This research project is particularly interested in why issues of abuse have made it onto the mental health policy agenda in NSW (through two specific policies) and not in Victoria. This question is based on the findings of study one which demonstrates differences in these two states; while many aspects can impact on the success of policy development and its implementation as those critical of a cyclical approach suggest; it can equally be said that the step of 'agenda' setting, that of an issue actually making it onto the agenda, is a vital one if policy is to be developed, even if other steps (consultation, implementation, evaluation just to name some) are left out in policy development. If an issue does not somehow make it onto the agenda and therefore is identified as a policy issue, policy will not be developed to address this issue. All these factors have contributed to the researcher's interest in what exactly has contributed towards setting the agenda for NSW in contrast to a lack of agenda-setting in Victoria in relation to the research topic.

Once an issue has actually made it onto the policy agenda, the next step in the cycle is that of policy analysis. In this step the aim is for policy experts to provide advice to government: policy analysis is the process of aggregating sound advice through research, and suggesting possible solutions to those with the power to make decisions about policy.

If it appears likely that the issue will be taken up by government, the next step is to identify the appropriate policy instrument to address it. "If results are the *ends* of the policy process, instruments are the means—the programs, staffing, budgets, organizations, campaigns and laws giving effect to policy decisions" (Bridgman &

Davis, 2004 p. 69, italics in original). Australian policy instruments have been identified as ‘advocacy’ (providing arguments as to why something ought to be attended to); ‘money’ (economic factors contributing towards policy decisions); ‘government action’; and ‘law’ (a legislative approach to policy). Which instrument will be chosen in the policy cycle will depend on the type of issue government is dealing with and according to Bridgman and Davis, hopefully based on which instrument is most “appropriate, effective, equitable and workable” (p. 77).

The next step in the policy cycle is that of a consultative process. “Consultation seeks input from individuals and groups to a policy decision” (Bridgman & Davis, 2004 p. 81). Consultation may be sought from key people, interest groups or others who are in a position to provide informed feedback about a policy proposal. A consultative process provides the opportunity for input and response to policy and this process may contribute towards a greater ‘uptake’ of the policy by involving people in its development.

Depending on the policy, coordination across government may need to occur, in particular if the policy spans several sections of government rather than sitting neatly within one department. If budgetary implications are a factor for the policy, the government department developing the policy needs to coordinate with Treasury.

Once all these processes have occurred a decision will be made about the proposed policy. When a decision has been made to proceed, implementation processes and designs need to be developed. “The task of the policy adviser includes identifying implementation and design problems and developing strategies to meet these” (Bridgman & Davis, 2004, p. 119). If implementation is not considered equally as important as policy formation, the policy can be of little or no use. Implementation challenges may include a lack of clarity about who is responsible for implementing the policy; and too many ‘players’ being involved in implementation. Equally if directives by government about the policy and its implications are unclear, implementation can be problematic. Furthermore, necessary resources for implementation may not have been made available and organisations may not be able to divert funds towards implementing this new policy. A well-designed implementation strategy takes into account the obstacles to effective policy implementation and provides an implementation framework that can assist those who are implementing the policy to deal with these.

“Policy-making does not come to an end once a policy is set out or approved”, rather “implementation is policy-making carried out by other means” (Parsons, 1995, p. 462). Similarly to Yeatman and as mentioned earlier, the implementation of policy can

also bee seen as ‘policy-making’, even if those given the responsibility of implementation may not always see this. There are ultimately a number of people involved in ensuring that a policy is implemented, at a minimum, the administrator who carries out the decisions of the policy formulated by a decision-maker and the service provider who carries out the policy which has been communicated by the administrator (Parsons, 1995). As with agenda setting, there are a number of approaches to explaining and conceptualising implementation of policy. Yeatman (1998) suggests that

> the ‘implementation’ of policy was not simply the technical translation into reality of decisions made by the government of the day. This was an insistence that the work of implementation of policy was itself a creative exercise demanding skill, judgment and value commitment (p. 26)

Policy implementation is not a straight forward and easy-to-follow step by step process; rather it is a complex interplay of many factors as well as people. Parsons provides an overview of the approaches to policy implementation. The ‘top-down system approach suggests that implementation follows a linear path; that once a policy is ‘handed down’ to those who have the job to implement it, implementation involves a series of clear steps in order to achieve the goals the policy outlines. Pressman and Wildavsky provided, for the first time, a critical analysis as to why ‘good ideas’ and good policy does not necessarily translate into the goals the policy proposes (Pressman & Wildavsky, 1984). Pressman and Wildavsky suggest that

> The rational model is imbued with the ideas that implementation is about getting people to do what they are told, and keeping control over a sequence of stages in a system; and about the development of a programme of control which minimizes conflict (p. xiii).

Parsons concurs and suggest that the ”rational model is essentially a prescriptive theory”, he suggests that there is

> too much emphasis [being] placed upon the definition of goals by the top, rather than on the role of the workers on the line. It assumes a great deal about goal definition and human interaction and behaviour, or (…) it blatantly excludes any consideration of how real people actually behave” (p. 467).

This ‘top-down’ approach to policy has proven to be too simplistic and negates taking processes and people into account; implementation is not a process whereby if *A* happens then *B* follows. A critique of this way of policy implementation, suggests that policy making involves those with the responsibility of implementing policy (Parsons, 1995; Yeatman, 1998). The rational ‘top-down’ model has been challenged by those

arguing that those involved in implementation play a vital part in the process. Those suggesting that the rational 'top-down' model does not adequately represent what policy implementation is about, point out that this way of approaching implementation assumes that "human beings [are] chains in a line of command" (Parsons, 1995, p. 468) and that people do not behave in this way or may not want to be 'told what and how' to do their work. Those critical of the 'top-down' approach, the 'bottom-up' approach, point out that the relationship between policy makers and deliverers is of crucial importance. Parsons states that "bottom-up models lay great stress on the fact that 'street-level' implementers have discretion in how they apply policy" (1995, p. 469). He further points out that other models suggest that implementation can also be seen as "a process which is structured by conflict and bargaining" (p. 470); bargaining or 'making deals' with government is not unusual in policy implementation, those given the responsibility of implementing policy will argue 'up' that they may be able to implement some of the policy, or may be able to implement it in a particular part of the organisation but not across the whole organisation. Those critical of both of these approaches argue that they simplify the complexity of policy implementation.

Yet another way to approach implementation is to understand it as an evolutionary process: the policy-action framework to policy implementation. Utilising the work of Barrett and Fudge (Barrett & Fudge, 1981) Parsons points out that this approach sees that an interactive process of negotiations between those given the task of implementation and those who seek that policy is implemented. Power between these players who undertake the bargaining and negotiations is crucial to the process. The approach furthermore recognises that policy is "something that 'evolves' or 'unfolds' (p. 473), rather than being a chain of commands, taking into account the realities of individuals and organisations.

Lastly, Parsons also points out that there is a relationship between the type of a policy and its implementation. He argues that the rationalist models of implementation disregard that "human problems are varied in their nature and complexity" (p. 480) and that not every policy can follow the same implementation 'path'. Parsons suggests that both, the type of policy and factors which impact on the implementation process will impact on the process. Drawing on the work of Van Meter and Van Horn (Van Meter & Van Horn, 1975) he states that if there is "a high degree of consensus and a low or marginal amount of change required, policy was likely to prove more successful" (p. 481). The opposite is true as well, the higher disagreement about a policy and the greater the change needed in order to implement policy, the less likely it is that policy will be implemented in the way it was intended.

In summary, there are a number of approaches to understanding the issues relating to policy implementation, each providing insight into different ways or aspects of the debate. Parsons suggests that

> the problem of implementation may be constructed in different ways. Each approach or theory gives some insight into a particular dimension of reality of implementation, and, as in the case of the somewhat constrained debate on top-down versus bottom-up, both approaches and their hybrids and variants provide us with part of the picture (p. 489).

The last step in the policy cycle, evaluation, includes a potential rethinking and adapting of the policy. This in turn could be the first step towards another consideration of the policy (going back to 'identifying issues'); and the cycle may be started all over again. Some authors, including Colebatch (Colebatch, 2002) point out that evaluation is more likely to sit (or needs to sit) alongside the cycle (process orientated evaluation) rather than at the end of the policy cycle. Ideally each step of the cycle is evaluated, if not formally then informally, for example by policy advisers reflecting on each step in discussion with each other. Some evaluations are only carried out after implementation is completed: this type of evaluation tries to understand if the policy has achieved its goals.

This brief overview describes the steps identified by Bridgman and Davis as crucial to understanding the development of policy in the Australian context. The cycle's initial step of agenda setting and the step of policy implementation are of particular interest to this study.

Critique of the Australian policy cycle

The leading text on policy, Bridgman and Davis' Australian Policy Handbook (1998, 2004), which stresses its practical 'how to' nature, is essentially an exercise in exhortation and does not seek to show that its prescriptions are derived from actual practice. (Colebatch, 2006, p. 4)

The explanation of policy development through a cyclical or staged approach has not been without its critics. It has been suggested that the real world of policy making is more complex than the cycle suggests; and that this process-orientated way of conceptualising the policy process lacks a focus on the content of policy. Critics suggest that a cycle does not address issues of power; neither does it provide "any causal explanation of how policy moves from one stage to another" (Parsons, 1995 p. 79). The suggestion of a staged process to understand policy development has also been critiqued for its lack of acknowledgement that policy is not just a 'top down

approach' but can also be driven by pressure or interest groups. Others propose that the Australian Policy Cycle is not a theoretical framework and is therefore questionable (Colebatch, 2006).

Everett argues that the Australian Policy Cycle is too simple, unable to be applied to complex or contentious issues and does not take into account issues of power or the political context within which policy is formulated and decided (Everett, 2003). She suggests that the policy cycle is solely process-orientated and fails to attend to content. She argues that policy can rarely be broken down into clear steps; and disagrees with Bridgman and Davis, that 'good policy includes good process'; in contrast she says that "good policy requires good content and good content does not necessarily result from an effective process" (p. 67). She believes that the policy cycle is merely a mechanism once a "process or decisions have already been made, or a mechanism to handle relatively uncomplicated matter" (p. 69). While Howard (Howard, 2005) does not critique the policy cycle in its entirety or as strongly as Everett, he does provide a critical voice about the cycle and its application in 'real-time' policy development. His arguments are based on findings from a small study with senior policy makers in federal government: his interviewees point out that in reality the eight stages of the cycle are not always given equal focus, with some steps only receiving a cursory look, or none at all. Similarly it is suggested that the steps are not always followed in the described sequence; for example some participants pointed out that sometimes the "selection of solutions came before the identification and analysis of problems" (p. 8).

Those who critique the policy cycle concede that it provides a useful normative description of the policy process; the framework is of particular relevance for conducting research on how policy actually proceeds. Bridgman and Davis themselves acknowledge the limitations of the cycle when they state that the "policy cycle is a first foray into complexity, organising observations into familiar patterns and so providing a guide to action. No policy model can claim universal application since every policy process is grounded in particular governmental institutions" (Bridgman & Davis, 2003 p. 99). They argue that they intended to provide a simplified representation of what occurs, in order to assist those unfamiliar with the process to understand policy development. They agree with Everett that "good content 'does not necessarily result from an effective process' …" (p. 101) and state that good processes sometimes produce bad results; they also agree that content and process both matter in developing good outcomes (well thought out policies, inclusive of appropriate consultation and implementation).

While Parsons' thorough discussion of public policy (Parsons, 1995) does not include a critique of the Australian Policy Cycle, he does agree with the general criticisms of a cyclic approach to policy; however he also suggests that the strength of this approach is "that it affords a rational structure within which we may consider the multiplicity … of reality …". He suggests that the stagist framework needs to be utilised with an awareness of its limitations and an appreciation of the fact that the framework allows the "complexities of the real world"(p. 80) to be dealt with.

Colebatch suggests that any conceptualisation of policy includes an underlying theory, even if such theory is not explicitly clear. He proposes that Bridgman and Davis' claim that the Australian Policy Cycle is a "toolkit, not a theory" (Bridgman & Davis, 2003, p. 102) does not hold up. Colebatch writes that "any 'pragmatic guide' to action … rests on a conceptual map of linked understandings about the underlying dynamic of the process; that is theory" (Colebatch, 2006, p. 6).

In summary, some of those who critique the policy cycle appear to take it as a literal and linear *prescription* of the development of policy, rather than a normative or idealised *description* of the processes involved if policy is to be developed following a clear and transparent process. Bridgman and Davis themselves do not intend the Australian Policy Cycle to be taken as a 'bible' to policy development but rather as a conceptual framework, a guide to understanding the development of policy in Australia, and indeed as an attempt to conceptualise the complexity of policy development. They propose the policy cycle as a "modest and flexible framework for policy makers" (Bridgman & Davis, 2003 p. 102); and further suggest that both process and content can be attended to within this framework.

The Australian Policy Cycle provides the framework for this study, bearing in mind that it is an approach which has limitations; and the steps of the cycle are not always strictly followed. The framework is utilised in particular for the questions on agenda setting and implementation, which are the main focus of enquiry for this study.

Having provided here an overview of the policy framework and its critique, the next chapter discusses the research methodology.

Chapter 5: Research Methodology

Introduction

This research conducts an analysis of policy designed to prevent and reduce the impact of violence on mental health and the development of mental illness.

A qualitative framework was applied to investigating the level of policy development in relation to addressing abuse issues and the investigation of the different levels of policy development and its implementation in two Australian states, namely Victoria and NSW.

Within the qualitative framework, the Australian Policy Cycle, a staged approach to policy development and implementation (Bridgman & Davis, 2004), was utilised to guide and focus the development of specific research questions. The cycle includes eight steps[10] and those of agenda setting and implementation were utilised to investigate the questions this research aimed to address (how and why abuse did/not get onto the policy agenda and issues relating to implementation of policies). The identification of an issue—setting the agenda—involves clarifying what the actual issue is: for example, is the issue 'how to reduce the impact of abuse on mental health', or 'how to provide mental health services that address sexual safety for its inpatients'? Once policy is developed it needs to be *implemented.* Implementation issues are generally considered as part of the development of the policy proposal, including barriers to and potential problems with implementation, and financial resources needed to implement the policy.

Qualitative research

Qualitative research concerns itself with understanding "individual events and interpretations to larger meaning systems and patterns" (Denzin & Lincoln, 2000, p. 8). Qualitative research studies attempt "to make sense of, or interpret phenomena in therms of the meaning people bring to them (Denzin & Lincoln, 2000, p. 3).

The methodological strategy for this research project, to answer the research questions, was developed early in the research process, it consist of

- a literature review which investigates and provides evidence for the connection between abuse and the development of mental health problems and mental illness;

[10] These have previously been described and discussed.

- a review of mental health service and policy development (historical overview) – in order to situated the research within its context;
- development of study one: a content analysis of policy documents;
- development of study two: key informant interviews.

Qualitative research is "grounded in a philosophical position which is broadly 'interpretivist' in the sense that it is concerned with how the social world is interpreted, understood, experienced, produced or constituted" (Mason, 2002, p. 3). Furthermore, qualitative research has no fixed data gathering methods, rather, as Mason points out; they need to be "both flexible and sensitive to the social context in which data are produced" (p. 3). Qualitative research does not utilise standardised or rigid methods which are unrelated to 'real life'. Concurrently, qualitative research "requires a highly active engagement from its practitioners" (Mason, 2002, p. 4). In qualitative research, Masons suggests, the researcher needs to resolve a range of issues pertaining to their specific research project, rather than applying standardised methods.

The overall framework applied to this research study is interpretive, while applying different methods of data gathering and analysis to study one (document analysis) and study two (key informant interviews), the overall aim of this study was to seek to understand what policies are provided to mental health services on working with issues of abuse; what these documents 'say'; and what has assisted to get these issues on to the agenda (NSW) and what are the barriers towards policy development (Victoria). "Qualitative research aims to elicit the commonsense interpretations of informants using the metaphors of 'getting inside people's minds', 'digging deeper into people's perceptions', and 'unearthing what is going on'" (Minichiello, Fulton, & Sullivan, 1999). The researcher was interested to find out about key informants' understanding and perceptions about the level of policy development and implementation.

The researcher applied an 'unobtrusive' method to data gathering in study one, that of analysing mental health policy documents. "Unobtrusive methods of research are those that do not involve the direct interaction of the researcher with the source of data" (Lupton, 1999, p. 450). This unobtrusive method of accessing policy documents was applied to study one, which utilised secondary data (policy documents) as the sample. Mason suggests that the researcher needs to "begin by asking (…) what you expect documents or visual data to be able to tell you about (…) and in particular to consider which parts of your intellectual puzzle they might potentially help to address" (Mason, 2002, p. 112-113). For this study the initial question was a rather simple one: do policy documents mention abuse (family violence, sexual abuse)? In this way, the

process of determining ‘what constitutes’ data within the text was clearly defined: each policy or section that addresses issues of abuse was considered data and was treated as a ‘unit of meaning’. Lupton (Lupton, 1999) points out that an unobtrusive method such as content analysis’ strength lies in the fact “that the material can be obtained without direct interaction with respondents (…) this reduces the potential for bias caused by respondents altering their answers (…) [because] they have interpreted a question differently from the meaning intended by the researcher” (p. 451). This was the case for study one: documents were analysed for their content. As will be discussed in the section on data analysis, a content analysis was then applied to the text.

The qualitative researcher, according to Mason (2002), needs to apply a ‘reflexive position’ throughout the research project, undertaking reflexive acts. She defines reflexivity as “thinking critically about what you are doing and why, confronting and often challenging your own assumptions, and recognizing the extent to which your thoughts, actions and decisions shape how you research and what you see” (p. 5). The researcher of this project applied reflexivity during the course of this project by checking with herself and by being asked by her supervisor about certain aspects of the research project. Discussions about ‘what governments should be doing’, about ‘does making someone take their medication constitute family violence’, the fact that I work at a clinical mental health service, that I have been involved on advisory groups for state government and other issues were discussed, challenged and reflected on by myself and in discussion with the supervisor.

According to Denzin and Lincoln, the “interpretive *bricoleur* understands that research is an interactive process shaped by his or her own personal history, biography, gender, social class, race, and ethnicity, and by those of the people in the setting.” (Denzin & Lincoln, 2005a, p. 6, italics in original). They furthermore point out that the researcher tells “stories about the worlds they have studied. Thus the narratives, or stories, scientists tell are accounts couched and framed within specific storytelling traditions, often defined as paradigms” (p. 6). While it is necessary to be able to ‘bracket’ one’s own ideas, prejudices, hopes and ambitions during research, it has equally been stated that qualitative research often starts with the researcher’s own interest (Polkinghorn, 1998) and that complete ‘bracketing’ is impossible. In a way the above descriptions of qualitative research stand in contrast to each other: on the one hand the researcher is likely to investigate an issue of interest to them, and on the other hand the researcher ought to demonstrate objectivity. In reality both of these factors can be worked with—bracketing includes bringing assumptions, ideas and interpretations to the forefront of the researcher’s mind and then (an attempt at)

'putting them aside'; the researcher then needs to stay open to the data and the information/interpretation the research reveals.

According to the La Trobe University the requirements for a candidate of a professional doctorate include "a substantial and original contribution to knowledge of direct relevance to the profession" (La Trobe University, 2006, p.4). This statement shows that the research student is part of the field and profession in which the research is undertaken. This is the case in the present study. I work in a clinical mental health service and have previously worked in the other two sectors relevant to this thesis. In my current role I manage a project that brings those three sectors together, in an attempt to increase quality of service provision to those who have a mental illness and who have also experienced sexual abuse and/or family violence. This and other work keeps me grounded in the day-to-day concerns inclusive of issues, dilemmas and challenges for managers, clinicians, support staff and consumers. Concurrently I have been involved in work with state government through employment in the mental health branch and have been—and still am—a member of statewide advisory committees. I have also been involved in the development and implementation of policy on a local level in this field. My desire to undertake this policy study has grown out of a long-standing interest and involvement in this field, spanning direct client work, management, service development, policy development and implementation. These experiences have given me an appreciation of the complexity of policy development and implementation, translation of policy into practice, and evaluation of such processes. It is this backdrop that has sharpened my interest, while the research project has in turn had positive impact on my work in this area (translating aspects of what I have learned into practice).

Through the process of triangulation (Denzin & Lincoln, 2005b; Liamputtong & Ezzy, 2005; Mason, 2002; Neuman, 2003) —looking at the same issue from a number of 'angles'—the use of more than one method was applied to approach the research questions. Triangulation can assist the researcher to "attempt to secure an in-depth understanding of the phenomenon in question" (Denzin & Lincoln, 2005a, p. 5) by taking "multiple measures of the same phenomena" (Neuman, 2003, p. 138). Triangulation was applied to data gathering by first analysing policy documents which demonstrate policy development and implementation (NSW) and a lack of policy development (Victoria); the key-informant interviews were utilised to obtain participants' opinions and perceptions about the level of policy development as well as its implementation. Mason suggests that "qualitative interviews may add an additional dimension, or may help you to approach your questions from a different angle, or in greater depth" (Mason, 2002, p. 66). This was the case for this study,

while the document analysis provided evidence about policy addressing abuse for mental health services, it was not possible to understand the difference between NSW and Victoria or gain understanding about implementation. The key informant interviews highlighted these issues from the perspective of the participants.

The document analysis (Study one) produced the initial data set which enabled examination of the key research questions for the thesis across Australian jurisdictions. As the results of the document analysis indicate, significant differences in policy development were found, particularly between Victoria and NSW. The second study followed from and built on the results of the first, by conducting a more detailed interview study to examine the factors that had resulted in differences in policy development between Victoria and NSW.

The next section provides a more detailed description of the methods of data gathering and analysis for study one and study two.

Study one

Data gathering method and sampling

Sampling for Study one began by compiling a chronological list of mental health policy both on a federal and state (Victorian) level since the beginning of policy formation (between the early 1990s and 2006). Prior to the 1990s no national or state mental health policies were published; given the relatively short time—16 years—of mental health policy, *all* documents published during this time constitute the sample for the policy analysis.

Documents were either stored in electronic files or hard copies were obtained—through an ordering service of the respective government department, through accessing the La Trobe University Library, or from the researcher's library. The next step involved scanning those documents that are electronically available, utilising the electronic 'find' function to locate terms that refer to abuse. The following search terms were used: 'domestic violence'; 'family violence'; 'violence'; 'sexual abuse'; 'sexual assault'; 'violence'; 'childhood sexual abuse'; 'childhood abuse'; and 'abuse'. Those policy documents not electronically available were read in their entirety and following the same search terms as the electronic analysis, issues of abuse were marked in the text. To ensure accuracy the researcher repeated the searches with a number of documents over the course of several weeks as well as double-checking notes taken during this phase of the research.

Those publications that make reference to family violence and/or sexual abuse (as defined and discussed in the literature review) constitute the subset of the sample for study one. Twenty-three national and 17 Victorian policies were analysed during this process. Additionally another seven specific policies/guidelines from NSW, Queensland and Western Australia, which focus on domestic/family violence and sexual abuse, were included in this part of the study.

Data analysis method: content analysis

Content analysis is a technique for examining information, or content, in written or symbolic material … a researcher first identifies a body of material to analyse … and then creates a system for recording specific aspects of it. (Neuman, 2003, p. 36)

As described above, the initial step of the analysis involved locating any reference made in relation to sexual abuse or family violence in both Commonwealth and Victorian policy documents. As with any other data gathering this research starts with a question, which for this part of the analysis is simply the following: *'is family violence or sexual abuse mentioned in the document?'* To undertake this initial step of data gathering the above mentioned search terms were used.

To undertake the analysis of mental health policy documents, the researcher utilised content analysis (also referred to as 'discourse' or 'thematic' analysis, see Lupton, 1999). Content analysis can be applied to both quantitative and qualitative research; in this case the researcher was not so much interested in the frequency of the content, rather than "whether or not something occurs" (Neuman, 2003, p. 312), namely whether or not policies say something about family violence and sexual abuse. According to Neuman, "content analysis is a technique for gathering and analysing the content of text. The *content* refers to words, meanings, pictures, symbols, ideas, themes, or any message that can be communicated (Neuman, 2003, p. 310, italics in original). The first step within content analysis reveals "the content in text but cannot interpret the content's significance" (Neuman, 2003, p. 311); what this step *can* establish is if certain words, concepts or phrases are present or not. This was the first step applied in the analysis of policy documents and this step created the sub-sample for studies one.

The second step in this process involved a closer analysis of those documents that included the search terms. This part of the analysis involved investigating the content in relation to family violence and sexual abuse; the question the researcher posed here is: *"What are these documents saying about family violence/sexual abuse"?* Lupton suggest that this step "seeks to address the question of 'how things are said'

and the underlying or symbolic meanings of text" (p. 453). This step also involves a search for underlying conceptual themes and patterns, taking a closer look at how the issues are expressed within the policy documents. The question posed for this section of the analysis is similar to what Neuman calls noting the 'direction' of messages, or the underlying discourse. Lupton describes discourse in this context as "identifiable patterns or themes used to represent people or things across texts, in words or images (Lupton, 1999, p. 454).

The researcher devised a table which included the name of each policy document and the themes that emerged through the analysis. This step was undertaken a second time by re-reading the notes taken at the initial analysis stage and by reorganising the policy documents under conceptual headings (such as 'vulnerability or 'abuse as risk factor'). The researcher noted "themes of important messages inherent in the material" (Liamputtong Rice & Ezzy, 1999, p. 106); the concepts were either specifically expressed within the documents or the researcher developed categories of concepts (units of meaning). Eight concepts (themes) were found in this stage of the analysis, these are: abuse constituting a 'risk factor for mental illness'; 'increased vulnerability'; 'safety' (protection); 'special or complex needs'; 'interventions'; 'prevention'; (mentioning of) 'data'; and the overall theme of 'policy guidance'.

In the next step of this analysis each theme was cross-checked, analysed and compared with the findings of the literature review.

The final step of the analysis was intended to investigate the implementation process of those issues/policies in Victoria; however this could not be undertaken, as it was impossible to locate any documents about implementation of policy for Victoria and for NSW there was limited documentation (data on screening for domestic violence) available. Questions about implementation were incorporated into study two, interviews with key informants, to obtain their views on issues relating to implementation, this will be further discussed under study two.

Study two

Study one documented differences in policy development and implementation between NSW and Victoria; this informed the conceptualisation of study two. In order to inquire further about mental health policy development and implementation in NSW and Victoria, the researcher decided that semi-structured in-depth interviews were the most appropriate way to gather data to answer the research questions. Building on study one, study two examined more closely via these interviews key stakeholder

opinions about what has assisted and/or hindered policy development and hence getting the issues of abuse onto the policy agenda (or not) and how the implementation of such policies has progressed. Study two needed to be undertaken in two distinct parts: namely interviews with key informants in NSW and interviews with key informants in Victoria, in order to investigate differences between those two states.

Data gathering method: key stakeholder interviews

Qualitative interviewing has been described as the "interactional exchange of dialogue" to find out informants perceptions of an issue (Mason, 2002, p. 62). Semi-structured interviews have a "relatively informal style, for example, the appearance in face-to-face interviewing of a conversation or discussion rather than a formal question and answer format (Mason, 2002, p. 62). To further investigate what study one found (differences of policy direction between NSW and Victoria), utilising interviews offered the opportunity to ask questions from those involved in or privy to policy development and its implementation. Mason suggests that this way of inquiry "lays emphasis on depth, nuance, complexity and roundedness in data, rather than the kind of broad surveys of surface patterns which, for example questionnaires might provide" (p. 65). There was no other way to investigate how and why policy has been developed (or not) than talking to key informants.

Semi-structured interviewing provides an ideal method of inquiry, combining an interview schedule with the possibility of probing for and clarifying of information (Liamputtong Rice & Ezzy, 1999; Neuman, 2003). Rice and Ezzy point out that "in-depth interviews aim to explore the complexity and in-process nature of meanings and interpretations that cannot be examined using positivist methodologies" (Liamputtong Rice & Ezzy, 1999, p. 53). It has been said that "a good interview is like a good conversation" (Liamputtong Rice & Ezzy, 1999, p. 51). However a good interview is also somewhat different from a conversation. The main aim of an interview is firstly for the researcher to listen to the interviewee, and secondly, to engage with the *content* of the interview while paying attention to the *structure* of the interview. Additionally the researcher may take notes during the interview, as was the case with this study.

There are both advantages and limitations to the use of interviews. They draw higher response rates than surveys mailed to participants. Interviews can assist in "discovering the subject meaning and interpretations that people give to their experiences" (Liamputtong Rice & Ezzy, 1999 p. 67); and interviews provide a forum to ask questions that it would be impossible to put using other methods of data

gathering. On the other hand, limitations to conducting interviews relate to the resources associated with undertaking them (in this case costs associated to travelling interstate); the level of skills of the student researcher in undertaking interviews; and the time it takes to conduct them (Liamputtong Rice & Ezzy, 1999; Minichiello, Madison, Hays, Courtney, & John, 1999; Neuman, 2003). Face-to-face interviews applied as data gathering method also need to include a consideration of the potential bias of the interviewer. The researcher was able to build on her skills developed during studies previously undertaken, which utilised both group and individual interviews. It has been stated that while all care can be taken to be 'objective', to bracket one's preconceived ideas, it is nearly impossible for a social science researcher to be completely neutral (Fontana & Frey, 2006). Interviews as data collection method also limit the size of the data and hence the study; however given the nature of this study (research in partial fulfilment of a professional doctorate) and the fact that two studies were conducted for this project, it is believed that in this instance use of the data gathering method is justified.

The process of conducting interviews includes the vital step of establishing rapport with participants, and in this case establishing rapport began prior to the researcher and participants actually meeting. Utilising her professional networks, the researcher contacted potential participants via email and phone and established a link through either naming the person who had suggested the participant for the interview or by recognising that researcher and interviewee knew each other through work. This provided a context and professional credibility for the researcher and—with the exception of those who did not feel they had anything worthwhile to contribute to the research—all those initially contacted, agreed to participate in the study. The researcher took much care in deciding on the content of the communication when she approached potential interviewees, in order to provide clear information in a considerate way, keeping in mind that all those approached would need to make time during work hours to be interviewed.

Sample

In order to gain access to key stakeholders for Study two, the researcher used a mixed sampling method, which incudes purposive and snowball sampling (Liamputtong & Ezzy, 2005; Neuman, 2003). The researcher, utilising professional contacts, contacted colleagues in NSW and in Victoria, to see if they would be interested in being interviewed and concurrently they were asked to suggest further key informants; the researcher then contacted those via phone and email; who were in turn asked to suggest other potential interviewees. The decision to begin with

purposive sampling was made to ensure that those individuals who were most likely able to contribute to the research would be asked to participate; individuals were approached who have knowledge of or work in the areas of mental health, family violence or sexual abuse policy. Purposive sampling "is used when it is likely that only certain individuals will have the information needed" (Schofield & Jamieson, 1999, p. 159) which is the case with this study. Equally, it was thought that individuals would know others who would be appropriate to contribute towards the research, and these individuals might not be known to the researcher. The danger of relying only on the researcher's contacts (purposive sampling) in deciding who may be appropriate to be interviewed has been asserted by Llewellyn, Sullivan and Minichiello as "the disadvantage of this method … [being] that the researcher may, in fact, lack information about the most suitable individuals to include in their sample, and thus produce information that is not representative" (Llewellyn, Sullivan, & Minichiello, 1999, p. 173). This mixed method was of particular validity for the NSW sample, as the researcher had only two professional contacts and relied on those to suggest other key stakeholders (and so on). While most suggestions were taken up and those approached agreed to be interviewed, not all those who were suggested were able to contribute to the research, due to their lack of knowledge of the policy area this study is concerned with. For the NSW interviews, the researcher travelled to Sydney to conduct eleven face-to-face semi-structured interviews.

Determining the exact sample size prior to undertaking qualitative research has been deemed difficult by writers on this subject. According to them, one way to assess if the sample is large enough is by reaching saturation or the point of redundancy (Liamputtong Rice & Ezzy, 1999; Llewellyn et al., 1999; Neuman, 2003). The point of saturation is reached when no new information is forthcoming from the research sample. At the outset of this study the researcher thought that between 12 and 24 interviewees might participate in Study two. It was thought that such sample size would provide sufficient information and that data gathering would reach saturation point. In the event, the interviews involved a total of 21 participants; eleven in NSW ten individuals in Victoria; and only one participant in the overall sample is male. This gender disparity is likely to be connected with the fact that those working on issues of abuse tend to be female; when the researcher contacted potential key informants and asked them to suggest others, gender did not come into question as much as the ability of the individual to be able to comment on policy development and implementation. Given this gender disparity, and to ensure anonymity, key informants' gender is rarely disclosed when quotes are provided.

Interview schedule

The researcher developed two interview schedules utilising the Australian Policy Cycle (Bridgman & Davis, 2003, 2004). The interview questions focus on policy drivers and barriers, as well as issues of implementation (see Appendix). The two sets of interview questions, one for NSW and one for Victoria, were approved through the ethics process of La Trobe University. It was intended that the initial interview questions would be adjusted if necessary; however there was no need for this and all interviews followed the questions initially developed. Some writers on research methods, when referring to the potential bias of the interviewer include the type of questions being asked during the interview (Neuman, 2003). It is believed that by utilising the Australian Policy Cycle in developing the three main questions, bias was avoided as much as possible.

Interviews in NSW aimed to explore agenda-setting and implementation of policies. Key informants were asked about how issues got on to the policy agenda; which barriers needed to be overcome and/or worked with for this to occur; and to identify any implementation issues.

Interview questions for Victoria needed to follow a slightly different path, due to the lack of specific policy development in this state. Following the Australian Policy Cycle, the particular focus of these interviews is the (lack of) policy development, with greater emphasis on barriers to policy development—and questions about implementation of the only relevant policy related to this area (Victorian Government Department of Human Services, 1997).

Both interview schedules include questions about key informants' perception of a causal link between abuse and mental illness and about their perception of the level of government policy direction around the issue of abuse. These questions assisted in gaining insight into the understanding of key informants about the broader issues connected to this research.

Arranging and conducting interviews

To undertake the interviews in NSW the researcher asked three professional contacts to provide suggestions for interviewees (key informants). A list of those potential key informants was compiled, including their current and previous positions and places of work, and a rationale for why they should be interviewed was provided. These suggestions were discussed with the supervisor and a final decision was made about the sample. The next step was to make contact via email with those individuals,

informing them of the context and the aim of the study; this was followed up with a phone call. During the phone call the researcher answered any questions and also asked the individual to name others they thought might be able to participate in the study (the snowball technique). Eventually the same names were being mentioned to the researcher—saturation of potential key informants. During this process the researcher emailed the information sheet, consent form and withdrawal form to potential interviewees, to provide them with as much information as possible. Once key informants agreed to be interviewed, the researcher organised a time for the interview (all interviews in NSW were held in the same week), with all interviews taking place at the key informants' places of work, except for two who preferred to meet at a coffee shop. At the beginning of each interview the researcher handed a 'participant information sheet', a 'consent form' and a 'withdrawal of consent' form' to the key informant and the consent form was signed by both parties. Copies of the consent form were later mailed to all participants along with a 'thank-you' card for their participation.

Interviews were taped; the researcher also took notes during the interviews and kept checking back with participants about the accuracy of her notes. While the intention had been to tape all interviews, five interviews in NSW could not be taped due to technical failure; hence the researcher took even more care with note-taking during these interviews.

Key informants

Twenty-one key informants were recruited for this study: 11 in NSW and 10 in Victoria. All key informants were currently or had previously been employed by state governments in the areas of mental health, family violence, sexual assault or a combination of these (such as government which focus on both family violence and sexual assault, or all three areas—family violence, sexual assault and mental illness). Of the ten Victorian key informants nine were currently or had previously worked in state government and one is an expert in sexual assault and has worked with Australian and Victorian peak bodies in the area of sexual assault and violence against women. Four key informants were from the area of mental health; two from family violence; three spanning both family violence and sexual assault; one spanning all three areas (mental health, sexual assault and family violence). The eleven key informants in NSW include eight informants who currently or previously worked for Government; and three who had not worked for Government; however these informants were involved in other ways with the current policies (i.e. through implementation responsibilities). Four informants span all three areas (family

violence, sexual assault and mental health/illness); four are from family/domestic violence with of these having experience in mental health services; one spans sexual assault and mental health; and one is from family violence. To ensure their anonymity, no characteristics about key informants are mentioned when presenting the findings. All but one of the key informants agreed to be quoted in this thesis if their anonymity was guaranteed by not using their positions or Department names alongside quotes. Twenty of the twenty-one key informants are women and only one male participated in the study; while gender was not considered of being of specific importance during the recruitment phase for this study, the gender disparity is evident. The fact that women tend to be more likely to work on these issues is likely to have played a role in the overwhelmingly greater number of women participating in this study. As mentioned key informants were approached and selected due to their knowledge and ability to comment on the interview questions, rather than their gender.

Data analysis

Qualitative data analysis is described by Neuman (2003) as the "researcher organizes the raw data into conceptual categories and creates themes or concepts, which he or she then uses to analyze data" (p. 441). The coding process applied to this data included several steps: organising the raw data into themes in correlation with the interview schedule; the development of further categories or concepts; and finally reassembling data on a "higher level of generality" (Liamputtong & Ezzy, 2005, p.269). According to Neuman (2003), "coding is two simultaneous activities: mechanical data reduction and analytic categorization of data into themes. The researcher imposes order on the data" (p. 442).

With the exception mentioned above (when due to a technical failure interviews could not be recorded and the researcher needed to rely on her note-taking), interviews were taped and the researcher also took notes, at times double-checking words or meaning of content with the key informant. The interviews were then transcribed by the researcher by listening to the recordings and double-checking notes. The first step of data analysis of the interviews involved reading through the transcripts several times in order for the researcher to immerse herself in the data and become more familiar with it.

The next step was to develop codes, in this process of open coding (Neuman, 2003) "the researcher locates themes and assigns initial codes or labels in a first attempt to condense the mass of data into categories" (p. 442). A colour-coding system was developed, with different colours representing themes correlated to the themes of the

interview questions, such as ‘drivers’, ‘barriers’ and ‘implementation issues’; as well as other themes which emerged as part of this process. Neuman suggests that “regardless of whether he or she begins with a list of themes, a researcher makes a list of themes *after* open coding.” (p. 443). This was the case with this stage of data analysis also; and this process assisted with recognising the emerging themes form the data.

The next step was a closer analysis of those categories (themes) developed in the previous step. This was done on large pieces of butcher’s paper—each with a separate theme (code) as heading—and sub-themes were recorded underneath those: those sub-themes contained several sub-codes by the time this step of analysis was finalised. One such example is the code for ‘implementation issues’, which contained several other codes, including ‘making the issue visible’ and ‘multi-layered approach’; these in turn contained further categories. The step of open coding seeks to “break down data and reconceptualize it”, while the following step of axial coding “puts those data back together in new ways by making connections between a category and its sub-categories” (Strauss & Corbin, 1998, p. 97 cited in Liamputtong, 2005). Neuman suggests that “during axial coding, a researcher asks about causes and consequences, conditions and interactions, strategies and processes, and looks for categories and concepts that cluster together” (p. 444). The initial step of axial coding for this study included utilising those same categories and sub-categories developed in the previous step and literally drawing connections on paper. This was followed by noting those categories and their relationships separately on a different piece of paper.

In the final step of data analysis, the researcher “identified the major themes of the research project’ (Neuman, 2003, p. 444). Concepts of steps one and two were reviewed, as were the relationships between those concepts (themes). Several overarching themes were developed in this process and these form the basis for the discussion of the data from study two.

The above described steps were undertaken for both sets of interviews separately (and these will be discussed in the next chapter).

The final step of study two was a comparison of the results between NSW and Victoria; this was undertaken in several steps. The main categories from both parts of the study were noted on a table, with the two areas (‘family violence’ and ‘sexual abuse’) constituting the overall categories. The section on ‘barriers’ was then more closely analysed. While the respondents in NSW talked about barriers that had been overcome in order to develop policy, the respondents in Victoria spoke about barriers

that contributed towards a lack of policy development, and additional barriers that would need to be overcome if more policy development, to occur in the future. The researcher developed a table and all those themes that had been developed in NSW were compared with the themes from Victorian interviews. Seven of the eight themes were the same for NSW and Victoria and these formed the basis for discussion of the comparison between the two states.

Ethics

Ethics approval to proceed with study two was provided by the La Trobe University, Faculty of Health Sciences' Faculty Human Research Committee. The ethics application included a participant information sheet, consent form, withdrawal of consent form and the interview schedules for NSW and Victoria. All relevant information including the information sheet was sent to key informants prior to conducting the interviews and original copies of these documents were provided upon meeting key informants for the interviews.

Confidentiality was discussed with key informants at several stages of this process. It was sometimes discussed during the initial phase of engaging potential key informants for an interview; and the issue was discussed with each participant at the outset of the interview. The researcher expressed her concern about privacy issues as a number of participants had previously been or were at the time of the interview employed by state governments. The need for openness when discussing potentially sensitive issues and the need to ensure that participants would not feel compromised in any way were addressed. Due to the status of employment of a number of key informants, the interview schedule did not include any demographic data about the person (as this was not relevant to this study) and assurance was provided that places of current or previous employment would not be included in the thesis. What can be stated here is that key informants were drawn from all three sectors (mental health, sexual abuse and family violence) both within and beyond state government as previously described in the section on key informants. When discussing confidentiality, the researcher invited interviewees to let her know during the course of the interview if they wished to strike anything out of the transcript and to instruct her to do so. The use of quotes was also discussed with each key informant and options were presented to them: these were a general agreement that quotes could be used without any limitations; that no quotes could be used; or that the researcher could double-check quotes with them during the writing-up phase of the study. These options were revisited with most key informants at the end of the interview, when they were in a better position to make a decision. One key informant requested that no

quotes be used; and one interviewee asked for a copy of a specific section of her interview, if it was to be used verbatim. All others agreed that quotes could be used without any restrictions.

All key informants received a card within two weeks of their participation to thank them for their participation in the study, with a copy of their consent form.

Research diary

The researcher kept a diary ('field notes') during the process of working on this research project. While this process was useful, it was of particular significance for noting reflections and impressions during the time of arranging and conducting interviews. The process of noting those impressions and thoughts had a dual purpose: firstly it formed part of the record keeping, and secondly it assisted the notion of 'bracketing' those aspects the researcher became aware of and wanted to 'put aside' in an attempt to work towards greater 'objectivity' when interacting with key informants.

The diary also provided a way of recording a story a key informant shared about a woman with mental illness who was killed by her husband, which affected the researcher in a distressing way. Having the opportunity to record her thoughts and feelings enabled her to reflect on what had occurred and to continue with the interviews the next day—this was particularly useful as this occurred during interviewing in NSW and the researcher did not have access to any debriefing.

The above section has provided the research methodology for Study two; with the next section providing an overview of findings from interviews with key informants in NSW, followed by a discussion of those. The interviews conducted with key stakeholders in Victoria will then be provided, followed by a discussion.

This chapter has provided an overview of the research methodology for study one and two, the next chapter provides and overview of Study one, inclusive of research findings and discussion of those.

Chapter 6: Study one

Introduction

It has been succinctly stated that violence is not simply a medical, social, political, or psychological issue; it is all of these things at once. (Wyshak, 2000, p. 632)

… the experience of abuse, endemic or even epidemic on a global scale, has been largely ignored or dismissed by social scientists and psychiatric epidemiologists in studies assessing risk factors for mental disorders. (Fishbach cited in Taft, 2003, p. 8)

Victorian public mental health services are guided by Commonwealth and state policy. The overall aim of Study one is to find out if Australian and Victorian mental health policies include issues of sexual abuse and/or family violence. The study has several sub-aims. These are to:

- ◊ investigate if policy documents make reference to sexual abuse and family violence
- ◊ investigate what those policies that include issues of abuse convey about sexual abuse and family violence
- ◊ compare the content of those policies to research findings on sexual abuse and family violence
- ◊ gain an understanding about policy implementation in this area in Victoria.

Prevalence rates of sexual abuse and/or family violence in the population of people with mental illness, and the link between the experience of violence and the development of mental illness have been discussed earlier. Based on research findings, it could be expected that mental health policy includes the issues of abuse and its connection to the development of mental illness, and also acknowledges the need for protection against abuse for those diagnosed with mental illness. It could be furthermore assumed that, if these issues are acknowledged within mental health policy, the policy documents also include implementation strategies and guidance for mental health services.

To undertake study one, the researcher undertook an analysis of policy documents (as described in the methodology chapter). Commonwealth and Victorian Government Mental Health Policy documents between the early 1990s – 2006 constitute the sample for the document analysis. The first step of the analysis involved locating any reference made in relation to sexual assault or family violence in policy documents; this was followed by a closer analysis of the content of those policies that make reference to sexual abuse and family violence; inclusive of

determining the underlying discourse of the messages conveyed by the documents. The content and its messages were then compared with the research literature in order to search for connections and disconnections between the research literature and policy direction.

The next section provides an overview of those Commonwealth and Victorian Government policy documents that make any reference to the search terms, followed by a discussion of the findings.

Commonwealth policies[11]

There is now very clear evidence of the continuity of disorders between childhood/adolescence and adult years … and of the contribution of earlier risk factors to adult disorder so that the rationale for the provision of the spectrum of interventions across childhood, adolescence and adult life can be strongly supported. (Raphael, 2000, p. 13)

The 'Mental Health Statement of Right and Responsibilities' adopted by the Australian Health Ministers in 1991 aims to ensure that the rights and responsibilities of those with mental illness are upheld (Australian Health Ministers, 1991). Through this document the Commonwealth of Australia recognises that "sexual and physical abuse are amongst risk factors for increased incidence of mental health problems and mental disorders" and furthermore that people with mental illness may "experience sexual and physical abuse" (p. viii). The document also points out that people with mental illness ought to be "protected from abuse and neglect" and that "it is essential to ensure that their needs for care, protection and rights to treatment and rehabilitation are satisfied" (p. ix). It outlines that a "consumer has the right to have mental health services provided in an environment in which he or she is protected from the threat of sexual harassment and abuse" (p. 7).

The first 'Australian National Mental Health Plan' (Australian Health Ministers, 1992a) recognises "that some groups in the community have special needs, and an underlying principle is that the mental health service system should be responsive to the varying needs of particular groups" (p. 16); one could assume that women (and associated issues) are a part of this group, when the policy "acknowledges the recommendations … [of the] National Women's Health Strategy" (p. 16). This strategy, which is articulated through the National Women's Health Policy (Commonwealth Department of Community Services and Health, 1989) includes reference to the fact that "violence is a mental health issue for women …. [and that] researchers have demonstrated that women who suffer sexual and physical violence are at greater risk of psychological problems" (p. 44). The policy further attends to the

[11] For a chronological overview of Commonwealth policies see appendix D.

impact of family violence on women's mental health and provides data on prevalence and the connection between domestic violence and mental illness.

The need to protect consumers from abuse is included in Standard 2 of the National Standards for Mental Health Services (National Mental Health Working Group, 1997). "Safety is considered in terms of physical, social, psychological and cultural dimensions. Consumers are protected from financial, sexual and physical abuse…" (p. 9). This standard about safety refers to the environment in which mental health services are delivered and includes activities undertaken as part of mental health service provision. The document also provides guidance about the fact that policies and procedures need to address these safety issues. Standard 6: "Prevention and mental health promotion" includes a statement about the need for mental health services to have "the capacity to identify and appropriately respond to the most vulnerable consumers and carers in the defined community"; and that this includes being able to link with "services for victims of abuse" as well as "elder abuse" (p. 14). Under Standard 7—which articulates that mental health services need to deliver "non-discriminatory treatment and support which are sensitive to the social and cultural values of the consumer and the consumer's family and a community"—the document briefly mentions providing services on "gender related issues such as incest [and] domestic violence" (p. 16). When referring consumers into supported accommodation which is provided by other agencies the document points out the need for mental health services not to…refer a consumer to accommodation where he/she is likely to be exploited and/or abused" (p. 39; Standard 11: Supported Accommodation). This standard includes the need for mental health services to have policies relating to these issues.

The Evaluation of the National Mental Health Strategy makes brief reference to the issues of sexual abuse in a section that addresses key issues of concern. Under a section titled "Undeveloped 'special needs' services" (p. 17) it is stated that services have not been developed in the way the strategy proposed, which included to "cater for special needs groups" (p. 17). It further points out that providers no longer see specialisation within their services as valued and that "as a consequence, services for people with special needs will remain undeveloped" (p. 17). Included in the special needs groups are survivors of child abuse and child sexual abuse. To address these issues it is suggested that service development needs to be strengthened and that this will have implications for mental health workforce training needs; it is further suggested that incentives may need to be established for mental health staff to pursue specialist interests.

The Second National Mental Health Plan sets out the priority areas of mental health promotion; community education; prevention of mental illness; and early intervention (Australian Health Ministers, 1998). The plan suggests that specific strategies for the prevention of mental illness need to be targeted to those most vulnerable to developing mental illness: included in this group are "children subject to abuse and neglect and adult survivors of childhood, sexual, emotional or physical abuse" (p. 13). The plan expresses the need for further exploration as to which responses can "lessen the risk of developing mental illnesses, especially [the area of] depression … needing further development" (p. 13).

The first Mental Health Promotion and Prevention National Action Plan (Commonwealth Department of Health and Aged Care, 1999)—from here on 'the plan'—makes reference to research- and evidence-based models of intervention and prevention strategies. Drawing on Mrazek and Haggerty's earlier work on the reduction of risk factors for mental illness (Mrazek & Haggerty, 1994), the Commonwealth acknowledges that "there is also evidence, based on randomised controlled trials, of efficacious interventions for adults affected by adverse life events" which include trauma and violence (p. 5). The plan points to issues of abuse and neglect constituting risk factors that may contribute towards development of mental illness and refers to selective interventions which have contributed to lowering child abuse and hence (while this is not spelled out in the document), have potential to contribute indirectly to lowering the incidence of mental illness in the community. The plan includes issues of child safety and child abuse in the first two age ranges of children (0−2 and 2−4); and it includes women's refuges as one of the strategic partners in addressing some of these issues. The need to research effective interventions for specific target groups, including those who have experienced sexual abuse or family violence, is identified. The plan does not continue with a similar inclusion of these issues beyond the age of four years, with the exception of a section on "Individuals, families and communities experiencing adverse life events" (p. 24). Under this section, it is proposed that mental health targets must include a reduction in "incidence and prevalence of psychosocial morbidity associated with adverse life events" (p. 24) which include assault and violence as well as physical, sexual and emotional child abuse and neglect. Drawing on research it is recognised that generic counselling "does not achieve prevention outcomes for those experiencing adverse life events such as child abuse…and trauma" (p. 25). It is further suggested that there is a need to develop partnerships; to promote policies and practice that assist in working with these issues; to develop evidence-based best practice guidelines for specific groups; to work with key stakeholders; and to implement and evaluate programs.

The ‘Population Health Model’ (Raphael, 2000), published the year after the emergence of the above plan makes one brief mention of domestic violence in a section on mental health promotion and prevention as it applies to the primary care sector: listed are specific programs that aim to undertake preventative work—and ‘domestic violence’ is mentioned among these.

The monograph titled ‘Promotion, Prevention and Early Intervention for Mental Health’ (Commonwealth Department of Health and Aged Care, 2000) provides the theoretical and conceptual framework for the ‘National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000’ (Mental Health and Special Programs Branch, 2000): the monograph will be discussed first. Family violence and neglect, as well as physical, sexual and emotional abuse are listed as potential contributing factors to developing mental illness (Commonwealth Department of Health and Aged Care, 2000). Protection from physical or psychological harm is listed as one of the protective factors, which can contribute to a reduced risk of developing mental illness. In a section on “Early Intervention” the document points to practice guidelines (which have since been rescinded) developed by the National Health and Medical Research Council (NHMRC), which include questions about physical, sexual and emotional abuse during a screening process (National Health and Medical Research Council, 1997). The document acknowledges that for many Aboriginal and Torres Straight Islander communities issues relating to the stolen generation are significant, not only due to forced removal but also because “removal prevented these children from having the opportunity to experience a normal family life, often instead experiencing institutionalised living and physical, sexual and emotional abuse” (p. 86). Higher rates of domestic violence within rural and remote communities is also briefly mentioned under this section on ‘special population groups’, alongside an acknowledgment that within those communities access to services is rather limited. The list of collaborative partners that mental health services need to consider working with includes ‘Centres Against Sexual Assault’ (CASAs).

The action plan which complements the monograph and builds on the work of the previous plan (Commonwealth Department of Health and Aged Care, 1999) provides guidance about implementation for promotion, prevention and early intervention activities. Most of the previously discussed areas of family violence and sexual abuse are mentioned again in this plan, and so only those areas that differ from the previous plan will be discussed here. As mentioned above, the previous plan only makes reference to issues of sexual abuse and child abuse for the first two age ranges of children (0–2 and 2–4); and whilst this is also included in the plan of 2000, it also lists family violence as a risk factor for 5–11 year olds and the reduction of child abuse as

one of the outcome indicators. The previous plan had not included a section on adults but this plan does and it includes issues of abuse. In order to prevent and reduce mental health problems and disorders, the plan aims to work towards a reduction in sexual harassment and to reduce those risk factors that contribute to the development of mental health problems and mental illness (Commonwealth Department of Health and Aged Care, 1999). The section on "older adults" includes the aim of reducing abuse towards the elderly. Even though the type of abuse which ought to be reduced is not defined, it could be assumed that family violence and/or sexual assault are issues contained within this statement (including 'elder abuse'). The second plan no longer explicitly mentions women's refuges and child abuse services in the organisations listed as potential collaborators. These may well be subsumed into the category of 'welfare agencies'—however the first plan mentions them specifically as collaborators.

The current national mental health plan (Australian Health Ministers, 2003) refers to the term "complex conditions" several times and provides the following definition

> Complex conditions: Conditions in which a person experiences mental illness as well as other multiple and complex social, emotional and/or physical health problems. Complex conditions include mental illness with problematic substance abuse, *histories of abuse* (italics added), intellectual disability, and challenging, at risk, suicidal and criminal behaviours. People with complex conditions often have needs that require a co-ordinated response from multiple service sectors. (Australian Health Ministers, 2003)

While this definition includes 'histories of abuse' as one such complex condition and the term 'complex needs' is used frequently throughout the document, no definition is provided for what constitutes abuse. It could be assumed that it includes (but is not limited to) childhood abuse (sexual, physical, emotional) and abuse experienced by adults (family violence, sexual abuse). The plan, adopting a population health framework (Raphael, 2000) "recognises the importance of mental health issues across the lifespan and in those with diverse and *complex needs* (italics added)" (Australian Health Ministers, 2003). The principles which underpin the plan and responsibilities for mental health care express a commitment to equitable access and quality of care for people with mental illness, regardless of factors such as the complexity of their needs. The plan acknowledges that there are barriers which preclude some from accessing mental health services and it is suggested that people with complex needs constitute one of those groups. In order to change this situation it is suggested that the provision of "a broader range of options for mental health care for these groups" is necessary, and to do this "linkages between mainstream mental

health services and population-specific services" need to be made. The list of services does, however, not include child abuse, family violence or sexual assault services.

'National safety priorities in mental health: a national plan for reducing harm' (National Mental Health working group, 2005) is "the first national statement about safety improvement activity in mental health" (p. iii). While the plan acknowledges that safety is critical to the quality of mental health services, it makes no reference to safety issues within inpatient or residential settings in relation to sexual assault or family violence. The document outlines ten principles which underpin the planning, development and implementation of safety strategies in order to improve processes in mental health services. While two of the principles could be interpreted to include issues of abuse, this is not made explicit and hence is left open to interpretation.

In summary, Commonwealth mental health policy began with an acknowledgment of the fact that sexual and physical abuse can contribute to the development to mental illness (Australian Health Ministers, 1991). The following years and policies provide less clear statements: while making some reference to abuse they leave much to the interpretation of the reader (Commonwealth Department of Health and Ageing, 2002); however this changes during 1999 and 2000 (Commonwealth Department of Health and Aged Care, 1999; Mental Health and Special Programs Branch, 2000). In particularly the second of these documents provides clear statements about abuse and violence and their impact on mental health. It acknowledges the impact of abuse through the life span for those with mental illness; however the document is weaker in its suggestions for collaborative partnership, leaving specialist abuse services out of the organisational list for collaborators. After this peak of acknowledgment and (some) direction setting by the National Plan of 1992, the Commonwealth policy documents that follow fall short of providing any real direction or strategy about abuse and mental illness: with the issue of abuse either being subsumed under the category of 'complex conditions' (Australian Health Ministers, 2003), or with safety issues within (mixed) gender facilities being left completely out of the national safety priorities in mental health— which nevertheless claims to constitute a national plan for reducing harm (National Mental Health working group, 2005).

While some of the Commonwealth policy documents state that abuse can be a contributing factor to the development of mental illness—correlating with research evidence—most documents are weak in providing clear guidance as to what to do, or indeed who needs to be working on these issues. Some, such as the National Action Plan (Mental Health and Special Programs Branch, 2000) suggest the need for

further investigation as to what mediates the impact of abuse on mental health/illness. However this is where the statement ends—it identifies a need, without any clarity as to who or which sectors ought to undertake this work. This is just one example of a missed opportunity to build a stronger relationship between the mental health sector and those sectors that work with survivors of abuse, both on a government and service provider level. It was not possible to obtain information about the level of implementation from the policy document analysis on any of the policies addressing abuse for mental health services.

Having discussed the Commonwealth policies that contain references to sexual assault and family violence, the next section will provide an overview of Victorian policies that include references to either term.

Victorian policies[12]

Policies and practices throughout mental health services should reflect the fact that many women using psychiatric services may have previously experienced some form of sexual assault involving physical, sexual and/or emotional abuse. (Victorian Government Department of Human Services, 1997, p. 11)

Some studies have suggested that 50 per cent or more of women using mental health services will have experienced some form of sexual abuse. (Victorian Government Department of Human Services, 1997, p. 5)

The second Victorian mental health policy document published in 1992 mentions sexual assault issues (Office of Psychiatric Services, 1992) within its 'Strategic Directions' document, in which it is pointed out that women ought to be a specific focus. The policy suggests a need to plan services that are sensitive to women's needs and that "community support programs for particularly vulnerable women with psycho-social disability, including homeless women, women with young children, older women and women from non-English speaking backgrounds, are especially required. Women specific programs may be developed as appropriate" (p. 20). While this section does not explicitly refer to women who have experienced family violence and/or sexual assault, one could infer that 'particular vulnerable' women would include those with abuse histories or vulnerability to future abuse. The document does mention that "program development will address particular issues faced by women, including the risk of sexual assault and abuse" and points to the need to collaborate with Sexual Assault Services. The need to develop "policies and procedures to minimise the risk of sexual harassment and abuse … together with mechanisms to deal appropriately with complaints" (p. 21) is emphasised. It is also suggested that quality assurance indicators need to be developed in order to

[12] A list of Victorian mental health policies can be found in appendix E.

substantiate and track if services are responsive to women. In summary, this is a first attempt to point to issues of sexual abuse and the potential for women to be exposed to such abuse. While it is acknowledged that there is a need for care and protection of particularly vulnerable women in relation to exposure to sexual harassment or sexual abuse, the document does not address issues of childhood or past adult sexual abuse or family violence issues.

The first 'framework' document for Victoria's Mental Health Services' service delivery (Psychiatric Services Division, 1994), identifies the need for a specific response to women in order to maximise mental health gain without making any mention of family violence or sexual abuse.

The 'General Adult Community Mental Health Services Guidelines for Service Provision' (Psychiatric Services Branch, 1996) do not refer specifically to the issue of sexual assault. It is suggested that one 'specialist clinical portfolio' could be on "gender sensitive practice" and while sexual abuse and family violence issues could be included in such a portfolio, this is left open to interpretation. The document also lists a "Program Management Circular" under relevant documents relating to services for women, which outlines how to respond to "Allegations of assault" (Psychiatric Services Branch, 1995). This program circular, which remains the only one of its kind ever published by Psychiatric Services/Mental Health Branch, outlines minimum standards for Area Mental Health Services relating to an appropriate response to allegations of either physical or sexual abuse made by staff members, clients or visitors (against staff members, clients or visitors) within a psychiatric facility (such as an inpatient unit). It points to the need for mental health services to develop policies and procedures in relation to this issue in order to ensure appropriate guidance and response to allegations of assault within their services.

The second 'framework' document for Victoria's mental health services was published in 1996 and made reference to sexual assault under the section titled "Making services for women more responsive" (Psychiatric Services Division, 1996). The department acknowledged the impact of childhood sexual abuse, when it specified that "the room for improvement remains significant ranging from … the aftermath of child sexual abuse through to ensuring the safety and privacy needs of women in bed-based settings" (p. 31). According to this document work for the future included "completion of policy, guidelines and standards for women-responsive services" as well as identification of training needs to "improve service performance with regard to women's needs" (p. 35). The department also proposed a need for the "development of practice guidelines as a result of the examination of the service

needs of child victims of sexual abuse and women who have a serious mental illness and were victims of childhood sexual assault" (p. 35). The department not only acknowledged the need for variation of service provision to ensure appropriate support to women, it also set up the 'Mental Health Women's Advisory Group', which would focus "specifically on the development of strategies to respond to these issues and to develop standards against which service performance can be assessed" (p. 35). In summary the department acknowledged that (many) women with serious mental illness have experienced childhood sexual assault and may therefore require a particular service response; it identified the need for further training of staff; as well as a need for the development of guidelines in order to ameliorate the impact of childhood sexual abuse.

The above-mentioned advisory group, renamed as the 'Women's Advisory Group' contributed to the only women's mental health policy published by the Victorian Government, titled 'Victoria's Mental Health Services, Tailoring Services to Meet the Needs of Women' (Victorian Government Department of Human Services, 1997). Through this document the department took a further step in acknowledging that "women experience mental ill-health differently to men and have particular needs which should be taken into account in the way mental health services are delivered" (p. iii). This milestone document provided, for the first time in the State of Victoria, guidance for mental health services in relation to issues of both childhood and adulthood sexual assault—not only by acknowledging its impact on women but also by providing guidelines about potential service responses. Through this document the department acknowledged—in greater detail than before—the prevalence of childhood sexual assault for women: it refers to a Victorian study undertaken by Cox (1995a) and states that "some studies have suggested that 50 per cent or more of women using mental health services will have experienced some form of sexual assault" (p. 5). It further acknowledged that, while not necessarily the only factor, an experience of

> …sexual assault, in particular childhood sexual abuse, has been linked with a number of psychiatric disorders…. [such as] higher rates of anxiety disorders (panic disorder, phobias and post-traumatic stress disorder), major depression, psychotic and suicidal symptoms, borderline personality disorder and dissociative disorders (p. 5).

The women's mental health policy promoted the need for policy and practices that reflect the high prevalence of sexual abuse in women with serious mental illness and the associated issues that may need to be attended to, including safety and privacy in inpatient and residential settings. It pointed to the fact that many women will not

disclose a history of sexual abuse and that mental health services need to take this fact into account. Guidance was provided about necessary responses to a disclosure of sexual abuse and that a professional response must not do any further harm, for example by staff displaying disbelief or providing inadequate support to the woman. The document made particular reference to the need to be mindful when women are placed in seclusion or restraint to assure this is done in a way that is minimally traumatising. The document made a number of suggestions as to further possible work by mental health services in this area, including the development of local policy and guidelines; nomination of liaison staff who work with local specialist sexual assault services; provision of training to mental health staff; and the exploration of service development opportunities in collaboration with sexual assault services. It further points out that if past "sexual, physical and/or emotional abuse is revealed, this should be taken into account in assessment and treatment planning" (p. 23). The policy falls short in the area of family violence, which, while briefly mentioned, does not receive any specific focus.

It was not until 2002 that the next policy document guiding mental health services in Victoria was released by the Mental Health Branch (Victorian Government Department of Human Services, 2002a). This policy points out that mental health services have experienced an "increased complexity of consumer needs" (p. 6), and this includes people who have "multiple and complex social and health problems, *histories of sexual abuse*" (p. 6, italics added). The document points to a project state government committed to undertake under the Victorian Women's Health and Wellbeing Strategy (Victorian Government Department of Human Services, 2002b) called "Building partnerships between mental health, sexual assault and domestic violence services" (p. 20); this document will be discussed in more detail further on.

A document relevant to this area, not published by the Department of Human Services, but nevertheless endorsed by the Mental Health Branch, can be found on the DHS website: "identifying and responding to family violence: a guide for mental health clinicians in Victoria" (Victorian Community Council Against Violence, 2004). This provides practical advice and guidance to mental health staff about family violence issues. The Department has not only shown endorsement of the document by featuring it on its website, during 2005 it also provided each Area Mental Health Service with several copies of the guide.

The most recent policy document published by the Department of Human Services' Mental Health Branch is the report of a statewide project that investigates the level of collaboration between mental health, family violence and sexual assault services in

Victoria (Mental Health Branch, 2006). Through this report the Mental Health Branch acknowledges the impact of violence and abuse on women's mental health outcomes. It recognises the high prevalence of violence in the lives of women diagnosed with a mental illness when it states that "it is clear that sexual and physical abuse histories are common among women and girls who have been diagnosed with mental illnesses, and that mental health problems are common among women who have been physically or sexually abused" (p. 8). The report furthermore acknowledges the "association between sexual abuse in childhood and mental health problems later in life" (p. 8) when it makes reference to research evidence. The report acknowledges heightened vulnerability of women with mental illness, including safety issues arising during stays in psychiatric inpatient units. The project documented in the report was a collaboration between the Mental Health Branch and those parts of the Department of Human Services responsible for family violence and sexual assault. The report makes several recommendations. It points to the need for training/professional development of mental health staff; for policies and procedures to address the need to work on these issues within mental health services; for cross-sector collaboration; for safety issues to be addressed, especially in inpatient units; for referral pathways between sectors; and for workforce development including undergraduate studies.

In summary, Victorian policy began similarly to that of the Commonwealth with a relatively clear statement about the need to address the risk of sexual abuse of women with mental illness and the need to collaborate with specialist sexual assault services through the development of policies and procedures and complaint procedures (Office of Psychiatric Services, 1992). Towards the mid 1990s reference to issues of abuse do either not exist (Psychiatric Services Division, 1994) or could be subsumed into the issue of 'gender sensitive practice' without being mentioned (Psychiatric Services Division, 1996) with one exception (Mental Health Branch, 2005). The issue of abuse gains greater attention during 1996 and 1997 through two policy documents, which acknowledge the impact of childhood sexual abuse on mental health and suggest the need for guidelines to redress such impact (Psychiatric Services Division, 1996; Victorian Government Department of Human Services, 1997). Victoria's women's mental health policy goes a step further in acknowledging the high prevalence and impact of abuse, and the need for further service development; it provides statements about the need to take previous abuse histories into account. After this peak of clarity Victoria saw a decline in this area, possibly mirroring Commonwealth policy trends: in 2002 those with histories of sexual abuse have become 'complex clients' with 'complex needs' (Victorian Government Department of Human Services, 2002a). Clearer statements on issues such as

impact and prevalence of abuse; heightened vulnerability and safety issues for those with histories of abuse; and the need for further policy development are made in a project report, published in 2006 (Mental Health Branch, 2006). This report, while the clearest in its acknowledgment of a number of issues relating to abuse and mental illness, is at the same time not clearly identified as a policy document.

Those policy documents that make reference to abuse do correlate with research when they acknowledge the impact of abuse on mental illness and the need to address these issues sensitively. Similarly to the Commonwealth documents, the statements made—while frequently clear—do not appear to bind mental health services to following up on these issues. As with the Commonwealth policies, it has been impossible to obtain written information about the implementation of these issues in Victoria.

Specific policy direction on abuse

During searches made for the policy analysis, it became evident that work has occurred in other Australian states that provides various levels of guidance to mental health services on issues of abuse. The Government of NSW has developed policies which guide health services, including mental health services, on issues of domestic/family violence (New South Wales Government, 2003; New South Wales Health Department, 1993). The Government of Queensland has developed policy which addresses sexual safety in psychiatric inpatient units and NSW has developed guidelines for the promotion of sexual safety in NSW mental health services (Queensland Government, 2004; New South Wales Health, 2004; Shelley, 2007). While the Queensland policy and the NSW guidelines on sexual safety are similar in content, it appears that NSW has greater capacity for implementation (and maintenance) of these, through the existence of a specialist unit within NSW government—the “Education Centre Against Violence” (ECAV), which delivers a number of training and development activities to NSW health and mental health services. Additionally, NSW is the only Australian state that has developed policy guidance for both domestic/family violence and sexual abuse/safety that is either exclusively aimed at promotion of sexual safety (for mental health services) or inclusive of mental health services (domestic violence policy). NSW furthermore provides clear guidance on implementation strategies and has the capacity for implementation and maintenance through a section of its own department. The next section describes these policies in greater detail.

NSW policy guidance for mental health services on abuse

Area Health Services will introduce universal routine screening for domestic violence in accordance with related protocols for all women 16 and over attending Mental Health Services. (NSW Health, 2005, p. 42)

The promotion of sexual safety in all mental health services, both community and inpatient, will do much to reduce the incidence of sexual assault of people with a mental problem or disorder. (New South Wales Health, 2004)

This section describes the 'Policy and Procedures for identifying and responding to domestic violence' (NSW Health, 2005) and the 'Guidelines for the promotion of sexual safety in NSW mental health services (New South Wales Health, 2004), both developed by NSW Health. The policy and procedures for the *identification* of domestic violence and for *responding* to domestic violence provide guidance to Area Health Services, which include mental health services. The document provides information on a broad range of issues in relation to area health services and domestic violence, spanning routine identification of domestic violence (routine screening); support provision; legal obligations; guidance on how to intervene with perpetrators of domestic violence; guidance on the need for training; discussion of documentation issues; data collection (reporting on screening for domestic violence); staff safety; and the need to collaborate with specialist organisations. The document also provides information for specific programs within Area Health Services in relation to identifying and responding to domestic violence, including (among others) emergency departments, maternal health services and *mental health services* (NSW Health, 2005, p. 41). The section on 'programmatic considerations' includes the directive to implement 'routine screening' as part of routine assessment phases in mental health services; additionally it is suggested that the questions be integrated into the "Mental health outcomes assessment tools (MH-OAT)" assessment procedure (p. 42). The accompanying policy directive from the Director-General of NSW Health provides a shortened version of the policy and guidelines, alerting all health services to the need to undertake this work; additionally, the directive identifies that "a core component of the policy is routine screening for domestic violence" (NSW Health, 2005). The directive provides a (web) link to an implementation package consisting of the screening protocol, an implementation package and training package.

The second policy produced by NSW Health (New South Wales Health, 2004; NSW Health Department, 1999) directs mental health services to ensure 'sexual safety' for clients accessing their services. While the document is of particular relevance to inpatient and residential units, it addresses all mental health service settings. This document provides guidance on promotion of sexual safety in mental health

services—including psychiatric inpatient units—and if such abuse occurs how to effectively respond and support the victim as part of the duty of care of mental health services. It provides guidance about how to achieve changes in workplace culture, including the need for local policy development and implementation, and the provision of support to staff to deal with the issue of sexual assault, including the need for education and training. The document states that monitoring and implementation are integral to promoting sexual safety. Aims, key principles and clear statements about what is expected from local mental health services are provided as guidelines.

The document describes implementation strategies to address specific areas of this work: 'risk assessment and management'; 'sexually disinhibited behaviour'; 'sexual activity'; and 'safety and design of mental health units'. Guidance is provided as to assessment of both vulnerability to sexual assault (and what needs to occur if this has been established) and of potential to harm others (and what needs to occur if this has been established). The vulnerability assessment includes establishing past sexual assault experience and guidance for situations where the assault has occurred within the same psychiatric inpatient unit the client is being admitted to. The document outlines appropriate responses to allegations of sexual assault which occur within inpatient units, and includes areas such as the "recognition of the rights and needs of someone who has been sexually assaulted"; "reactions to disclosure or suspicion of sexual assault"; "responding to sexual assault"; "re-establishing safety" (p. 13); and how to record the incident; as well as referral and reporting options (both internal and external). The guidelines promote interagency collaboration in order to provide optimal care and include reference to police and specialist sexual assault services.

In order to implement these guidelines mental health services are directed to develop local policy, procedures and implementation strategies including local training plans, in order to bring about a change in workplace culture. Training is to include "education of staff about the effects of past and recent sexual assault [as this is perceived as] an important element for the client's ongoing clinical care" (p. 22). Instructions are included for implementation, monitoring and evaluation: these are to be undertaken both on a statewide (by government) and a local level (by mental health services). The statewide evaluation is to include an audit 12 months after the distribution of the (second) edition of the guidelines. It is proposed that mental health services need to "be proactive in seeking intra and interagency collaboration" (p. 23) in order to develop and implement the guidelines. The guidelines include three flow charts to guide the response to sexual assault:

◊ initial responses by staff to a report of an alleged sexual assault in an inpatient or community mental health service

◊ senior management response to a report of an alleged sexual assault, where both victim and alleged perpetrator are clients of the service

◊ senior management response to a report of an alleged sexual assault, where the victim is a client of the service and the alleged perpetrator is a NSW Health employee or a contracted health worker (p. 29-31).

The guidelines conclude with a list of resources and a checklist for the promotion of sexual safety in mental health services.

Following this overview of two specific policy documents developed and implemented in NSW, the next section provides an overview of findings of Study one.

Summary of findings

The content analysis of mental health policy (document review) identified eight themes in relation to abuse and violence: abuse as risk factor for the development of mental illness; increased vulnerability; safety; special/complex needs; interventions; prevention; data and an overall theme of policy guidance. This section discusses these themes in conjunction with the relevant research literature.

Abuse as risk factor for the development of mental illness

Sexual and physical abuse are amongst risk factors for increased incidence of mental health problems and mental disorders. (Australian Health Ministers, 1991, p. viii)

Issues of (childhood) sexual abuse are mentioned as a possible contributing factor to later onset of mental illness in several of the early policy documents (Australian Health Ministers, 1991; Australian Health Ministers, 1991; Psychiatric Services Division, 1996; Victorian Government Department of Human Services, 1997; (Australian Health Ministers, 1998; Commonwealth Department of Health and Aged Care, 1999; Commonwealth Department of Health and Aged Care, 2000; Mental Health and Special Programs Branch, 2000; Mental Health Branch, 2006).

Research studies provide ample evidence about a connection between childhood sexual abuse and the development of mental illness or its impact on mental health. An experience of childhood sexual abuse may increase the risk of developing depression and anxiety (Briere & Elliott, 1994); (Difede et al., 1997; Paolucci et al., 2001; Zlotnick et al., 2001); may pose a higher risk for suicidality (Davidson et al., 1996; Read et al., 2001); contribute to the development of post traumatic stress

disorder (Briggs & Joyce, 1997; Golding, 1999; Herman, 1992; Read, 1997); eating disorders (Matsunga et al., 1999; Mullen et al., 1993; Read, 1997; Tobin & Griffing, 1996); borderline personality disorder (Everett & Gallop, 2001; Herman, 1992; Herman et al., 1989; Silk et al., 1995); and may relate to psychotic symptoms for people diagnosed with psychotic disorders (Mullen et al., 1993; Read, 1997; Read et al., 2003).

An experience of family violence may contribute to or be the reason for the development of depression and/or anxiety (Campbell, 2002; Campbell et al., 1996; Golding, 1999; Roberts et al., 1998); Post Traumatic Stress Disorder (Briere & Jordan, 2004; Cascardi et al., 1999; Golding, 1999; Goodman et al., 1997; Roberts et al., 1998); and drug or alcohol dependency (Briere & Jordan, 2004; Roberts et al., 1998).

Even though both Mental Health Promotion and Prevention National Action Plans (Commonwealth Department of Health and Aged Care, 1999; Mental Health and Special Programs Branch, 2000) provide the most comprehensive information about the connection between childhood sexual abuse and the development of mental illness, they fall short in articulating this connection for adults with mental illness. Both documents include childhood sexual abuse as risk factor for children, and the second plan includes these issues also for adolescents; however neither document acknowledges the connection between childhood sexual abuse and *adult* mental illness. Research evidence demonstrates a clear link between childhood sexual abuse and mental illness in children, young people and adults. It is peculiar that these documents refrain from acknowledging the long-term effects of sexual abuse for adults—despite the research evidence.

The report on the 'building partnerships project' (Mental Health Branch, 2006) does acknowledge the link between abuse and mental illness and links this acknowledgment with research studies. However the report solely focuses on women consumers, leaving out males with mental illness who have experienced abuse.

NSW Health's 'guidelines on promotion of sexual safety in NSW mental health services' (New South Wales Health, 2004) make specific reference to the connection between childhood abuse and mental illness by noting that this has been established by research studies.

Increased vulnerability

Another important factor for women is their psychiatric vulnerability as a consequence of a past history of abuse and their vulnerability to abuse by treating therapists or

within a health care system. (Human Rights and Equal Opportunity Commission, 1993b, p. 863)

Some of the policy documents acknowledge that people with mental illness, especially women, may experience increased vulnerability to experiencing abuse. These documents make reference to the need for service providers to be mindful of this fact when organising accommodation and providing services within a safe environment (National Mental Health working group, 2005); while others acknowledge increased vulnerability for women with abuse histories when admitted to psychiatric wards (Goodman et al., 1997; Mouzos & Makkai, 2004). However the issue of increased vulnerability is associated with a broader range of issues than acknowledged in the above policies. Whilst some of the policy documents mention this heightened vulnerability, they do not reflect the research evidence, which could provide greater impetus for the development of strategies to either prevent further abuse or at least develop strategies to address revictimisation in adults with mental illness.

Research evidence also suggests the need for safety within mixed-gender wards (M. H. Department of Health, Health & Social Care Standards & Quality Group,, 2003a; Mental Health Branch/Department of Human Services, 2007a; Morrow & Chappell, 1999); (Mental Health Branch/Department of Human Services, 2007b), this will be discussed in more detail in the following section on safety.

Safety

Mental Health is to feel safe and know that you won't suffer further abuse while using services. (Cox, 1995b, p. 2)

The inquiry heard disturbingly frequent allegations about sexual assault of women inpatients … who sometimes find themselves in non-segregated areas where they are particularly vulnerable. (HREOC, 1993b)

The need for safety within psychiatric inpatient units has been discussed by a number of researchers and writers (Everett & Gallop, 2001; Frueh et al., 2005; HEROC, 1993c; Quirk et al., 2004). This need for safety is expressed in some of the policy documents discussed above; however generally they do not provide guidance as how to achieve safety within inpatient units.

Some policy documents make reference to a need for the protection of mental health clients from abuse (Australian Health Ministers, 1991; National Mental Health Working Group, 1997). The high level of revictimisation of those who have experienced childhood abuse, combined with heightened vulnerability of those with mental illness to being abused by others, has been confirmed by research (M. H.

Department of Health, Health & Social Care Standards & Quality Group, 2003b; New South Wales Health, 2004). Such high revictimisation rates of those who have been abused as a child clearly indicates a need for protection, including the need to provide safe environments. While some documents refer to this fact (Mental Health Branch, 2006; Victorian Government Department of Human Services, 1997), safety needs are expressed vaguely, lacking clear guidance.

However, this issue of the need for mental health services to provide safety for inpatients/consumers, has been picked up in other Australian states, such as Queensland (Queensland Government, 2004) and NSW (New South Wales Health, 2004). The need was initially documented by the National Inquiry into the Human Rights of People with Mental Illness (HEROC, 1993c) in its call for action in relation to the findings of the inquiry—which documented human rights abuse of people with mental illness perpetrated within mental health facilities.

Some studies document the level of abuse experienced by women during their stay in psychiatric inpatient units. While due to small sample sizes it is not possible to generalise their findings they correlate with international studies in this area. Graham found in her study that the majority of women had experienced or witnessed sexual assault (1994). Similarly, Davidson found high levels of abuse of women being perpetrated during their stay in psychiatric inpatient units (Davidson, 1997); this is echoed by other researchers such as Nibert et al, who found high rates of sexual abuse being perpetrated against women in psychiatric inpatient units (Nibert, Cooper, & Crossmaker, 1989); and Musick found 180 incidents of assaults within psychiatric institutions reported by twenty-six former patients and sixty-five staff (Musick, 1994); similar results are provided by others (Frueh et al., 2005; Hawthorne et al., 1996). Equally the Human Rights and Equal Opportunity Commission (Human Rights and Equal Opportunity Commission, 1993b) found through its consultations across Australia that “allegations of assault and harassment of women inpatients by staff and other patients, or visitors, are common” (p. 930). The Victorian Women and Mental Health Network has undertaken a project that aims to highlight safety issues for women on psychiatric wards. While this is not a research study it provides information from across Victoria of women who spoke about their experiences of safety issues within psychiatric inpatient units (Victorian Women and Mental Health Network, 2008).

Special/complex needs

Most consumers of mental health services have complex needs. (Office of the Chief Psychiatrist, 2003)

Complex conditions: in which a person experiences mental illness as well as other multiple and complex social, emotional and/or physical health problems. Complex conditions include mental illness with problematic substance abuse, histories of abuse, intellectual disability, and challenging, at risk, suicidal and criminal behaviour. People with complex conditions often have needs that require a co-ordinated response from multiple service sectors. (Australian Health Ministers, 2003, p. 33)

Abuse issues are increasingly subsumed under the umbrella term of 'special' or 'complex needs', in policy documents of more recent years. The concept of 'special or complex needs' takes an array of issues into account, such as problematic drug or alcohol use or addiction, multiple health issues, or a combination of several of these and other 'conditions'. Some documents also include child sexual abuse and child abuse (National Mental Health Strategy Evaluation Steering Committee - for the Australian Health Ministers Advisory Council, 1997; Victorian Government Department of Human Services, 2002a), or "emotional and/or physical health problems" (Australian Health Ministers, 2003).

The term 'complex need' is not used in a consistent way throughout policy documents. For example the Department of Human Services established the Multiple and Complex Needs Initiative (MACNI) (Office of the Chief Psychiatrist, 2004, p. 12), however it appears that in this case the Department aims to address needs of those who have entered the forensic mental health system.

Dual diagnosis (having both a mental illness and a substance abuse problem) is high within the population of public mental health consumers. Prevalence rates range between 64% for psychiatric in-patients to an estimated 90% of males with schizophrenia having a substance abuse problem (Victorian Government, 2005). Prevalence rates for women with mental illness who have also experienced abuse range between 50 and 80%; while those for men with mental illness and abuse experience are lower. Prevalence rates tend to be higher for inpatient populations as compared to community based samples (Golding, 1999; Hawthorne et al., 1996; Muenzenmaier et al., 1993). Research evidence suggests a high prevalence of both drug/alcohol addiction and abuse in the lives of those with mental illness. It seems peculiar to group people who belong to the *majority* of clients into a 'special or complex needs' category.

Given such knowledge about the high prevalence of abuse and associated issues, it could be argued that service conceptualisation, policy and service development and implementation ought to address abuse as a core issue—similarly to alcohol and other drug issues; demonstrated by the implementation of a statewide policy its implementation.

However this is not reflected in Australian policy documents or suggestions for policy implementation. Recommendations from international and Australian research suggest a need for the inclusion of abuse issues of all service levels, including service and policy development; provision of adequate response to consumers who disclose abuse; collaboration with specialist organisations; as well as mental health workforce development and training (Creedy, Nizette, & Henderson, 1998; Hague, 2001; Read, 1997; Agar & Read, 2002; Briere & Jordan, 2004; Danielson et al., 1998; Jones et al., 2001).

Interventions

We are the specialists in mental illness, but there are some specialists out there who can assist and even ease the workload. (Mental Health Branch, 2006, p.14)

All mental health services should develop specific treatment/support protocols for women with present and past experiences of physical and/or sexual violence. (Morrow, 2003, p. 10)

Some of the policy documents provide suggestions about how to address abuse issues for mental health services' clients; (Commonwealth Department of Health and Aged Care, 1999; Mental Health Branch, 2006) while others recommend the need to increase collaboration to address referral pathways, consultation, training and workforce development (Mental Health Branch, 2006). Practice guidelines as one way to attend to issues of abuse are suggested via other policies (Psychiatric Services Division, 1996); (Mental Health Branch, 2006; Victorian Government Department of Human Services, 1997). The program circular published in 1995 (Psychiatric Services Branch, 1995) outlines minimum standards for Area Mental Health Services as an appropriate response to allegations of both physical or sexual abuse made towards staff members, clients or visitors. The circular falls short in providing guidance about how to respond to the issues of (childhood or adulthood) sexual abuse if they are part of a person's life history or family violence (recent or past). The document on collaboration between mental health, family violence and sexual assault services (Mental Health Branch, 2006) goes a step further and includes abuse issues generally when it is suggested that "mental health clinicians should consider the impact of past or current abuse on their patients' mental health and incorporate these issues into assessment, treatment and care planning" (p. 21).

While the discussed policy documents make reference to a number of interventions in response to issues of abuse, without exception they fall short in addressing issues for men who have a mental illness and who have suffered abuse (most likely childhood sexual abuse). As discussed in the literature review, research on males (with mental illness) and (childhood) sexual abuse has been scarce—and it appears that this trend

is currently being maintained. It is perhaps therefore not surprising that policy makers have not included males when addressing issues of abuse; it does however leave a gap in policy and quite likely in provision of mental health services.

Recommendations for interventions by mental health professionals and organisations are provided by many studies on an international level; there are also ample examples of interventions that aim to increase available service responses. Interventions suggested include screening and assessment; a change in service provision to incorporate a trauma framework; policies and guidelines that provide assistance for clinicians about how to appropriately respond or ask about violence; appropriate service provision within psychiatric inpatient units; and the need to adapt service provision to those with a history of abuse (Hague, 1998; Harris, 1997; Spielvogel & Floyd, 1997; Wile, 1997; Davidson, King, Garcia, & Marchant, 2001; Department of Health Western Australia, 1998; Everett & Gallop, 2001; Fallot & Harris, 2002; New York State Office for the Prevention of Domestic Violence, 2000; Warshaw & Ganley, 1998; Christensen et al., 2005; The Family Violence Prevention Fund, 2004a).

Prevention

We need both comprehensive public health approaches to prevent CSA, and effective treatment to recover from the traumatic effects of CSA. (Molnar, Berkman, & Buka, 2001, p. 97)

Few policy documents address the issue of prevention of (childhood) sexual abuse or family violence, which may not be entirely surprising given that most policy documents focus on service provision after an experience of abuse (with the exception of safety in mixed-gender settings). Some policies do refer to specific interventions that may assist or may be needed to lower incidence of child abuse in order to reduce the risk of developing mental illness (Commonwealth Department of Health and Aged Care, 1999, 2000).

Those policy documents that do mention prevention suggest the need for a reduction of violence in order to prevent the development of mental health problems. They generally do not focus on what is needed to lessen the mental health impact for those who have already suffered interpersonal violence.

International and national studies of interpersonal violence as well as large scale initiatives aim to reduce violence within the general population. Global initiatives include work undertaken by WHO (2002b, 2004) and Amnesty International (Amnesty International, 2004). The Australian Government's campaign to reduce violence

against women through the 'Women's Safety Agenda' aims to eliminate sexual assault and domestic violence in the Australian community (Office for Women, 2006). A the time of writing this thesis the Victorian state government is in the middle of redeveloping the family violence sector (Department of Victorian Communities, 2005); the Victorian Office of Women's Policy has also been working on these issues through its 'Women's Safety Strategy' (Office of Women's Policy, 2005b). Many studies recommend a focus on prevention: either prevention of violence occurring (Crime Prevention Victoria, 2002; Flitcraft, 1996; King, 1998; Urbis Keys Young, 2004) or prevention and early intervention that needs to be undertaken in order to minimise the effects of violence on the individual (Family Violence Prevention Fund, 2004; Ganley, 1998; King, 1998; Lia-Hogberg, Kragthorpe, Schaffer, & Hill, 2001). Preventing (further) abuse within mental health care settings has been one approach to redress heightened vulnerability, revictimisation and potential for abuse of those within these settings. Examples include development of policy and guidelines on how to address issues of abuse combined with workforce development (Hoff, 1994; Department of Health, 2000; New South Wales Health, 2004; New South Wales Health, 2004; Queensland Government, 2004; Women's Aid, 2004).

Data

The mental health system is filled with survivors of prolonged, repeated childhood trauma. This is true even though most people who have been abused in childhood never come to psychiatric attention. (Herman, 1992, p. 122)

Women in psychiatric hospitals are … approximately twice as likely as other women to have been abused as children. (Read, 1997, p. 449)

Few policy documents provide clarity about the prevalence of violence in the lives of people with mental illness; generally if any reference is made it is expressed in generic terms such as 'many', 'significant' or a 'high proportion' of *women* with mental illness having experienced violence; data on males is mostly missing in these documents. Two documents make clear statements about prevalence rates through acknowledging that "some studies suggested that 50 per cent of women using mental health services will have experienced some form of sexual assault" (Victorian Government Department of Human Services, 1997, p. 5); clearly drawing on research studies, the other document provides examples from the general population as well as women with mental illness (Mental Health Branch, 2006).

As discussed in the literature review, a large number of studies provide data on prevalence rates of abuse and interpersonal violence in the lives of mostly women and some men. Lifetime experience of abuse ranges between 49 and 90% for women psychiatric inpatients (Morrow & Chappell, 1999). The large difference

between the data of 49 and 90 relate to a number of factors that vary between research studies: the setting of the sample; definitions and age ranges (inclusion and exclusion). Others found that just under half of all abused women suffered from clinical depression (Golding, 1999). Those studies which include men do provide evidence about male inpatients having experienced childhood abuse (Mullen & Flemming, 1998; Read, 1997, 1998) and some have found that prevalence rates for males in psychiatric inpatient settings are twice as high as those for men in general (Read, 1997).

Policy guidance

We can see here that 'policy' can mean not a set of objectives for the activity, or even the guiding principles, but simply the standardization and articulation of practice 'This is the way we do it here'. (Colebatch, 1998, p. 6)

Child abuse, on the other hand, was not a new problem, merely a newly recognized one. (Nelson, 1984, p. X)

Policies by both Commonwealth and state governments provide broad guidance and direction for mental health services on issues pertinent to mental health care. Some of the policy documents discussed above contain directions/guidance on how to work with or consider issues of sexual abuse and family violence within the mental health service sector. Some refer to the need for safety and protection—especially the need for mental health services to provide such an environment (National Mental Health Working Group, 1997) (Victorian Government Department of Human Services, 2002a); others talk about the need to take personal safety issues into account during the assessment phase (Psychiatric Services Branch, 1996). Some point to the need for the development of guidelines to work with issues of abuse (Mental Health Branch, 2006; Psychiatric Services Branch, 1996; Victorian Government Department of Human Services, 1997); others suggest that in order to provide adequate service, a coordinated approach is needed (Commonwealth Department of Health and Aged Care, 2000; Mental Health and Special Programs Branch, 2000; Mental Health Branch, 2006). Other documents again suggest the need for specialist portfolios to be held by mental health staff (Mental Health Branch, 2006; Psychiatric Services Branch, 1996); a need for the development of policies as well as training for mental health staff (Mental Health Branch, 2006; Victorian Government Department of Human Services, 2002a); or for recognition of the whole-of-life span (Australian Health Ministers, 2003).

Another way to address issues of abuse, as suggested in some policies, is the development of guidelines. Even though no guidelines have been developed by either the Commonwealth or the Victorian state government in order to provide a

blueprint on working with issues of abuse within a mental health service context, it appears that given the prevalence rates of abuse within the population of mentally ill people this would be one way to provide guidance as well as a closer step towards implementation of policy for mental health services. There are many international and some national examples of guidelines for specific professional groups as well as mental health services. Western Australia has developed 'Responding to Family & Domestic Violence. A Guide for Health Care Professionals in Western Australia' (Department of Health, 2001), which accompanies the 'Guidelines for developing protocols on intervention and management of family and domestic violence for hospitals in Western Australia' (Department of Health Western Australia, 1999) as well as a resource manual (Department of Health Western Australia, 1999). Whilst it is minimal (two-hour sessions via teleconferencing) training accompanies these strategies and is provided by the West Australian Government for health and mental health services (Symonds, 2003). NSW Health provides guidance on domestic violence (New South Wales Government, 2003) which introduces routine screening for domestic violence in order to identify and support those women who access health and mental health services. Furthermore NSW has developed 'guidelines for the promotion of sexual safety in NSW mental health services' (New South Wales Health, 2004), which provide comprehensive guidance about how to implement safety in psychiatric inpatient units, with the assistance of the 'Education Centre Against Violence' (NSW Health). Queensland Health has produced a similar document (Queensland Government, 2004), which was accompanied by one-off training provided to mental health inpatient staff (Shelley, 2007). International examples include guidelines for health sector providers in New Zealand (Ministry of Health, 1998); guidelines for mental health professionals in the UK (Department of Health, 2000; Office for the Prevention of Domestic Violence, 2000; Women's Aid, 2004). The USA and British Columbia have equally developed such strategies (Morrow & Varcoe, 2000; The Family Violence Prevention Fund, 2004b). The latest such policy in the UK provides guidance and an implementation plan on asking questions about childhood sexual abuse when consumers are assessed in mental health services (Department of Health, 2008)

Another aspect of an adequate response to abuse within the population of mentally ill consumers is to collaborate with specialist agencies, in order to provide the best possible care and response to consumers; this is also suggested in some of the Australian and Victorian policy documents (Mental Health Branch, 2006). International examples include guides for partnerships (Home Office, 2005) as well as projects which address collaboration issues (Warshaw, Gugenheim, Moroney, & Barnes, 2003; Huntington, Moses, & Veysey, 2005).

Training for mental health staff as one way of addressing the issue of abuse within mental health services has been suggested by some of the policy documents. This is supported by research into the level of skills, the barriers that prohibit adequate responses to disclosure or encourage disclosure, and the fact that mental health staff do not 'automatically' know how to respond to these issues (Agar et al., 2002; Jones et al., 2001). As discussed earlier, NSW Health has developed a training strategy for both issues—that of sexual abuse and domestic violence, carried out via the 'Education Centre Against Violence' (NSW Health). This centre provides multiple level training on these issues aimed at health and mental health staff; it also provides education to psychiatrists via the NSW Colleague of Psychiatry's continuing education program on sexual abuse and mental illness.

The adoption of a population health framework (Raphael, 2000) and the intervention spectrum for mental illness (Mrazek & Haggerty, 1994) would provide an opportunity to truly 'broaden the gaze' from a narrow biological focus on mental illness, towards a more inclusive and 'whole-of-life' approach, bringing social and environmental factors into focus. This move towards 'broadening the gaze' is an opportunity for mental health service providers to be cognisant of issues such as abuse and also to take the issue into account during all phases of service provision. However there is no clear direction provided by either the Commonwealth or Victorian State Government about how to integrate issues of abuse into this 'wider gaze' and to truly take a population health approach. Whilst policies provide some guidance on the issues that ought to be addressed, both the Commonwealth and Victorian governments fall short in providing clear guidance—by, for example, providing guidelines, policies (or policy templates), or implementation strategies—as seems to have occurred at least to some degree in other Australian States, namely NSW, WA and Queensland, and in other countries. Within Australia, it appears that NSW has the most comprehensive implementation strategy for guiding mental health services on both domestic violence and sexual safety. This is documented through a number of evaluation reports (NSW Department of Health, 2004, 2005, 2007) relating to (part of) the domestic violence policy, and through availability of training. The guidelines on sexual safety include an implementation strategy and training through the Education Centre Against Violence, and local implementation strategies (New South Wales Health, 2004; NSW Health Department, 1999; Education Centre Against Violence, 2008).

While the policies discussed above provide some guidance to Victorian mental health services on issues of abuse, a lack of clarity prevails as to who is responsible for the development and implementation of such policy, and exactly how to improve service responses to this client group.

Implementation

To say that implementation should be part of design is to suggest that policy theory be formulated with a view toward its execution. (Majone & Wildavsky, cited in Pressman, 1984, p. 175)

At the outset of the analysis of the policy documents, it was envisaged that the last step of the analysis would constitute the investigation of policy implementation of both Commonwealth and state policies. In fact it has not been possible to do this by analysing the policy documents, as there are no references to implementation strategies, expected outcomes, or report-back mechanisms, or documents in relation to implementation. At the same time, there is not 'one policy' available that addresses issues of abuse within the mental health service system (with the exception of the NSW policies) and it has been left up to mental health services to develop implementation strategies to address issues of abuse on a local level—if indeed they chose to do so. One of the only suggestions for a monitoring process in this area of work is provided by the Mental Health Branch of Victoria (Mental Health Branch, 2006) when it suggests that "performance in this area should be included in service reporting against the National Standards for Mental Health Services with specific reference to activities for women (standard 2) and privacy and confidentiality (standard 5)" (p. 21). This document was published in August 2006 and it has not been possible to obtain written evidence of such reporting by mental health services to the state government.

There is some anecdotal as well as documented evidence of local projects being undertaken across the state of Victoria in order to address issues of abuse within the context of mental health service provision. Some of these initiatives are mentioned in the report on collaborations (Mental Health Branch, 2006), in a section on 'partnerships in practice' through the provision of examples of cross-sector collaborations. The researcher is also cognisant of and involved in local and regional projects which aim to address these issues, partly as a response to the Mental Health Branch's 'building partnerships project'; however there are no reporting mechanisms that provide evidence about these projects, other than local reports (Fernbacher, 2005, 2006, 2007).

Pressman and Wildavsky talk about the difficulties of policy implementation, when they point out that

> The great problem, as we understand it, is to make the difficulties of implementation a part of the initial formulation of policy. Implementation must not be conceived as a process that takes place after, and independent of, the

> design of the policy. Means and ends can be brought into somewhat closer correspondence only by making each partially dependent on each other. (Pressman & Wildavsky, 1984, p. 143)

Similarly to the difficulties of determining the level of policy implementation in Victoria, it is not possible to ascertain levels of implementation for the previously mentioned policy on domestic violence in Western Australia (Department of Health, 2001) or Queensland (Queensland Government, 2004). While training was delivered to all psychiatric inpatient units in Queensland, no evaluation report of either the training or the implementation of the guidelines has been published (Shelley, 2007).

In contrast, NSW Health has a more comprehensive implementation strategy for the guidelines on sexual safety for mental health services (New South Wales Health, 2004; NSW Health Department, 1999) as well as the domestic violence policy (New South Wales Government, 2003; NSW Department of Health, 2004, 2005, 2007). For several years training has been provided by the 'Education Centre Against Violence' (ECAV) for mental health services.

Implementation of the initial guidelines (NSW Health Department, 1999) included the process of reviewing the implementation processes and gathering feedback from those responsible for implementation. This information led to the development and refinement of the second edition of the guidelines (New South Wales Health, 2004), which in turn include guidance for implementation.

In summary, it has been possible to establish that issues of abuse have been mentioned in policy documents in Australia and Victoria since the early 1990s. It has equally been established through this analysis, that there is no obtainable evidence about policy implementation for Victorian mental health services through document searches for either Commonwealth or Victorian policy. Therefore investigation of implementation issues forms part of Study two (interviews with key stakeholders). There is also evidence that NSW has not only developed two specific policy documents to address issues of abuse, it has also provided an implementation strategy for both forms of abuse, which has been maintained over several years (NSW Department of Health, 2004)New South Wales Health, 2004; NSW Department of Health, 2005; NSW Department of Health, 2007; Education Centre Against Violence, 2008).

Conclusion

Those policy documents that do mention abuse—most of which do not explicitly state a connection to research evidence—nevertheless correlate with research studies in

relation to prevalence rates (i.e. ‘high’); the connection between abuse and mental health problems; increase in vulnerability for those diagnosed with mental illness; safety issues and the need for protection; and the need for mental health services to not only be cognisant of the issues of abuse but also develop service responses that are adequate to support those with abuse histories.

Given that (sexual) abuse is a risk factor for developing mental illness, and given that data shows prevalence rates for both women and men, it appears peculiar that those with a history of abuse are increasingly summarised under a category of ‘special or complex’ needs, as is the case in later policy documents. It can be said that there is nothing ‘special’ or ‘complex’ about them, or their needs—rather they constitute the majority of clients of mental health services, which appear to lack adequate responses to address the ongoing support needs of the majority of their clients. If heightened vulnerability (as previously discussed) is recognised as a risk factor for those who have already experienced abuse and have a mental illness, then planning for appropriate interventions clearly needs to be addressed, including consideration of safety issues in mixed-gender facilities or indeed consideration of developing single-sex facilities. If a connection between childhood sexual abuse and later development of mental illness is recognised, as is demonstrated by research and referred to by some of the policy documents, a reorientation of mental health policy and mental health services towards providing trauma-informed services (as has been the case elsewhere) ought to occur (Briere, 1989, 1992, 2001, 2002; Goodman et al., 2001; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Salasin, 2005). The only references made in policy documents to changing what mental health services provide are expressed in a way that demands minimal change in service provision and leaves ample room for interpretation: suggestions such as “mental health clinicians should consider the impact of past or current abuse on their patients” leave it up to the individual what ‘taking into consideration’ actually means (Mental Health Branch, 2006, p. 21). Equally the suggestion that “policies and practices throughout mental health services should reflect the fact that many women using psychiatric services may have previously experienced some form of sexual assault involving physical, sexual and/or emotional abuse” (Victorian Government Department of Human Services, 1997, p. 11) does not indicate what exactly ought to occur—indeed falling short in providing any clear statement about the inclusion of a trauma model within mental health care.

In summary, this policy analysis provides examples of some degree of recognition of the prevalence, connection and outcomes of abuse in the life of those diagnosed with mental illness (women) in both Commonwealth and Victorian policies. It furthermore

provides evidence about the differences between NSW and Victorian policies guiding mental health services to ameliorate the effects of abuse on mental health or to prevent abuse from occurring. While Victoria lacks specific policy on the issue of abuse and its prevention for those with mental illness, NSW provides its mental health services with a clear message about the need to address these issues through providing safe environments (New South Wales Health, 2004) and the detection of previous or current domestic violence occurring (New South Wales Government, 2003; New South Wales Health Department, 1993; NSW Health, 2005). This approach to 'preventing and identifying abuse' in the lives of those with mental illness correlates with national and international developments, which promote the rights of those with mental illness. The United Nations' 'Principles for the protection of persons with mental illness' outline the "right to protection from … sexual and other forms of exploitation, physical or other abuse and degrading treatment" (Singh, 2007d, p. 52; United Nations, 1991). Similarly the Australian 'Inquiry into the Human Rights of People with Mental Illness', not only documented the high prevalence of abuse in the lives of women with mental illness, but also made recommendations about the need to protect those with mental illness, and to develop appropriate responses to assault within psychiatric institutions (HEROC, 1993b).

The document analysis could not determine if Victorian mental health services have made any changes to the way they provide services. Furthermore there is no indication that mental health services have been encouraged to make actual policy or clinical practice changes to provide treatment and care for those clients who have a mental illness *and* an experience of abuse. At the same time as some of the policy documents acknowledge the impact of abuse and its connection to the development of mental illness as causal or contributing factor (especially for depression, anxiety, borderline personality disorder, eating disorders), there is a lack of consistency about this knowledge being integrated into a policy framework. A more systematic framework would include the need to address issues of abuse in all steps of services provision, including prevention (strategies), mental health promotion and rehabilitation. This in turn could lead to a more comprehensive, coherent and unified approach to addressing abuse in the lives of those diagnosed with mental illness.

This chapter has highlighted the differences between Victoria and NSW in the direction of policy, and its implementation, in relation to addressing abuse issues within mental health services. In contrast to Victorian developments, NSW has a domestic violence policy (for health and mental health services) as well as a policy that addresses sexual safety and sexual abuse for mental health services. Victoria does have a women's mental health policy which includes issues of abuse—however

it does so to a much lesser degree than the NSW policies, which have been specifically developed to address issues of both domestic/family violence and sexual abuse/safety. It is apparent furthermore that NSW not only developed those specific policies but also included an implementation strategy, which has been maintained for several years. This strategy includes workforce development through ongoing training as well as data collection on routine screening for domestic violence. In contrast Victoria developed a one-year implementation strategy during 1998, and no further implementation strategy followed for over ten years.

The findings of Study one demonstrate an obvious difference between the level of policy direction on the issue of abuse between NSW and Victoria. Therefore Study two was developed to investigate and understand the factors that have led to this difference.

The next chapter discusses the findings of Study two, including research methodology and findings.

Chapter 7: Study two

Introduction

> [it is] hard to believe now that fifteen years ago they didn't think it [violence] had anything to do with them [13].

The overall aim of Study two is to investigate what has contributed towards different levels of policy development—on working with abuse (family violence and sexual abuse) experienced by mental health clients—in the states of NSW and Victoria (as discovered in Study one). The rationale for comparing Victoria with NSW (rather than with another Australian state) is, that not only has NSW developed specific policies (New South Wales Health, 2004); but it has also funded and guided implementation of these policies, including aspects of evaluation. This is the most comprehensive attempt to develop and implement such policies in Australia. To enable a comparison between the two states, Study two is undertaken in two distinct parts: interviews with key stakeholders in NSW and interviews with key stakeholders in Victoria.

Semi-structured interviews were utilised as method of inquiry for study two, allowing for state differences in policy development, as discovered in study one. The researcher began recruiting for the interviews via her professional contacts (purposive sampling) and additionally applied the 'snow-ball' technique (those already approached suggest others for interviews) to ensure that those with relevant experience in this area were approached for an interview. Interviews were conducted at a time and place convenient to the participants; a total of twenty-one informants were recruited (11 in NSW and 10 in Victoria). Interviews were taped (were possible), the researcher also took notes and consequently transcribed all interviews herself. Data analysis followed a thematic analysis, initially organising raw data into themes, in correlation with the interview schedule; development of categories and reassembling data to a higher level of analysis. These steps were followed for each set of interviews (NSW and Victoria); this was followed by a comparison between the results of the two states. The comparison involved a closer analysis of the barriers to policy development – those that had been overcome in NSW and those that needed to be overcome in Victoria. All other themes from the initial analysis of each state were compared and formed the basis of the discussion of findings.

[13] Quotes by key informants are given in block text or integrated into the text by using quotation marks.

NSW interviews

The key questions for this part of the study relate to the issues of agenda-setting and policy implementation in mental health services in NSW. In the Australian Policy Cycle, 'issue identification/agenda setting' is the first step in developing policy, while 'implementation' and 'evaluation' are the last two steps of the cycle.

Two policy directives form the basis for the exploration of these issues, as identified and discussed in Study one. The first is the document on 'identifying and responding to domestic violence' (New South Wales Government, 2003; NSW Health, 2005) and the second 'the promotion of sexual safety in NSW mental health services' (New South Wales Health, 2004). The policy on domestic violence is directed at Area Health Services, including mental health services. While not the only focus, routine screening of any woman accessing mental health services for domestic violence has become the main focus of the implementation of this policy. This standardised way of inquiring about domestic violence when any woman enters mental health services has been the focus of data collection which documents policy implementation; since its inception four annual reports have been produce (NSW Department of Health, 2004, 2005, 2007) which document the level of screening and which type of support was offered. Prior to the policy release, a one-year pilot was undertaken for routine screening and the data from this pilot fed into the policy.

The 'guidelines for the promotion of sexual safety in NSW mental health services' (New South Wales Health, 2004; NSW Health Department, 1999) direct mental health services about the way to increase sexual safety in mental health services (specifically in psychiatric inpatient units); the need to assess for previous sexual abuse and vulnerability; how to respond to an incident of sexual abuse; workforce development issues; and the need for the development of local (area-specific) policy and implementation.

Implementation of both policies is the responsibility of local mental health services; it includes local workforce development strategies and training. Implementation is also aided by the 'Education Centre Against Violence' NSW Health, which delivers training to NSW health and mental health services. Using the two policy documents NSW Health guides mental health services as to the work to be undertaken. A detailed description of what is involved and how this work needs to occur provides a comprehensive 'toolkit' to mental health services. Routine screening for domestic violence is to be integrated into the mental health assessment. The continuation of training courses by the 'Education Centre Against Violence' (from here onwards ECAV) demonstrates ongoing implementation (and maintenance) of the guidelines;

while the snapshot reports on routine screening document the continuation of implementation (and maintenance) of routine screening for domestic violence.

The history, development, and implementation of the two documents occurred quite differently and will therefore initially be discussed separately. The first section describes the drivers that assisted in placing domestic violence on to the agenda for the mental/health sector in NSW.

Drivers of domestic violence policy and procedures

> I think the policies that get up are ones that are a little more ideological, more around how we work and how we approach people and how we work smart with what we've got. Policies that come up around new sources of funding tend to be a bit more competitive and not so effective ….

New South Wales' policy on domestic violence (New South Wales Government, 2003) was developed to guide health services about using a screening process to find out if clients have experienced domestic violence, and how to best provide support. While the policy provides guidance to health services in general, mental health services are included—and it is this inclusion of mental health services and the adoption of this policy that is of specific interest to this study.

The process of screening suggests that each woman who accesses a mental health service needs to be asked the same questions in order to ascertain whether she has previously experienced or is currently experiencing domestic violence; to find out whether she wants any assistance in relation to such an experience and to provide such assistance (directly or by referring to a specialist service). The document includes instructions about responding to disclosure of domestic violence, including 'immediate/crisis intervention'; 'counselling'; provision of information; and 'referral' (to specialist domestic violence services). Four annual evaluations have been undertaken by NSW Health to obtain information about the number of women screened and the type of support offered to those who agree to receive support (NSW Department of Health, 2004, 2005, 2007).

Key informants were asked for their opinions about which factors have contributed towards the development of this policy and which barriers needed to be overcome during this process. They were also asked to comment on issues pertaining to implementation. The following section provides an overview of drivers to policy development identified by key informants, followed by barriers and implementation issues.

Building on previous policy

The existence of a previous policy (New South Wales Health Department, 1993), which was due to be reviewed formed the basis for the development of the more recent policy, which includes routine screening (New South Wales Government, 2003). The fact that a policy already existed and could be built on—rather than having to start without any previous document—is seen by a number of key informants as a definite driver towards the development of the second domestic violence policy in NSW.

> … there wasn't really anything wrong with the old policy, it needed dusting off.

Universality

The identification of the fact that a large number of women accessing mental/health services have experienced or are experiencing domestic violence, and the failure to identify this fact through usual work practice contributed towards the development of a universal screening tool. The view expressed by a number of key informants and described by one as the "recognition that dv[14] presents across the whole health system" is seen as a driver towards the need for a universal response—one that ensures that disclosure of domestic violence is not left up to chance or the initiative of the consumer.

Consultation processes

The specific structure NSW Health employs to develop policy is also mentioned by key informants as a contributor towards enabling policy development in this area. Policies developed within NSW Health go through a Policy Review Committee, which undertakes extensive consultation processes. Key people from beyond NSW Health were invited to the committee for the review of the domestic violence policy and this is seen as a major driver for the success of the review and development of the second policy. The Policy Review Committee is an

> interagency group, which includes some of those agencies [external organisations, individuals and advocacy groups], which make representation on behalf of specific groups and experiences they have…; this is the consultancy process within NSW.

[14] In this thesis and in the quotes by key informants the following terms are used in abbreviation, according to key informants' language: 'dv' stands for 'domestic violence'; 'sa' stands for 'sexual abuse/assault'; and '' stands for child sexual abuse/assault. Key informants (at times) abbreviated both terms and when quotes are provided these abbreviations reflect their actual language.

It was pointed out that the consultancy process is broad and the domestic violence policy was sent to some 45 people, who were invited to provide feedback. As one informant suggests, the existence of the review committee is "one of the strengths within NSW".

State government leadership

Leadership by two specific sections of NSW Health is mentioned as being instrumental in driving the development of the policy: the 'Women's Health Policy Unit' and the 'Education Centre Against Violence'.

Several key informants point out that the Women's Health Policy Unit and key staff within the unit were vital to both the development of the policy, including the literature review (policy analysis, which is step two of the policy cycle) and the pilot on routine screening (which provides local data to contribute to the development of the domestic violence policy). This informant suggests that

> one of the ideas was routine screening … [we] got some Commonwealth funding for routine screening, took a year out to actually set that up, run it, evaluate it, look at the results of that, develop policy and materials ….

Another key informant points out that the "Women's health policy unit was critical to drive the issue". More than merely having supportive staff within the unit, several informants speak about the high level of leadership provided by those within the unit and also that the Director-General (of NSW Health) at the time "certainly recognised that these issues are very important", which assisted in the development of the policy.

The other constituent of NSW Health, which constitutes a major driver, enabler and supporter of the development of the policy, is ECAV. The centre, individual staff, its quality of work, its strong connection with various sectors and other government, the professionalism and the leadership by individuals within the centre and the centre overall, are mentioned time and time again by key informants. During the development phase of the domestic violence policy ECAV's work is seen as inextricably "connected with the domestic violence plan". The fact that ECAV had such a good reputation in this area facilitated development of a policy and its implementation—including training, because of knowledge that high-level training would be delivered. Furthermore ECAV's reputation as a leader in this area is seen as instrumental in the development of the policy. As one key informant states

> ECAV had a place at that reference group table and … they are very well connected and people are well informed about their work and I think there

> was a shared understanding around that table that there has been some brilliant training done.

Minimal resource implications

Funding provided through the Commonwealth made possible the pilot of routine screening, the evaluation and an additional position for ECAV to oversee the pilot and to provide training. While a number of key informants talk about the lack of state funding for the development of the domestic violence policy, it is also pointed out that it was exactly the lack of state funding that contributed toward policy officers' thinking about how to develop policy within current budget constraints. As expressed by this key informant

> it was pretty clear there wasn't going to be dollars attached to the policy … and [dv screening] came out of that process. The thinking really was to look around health service practice and find ways that would make a difference.

The need to make minimal demands on resources is seen as an enabler/driver of getting routine screening off the ground as part of this policy.

External developments

A number of external drivers are also mentioned by key informants, including the work of WHO (WHO, 1997, 2002b), which put the issue of interpersonal violence firmly on the international agenda for mental/health providers. Additionally, the 'Reduce Violence Against Women Strategy' by the NSW Government developed during the early 1990s was still as relevant as it had been at its inception; this, according to one key informant, also provided the backdrop to the development of the policy, with the (then) Office of Women's Policy providing the 'broader driver' through keeping the strategic plan alive. External lobby groups—NGOs—are also mentioned as having contributed to push these issues with government, as suggested by this informant:

> … you need the NGOs to do that kind of pushing, because … there are some things you can't do from within, so they can sometimes go directly to the top … [you] need the push from the community as well ….

According to another informant work undertaken on a national level in the area of domestic violence at that time, constituted a driver to speed up work in this area,

> … [because] dv national stuff was happening, a bit of state shame [occurred] that there wasn't anything [happening in NSW].

Legislation

Another driver for the domestic violence policy, mentioned by a number of key informants, was legislative change to the Children and Young Persons (Care and Protection) Act, which precipitated the need to train mental/health staff in the Act. This in turn provided an avenue to include issues of domestic violence in training, as changes to the Act included the recognition that domestic violence is also a child protection issue. The synchronicity of the two developments is seen as beneficial to the development of the domestic violence policy, with this key informant suggesting that the "Act was just coming in when routine screening was being piloted".

In summary, the main drivers for the development of the domestic violence policy and procedures for mental/health services were the following: the existence of a previous policy for mental/health services; the identification of the need for a universal response (routine screening); a well-developed and inclusive NSW Health consultation process about new policies; leadership by state government and by individuals within those; minimal resource implications ('doing things differently' rather than 'doing something additional'); international and national work that put the issue of domestic violence on to the mental/health agenda; and existence of new legislation linked to domestic violence.

Having provided an overview of the drivers for the development of the domestic violence policy in NSW, the next section will discuss the drivers identified by key informants, which contributed towards the development of the 'guidelines for the promotion of sexual safety in NSW mental health services' (New South Wales Health, 2004).

Drivers of sexual abuse guidelines

> [The guidelines were developed] … in response to finding that this [mental health service] is an unsafe place for people … and no doubt it is for many people ….

While guidelines are not strictly policy, it appears that these guidelines have been used like a policy. One key informant (with intimate knowledge of the guidelines) refers to the guidelines as 'policy' on numerous occasions during the interview, even though it is clear that she refers to the guidelines, rather than local policy that was developed due to the guidelines. The guidelines are the framework both for improving quality of care and for policy development: the document stipulates the need and indeed the expectation for the development of policy by and for local mental health services. According to the guidelines local implementation committees needed to

involve local specialist agencies as well as the ECAV, which was also to provide training on a state level.

Exposure of a 'duty of care issue'

The most common driver mentioned for the development of the guidelines is that sexual abuse occurs *within* mental health services. Key informants talk about a number of different ways that incidents of abuse were brought to the attention of state government, including complaints to the Health Department about assaults within mental health facilities; and the fact that "sexual assault services reported directly to a person in the Department" about matters including abuse within psychiatric settings. The major driver which exposed this 'duty of care' issue was a research study, mentioned numerous times by several key informants. The study highlights the issue of sexual abuse being perpetrated against women, including by staff, during their stay in psychiatric inpatient units (Davidson, 1997). As this key informant suggests, this fact meant

> … that the department had to act, in particular [because] it had been mental health workers and psychiatrists who had been named [as perpetrators].

This point is reiterated by this key informant when she suggests that

> … [there was a] growing nervousness about duty of care, so you couldn't just send it away.

The fact that the research had been done by an external group (constituting an external driver) and that it highlighted this duty of care issue, is seen as contributing towards the issue gaining attention: the report was

> … written by an NGO…and so … damning of the mental health system and talking about something, a service that is meant to be safe ….

As one key informant recalls, the publication of the study "caused an absolute crisis" in NSW Health, and a response needed to be formulated rather quickly. Members of the Women and Mental Health Network Group

> …felt it was hard [for policy makers/mental health services] to ignore [that sexual abuse was happening, and that] if the sector wouldn't open up to it, we would at least be able to make a lot of political noise.

According to another key informant: "sexual assault services reported directly to a person in the Department" of NSW Health at that time, including mentions of

incidents of sexual abuse occurring within mental health facilities—adding to the growing knowledge about such abuse occurring.

External drivers with 'insider' knowledge

The fact that the research discussed above had been undertaken by a non government organisation is seen as an important factor. A key informant illustrates this issue:

> That report could not have been written from within the department, any woman in mental health could have written that—but [the writer/researcher] needed to be outside ….

The research project was overseen by a steering group which included women who had experience in working 'in and around' mental health services, which appears vital in moving the research along; a research expert committee also oversaw the project. The importance of understanding the mental health system during this process is pointed out by a number of informants; as one informant suggests, the mental health system was (at the time) perceived as an "intimidating sector" and those working on these issues needed knowledge about that sector. Gaining ethics approval was, according to a couple of informants, obtained "by sheer determination"; particularly knowing the mental health system was essential to gaining ethics approval for a study that from the outset could be perceived as controversial by those in a position to provide such approval.

> Politically we thought we needed to be able to shift … an extremely closed department [mental health] … nobody had been able to [do that].

Here is the problem and here is the solution, we are here to save you from it.

Rather than simply identifying a problem, a solution to the problem was offered simultaneously. As an informant suggested,

> it is not enough to do research, to outline a problem; you need to solve the problem for the department, which gives them more reason to take it up ….

The solutions provided in the form of the research report recommendations referred to the need to provide training for all psychiatric staff on sexual abuse and sexual safety and suggested that ECAV would deliver such training. Members of the network were aware that taking on the issue of sexual abuse as part of clinical practice would be a major cultural shift for mental health services.

State government leadership

Positive and established working relationships between NSW Health bureaucrats, ECAV and those involved in the research are named as a driver for successful development of the guidelines: a staff member of ECAV was also a member of the Women and Mental Health Network and the group overseeing the research.

> A good relationship between [the] semi-independent researcher and training [ECAV] and government

is mentioned as a driver towards getting the issue on the agenda.

Similarly to the domestic violence policy, ECAV was again frequently mentioned as a major driver towards putting sexual safety on the policy agenda. The existence of ECAV as a respected training body and its well-established relationship with mental health services are seen as essential; these established relationships (led by the director of ECAV) included those with “policy people” and the director of the Centre for Mental Health. The employment of a staff member who had previously worked in mental health services and therefore understood those services, is also mentioned as a major contributor, as she

> had [a] relationship and trust [and a] connection with mental health and NGOs.

Several key informants describe this staff member as being a key person who understood the culture of mental health services. Furthermore it is suggested that ECAV was

> just as good at working with bureaucracy as they were with training staff.

In addition to the positive image and work of ECAV and its significant people, staff within other sections of NSW government were also instrumental in this work; some of the key people within the NSW Health had previously worked in the sexual abuse field and this informant suggests that

> we got into bureaucracy, but we weren’t embedded enough to shut up [about sexual abuse issues].

Additionally the director of the Centre for Mental Health of that time is characterised as having pushed issues along in her own unique way. When provided with the findings from the study she was responsive to the issue of sexual abuse and the associated need to do something about it.

Minimal resource implications

The provision of resources in the form of an additional position for ECAV was vital for the development of the guidelines. The existence and ability of ECAV to provide the training associated with the policy was seen as a driver by an informant, when she suggested that "having a training body, providing [a] solution" constitutes a definite driver for policy development in providing government with a solution; at the same time government would only need to provide minimal resources by increasing funding to ECAV to provide training and service development across NSW.

External developments

The work of the feminist movement (including the 'Women and Mental Health Network') is seen as vital to developments in this area,

> … everything we got up is on the back of the women's movement; we would have nothing [without it].

As previously mentioned, some of those feminists had by this time moved into government and they were then "able to advocate from the inside". The work of those working towards sexual abuse guidelines (both within and outside government) was aided by a public forum on trauma and mental health impact following the appearance of a publication by Judith Herman, an American psychiatrist (Herman, 1992). A key informant points out that the forum not only brought those sectors together for the first time, it furthermore laid the groundwork for the development of work in NSW, aided by the fact that a prominent and respected psychiatrist spoke about trauma and recovery.

In summary, the key drivers for the development of the sexual safety guidelines are as follows: the exposure of a 'duty of care issue'; external drivers such as individuals with inside knowledge of the mental health service sector and its culture; provision of suggestions for a solution; the level of state government leadership; minimal resource implications for implementation of the guidelines; and external developments.

Having discussed the drivers that assisted in the development of domestic violence and sexual abuse policy directives, the next section will focus on the barriers that needed to be overcome to develop these.

Barriers

While the domestic violence policy and the guidelines for sexual safety have quite different developmental histories, the investigation of barriers that had to be

overcome in order to develop both documents have more commonalities than differences. This next section describes the barriers that needed to be overcome in order to develop these documents.

Abuse is not the core business of mental heath

An issue raised numerous times by key informants is the lack of acknowledgment that abuse (domestic violence or sexual abuse) is core business for mental health services.

> … the [mental] health system doesn't see violence as its core business, if you're the police, if you're the court, those type of people, that's your business.

> … it feels like it crosses that personal/public divide going into a place that is personal and private, doesn't fit in the centre—that is a barrier—that it doesn't sit at the centre.

This failure to place abuse in the centre of mental health service provision—including a responsibility to attend to issues of abuse—is reflected in the lack of knowledge about these issues by key government staff.

> Lack of training or value-based training for the decision-makers was a very big barrier.

This key informant furthermore states that this fact is still the case. Accompanying this lack of knowledge is a level of "ignorance and discomfort" about dealing with domestic violence. Lack of knowledge and of or engagement with issues of abuse is, according to key informants, at times connected to staff believing that

> women/men make up sexual abuse and when they have a mental illness … how could you trust anyone with mental illness, by definition they have lost contact with reality.

Disbelieving is seen as part of prejudice which exists within mental health services against people with mental illness—especially when it comes to believing reports of abuse.

The medicalised mental health system

Lack of uptake of the issue of sexual abuse, or failing to see it as a core issue in clinical practice is also attributed to mental health services working within a medical model to the exclusion of issues that do not seem to fit into a medical approach.

> Most critically: sexual abuse is not [seen as] core business of mental health, [people] didn't see how it related to mental health, [they are] saturated in the medical model.
>
> They didn't see their role in assisting with this—getting mental health up to [speed] … re domestic violence; [it is] not seen as part of their [government's] role.

The hierarchical structure of a medical system, according to some key informants, also means that policy is driven from "top down, [with] no workers involved, top down, no bottom up". Mental health services are perceived as a closed system: several informants make reference to a 'silo' mentality, both within the sector and within government, as well as lack of collaboration between sectors or government. All of these factors are seen as barriers to policy development. One informant suggests that

> historically mental health services have not worked collaboratively, they tend to work in isolation.

It is also suggested that this 'medical approach' to mental illness may contribute towards disbelief of women who talk about having experienced domestic violence, similarly to those who report sexual abuse.

Feminism never came to mental health

Key informants speak about the fact that it is feminists who continue to bring the issues of abuse to the forefront of society. Both policy documents have 'feminist overtones', which in turn can be experienced as problematic by policy makers. One key informant suggests that "mental health sees feminists as biased": hence getting policy up which has clear feminist 'overtones' can be difficult, as some policy makers feel uncomfortable with such 'bias'. Concurrently, some participants reported experiencing "a lot of resistance from men [within the department] and from "men's health advisors".

Resource implications

Those working on the development of the domestic violence policy are aware that no extra or only minimal extra funding will be available for this work; this in turn means that policy implementation needs to occur within current funding parameters. Therefore routine screening is seen as a chance to be 'doing something' to make a difference.

The issue of potential resource implications is again raised as a stumbling block in the development of the sexual safety guidelines, when a key informant suggests that there was

> anxiety and nervousness about the implications for resources [and the] resource implications, should you change [the] design [of inpatient wards.

Another informant also talks about the fact that implications of this work could have included suggestions to separate women and men, "if [it was possible to] influence the design guidelines", which were under review at the time. A lack of resources—in other words the financial implications of a comprehensive training strategy requiring of releasing staff[15]—is mentioned as a barrier that had to be overcome in the development of the domestic violence policy.

Universality

The fact that women with domestic violence experiences can present in all areas of mental/health is perceived as a potential problem by key informants.

> Another barrier is, that it [domestic violence] presents in all programs …. so to try and develop policy and develop an approach to working across those different programs is very difficult ….

The breadth and type of services needing to be included and consulted with in the development of the policy is here seen as an impediment to policy development. As a key informant suggests, "an awful lot of areas, branches, etc … needed to be involved".

Learning from previous policy

Another potential barrier that policy makers need to address is the fact that experience of implementing the previous domestic violence policy showed that there was not a high level of uptake of training. As one informant expresses it:

> you had to badger people to come to the training, it was quite difficult.

This implementation issue arising from the first policy implies that developing a policy and delivering training may in itself not have a great a impact on changing service provision, due to lack of uptake. This informant suggests that it was necessary to look

[15] Mental health positions frequently need to be 'backfilled' if they attend training, especially if they work in acute settings; this means that resources for sessional staff need to be available to release staff to attend training programs.

> at how you could have a more effective implementation strategy rather than just training. So what we did … was looking at what they'd been doing at other places, in other countries and … suggested screening for domestic violence in key services.

Silos

Lack of connection between the mental health and sexual assault sectors is mentioned as one of the barriers to development of the sexual safety guidelines: as one informant suggests

> there just wasn't any conversation happening between sexual assault [services] and mental health [services] …. that must be a barrier.

This lack of connection between the sectors is amplified by lack of trust between the sectors: a statement from this key informant highlights this issue.

> I think it was that sexual assault services didn't trust that mental health services wouldn't re-traumatise their clients, that there would have been a reluctance to refer, and I imagine that sexual assault [services] were stereotyped as social workers.

This separateness and disconnection is echoed within the department, according to this informant, who suggests that

> mental health policy still sits very separately to the policy that … [others] are responsible for, domestic violence, sexual abuse.

In summary, the barriers that existed and needed to be worked through to enable the development of the policy and guidelines include a belief about what constitutes core business for mental health services—one which excludes abuse issues. Included in the view of what constitutes 'core business' is the mental health system's medical (biological) view of mental illness, which tends to perceive social factors such as abuse as less important in treatment of those with mental illness. Furthermore, the mental health system in general does not have a history of collaboration with other service sectors, such as specialists in abuse and trauma. The potential for such policy to be seen as aligned with feminist theory is also a barrier to policy development. Potential resource implications for the development (and implementation) of policy are seen as another barrier that needs to be worked with; similarly the fact that those with an experience of abuse present at any and all service types can make a response more challenging, if a universal approach is sought. Previous experience in relation to a lack of uptake of training on domestic violence

plays a role as a potential barrier in the development of domestic violence policy. Finally, the lack of connection between service sectors, such as between sexual assault or domestic violence services and the mental health sector (the 'silo' mentality) constitutes a barrier that needs to be overcome.

Having provided a summary of the barriers that need to be worked through to develop the policy and guidelines, the next section will provide an overview of the findings regarding implementation.

Implementation issues: domestic violence policy

> Nobody owns domestic violence; who is going to own the policy and implementation? It's fallen to women's health, relying on fantastic people on the ground to make it happen.

In this part of the interviews key informants are asked to comment on any implementation issues in relation to the policy on domestic violence and the guidelines on sexual safety.

Mandating screening

Issues relating to the implementation of screening are discussed numerous times. One key informant, involved in implementing the policy on a local level, points out that under the previous policy (which did not include the mandate to screen), it had been very difficult to get staff to attend training. It appears that the introduction of routine screening and the mandate for all services to undertake training provides a welcome response to this problem. However, even under the second policy getting people trained remains problematic, with this key informant suggesting that "getting people to training is always difficult".

Despite the fact that it had been difficult, at times, to get staff to attend training, key informants also point out the value of introducing routine screening as a practical and tangible tool which allows other work to follow.

> Without routine screening there would have been no shift in [mental] health services, because it gave people something to hold on …. if policy had been just a policy with nothing tangible, it would have not had the same impact.

Abuse as core issue in workforce development

While mandatory screening constitutes a universal approach to positioning abuse as a central issue within mental health services, not all of them carry out screening. This key informant suggests that

> we know that psychiatrists have certainly not been doing the screening…and when you try and provide training to them, they … [think] it's not their business and they are not doing that at all.

Clearly the introduction of screening and the tool to undertake it provide an opportunity for a uniform approach to the detection of domestic violence; at the same time routine screening provides the opportunity to respond to and support those who disclose such an experience. The introduction of screening and the necessary combination with training is seen as

> a workforce development strategy, it's been really significant in the way it has up-skilled services that wouldn't normally have seen dv as a primary issue. To ask questions and then to respond … there are cursory nods …'this is something we do'. I certainly know that the people more senior [within government] … don't necessarily know that that is a massive impact. Like that was a really significant coup to get those particular sectors to ask questions about domestic violence.

Work undertaken by WHO (1997, 2004) and VicHealth (Flood & Pease, 2006; VicHealth, 2004) which contributes towards making domestic violence core business for mental health services, is also seen as providing a broader platform which supports work within mental/health services and state government. As this informant suggests:

> that kind of thing really supports it … in terms of the health [and mental health] system recognising that it actually is a health issue, cause I can remember even comments in '93 [were] 'this is a legal or social issue', it's nothing to do with health ….

We know how to ask the question but not what to do/where to refer.

While some see screening as vital for the success of the policy, others point out that the training does not quite go far enough. One key informant reflects on the fact that some staff are comfortable about asking screening questions; however they do not feel skilled enough to offer adequate support. Equally this informant points out that

> if people are skilled up, they might still feel uncomfortable about asking because there is nowhere to send people.

The fact that not enough referral options exist can be a barrier to carrying out screening. This can be combined with a sentiment that if questions are asked, a response is needed; the following statement highlights this issue.

> If I ask about something [domestic violence] and I bring it to the forefront then … I need to deal with it, so I rather not ask.

Monitoring is very important

Key informants suggest that simply developing a policy and telling services to implement the policy is not enough. The directive of the policy to develop local implementation plans and the need to report back is believed to have led to increase in uptake and implementation of the policy in local services, including mental health services.

> The other thing … that was important was [that] we asked services for an implementation plan, with timeframes on it and we asked to report against that …. so, monitoring is very important, it really, really is very important. I don't know, that's 'policy 101' but the steps that we took were very important, and that monitoring continues in the form of the one-months snapshot [evaluation reports] for the routine screening.

It is this need to comply with reporting about local implementation that is seen by many as a vital part towards successful implementation of the policy: as a key informant suggests "having that sort of accountability" is the factor that is integral to this policy and its implementation.

> Once the department starts asking … for progress reports, you have the authority to ask … for the progress report.

This reference to the authority provided by progress reports is echoed by another key informant who points out that

> if you don't force it to happen, it won't happen, if you say 'implement this policy' without requiring something really clear and strong back, I think it's the minimum we can actually ask for, you're just not going to get it, if they are answerable they have to do it.

Monitoring the implementation of the policy is seen as being

> very important, and that monitoring continues in the form of the one-month snapshots for the routine screening.

At the same time, there are some difficulties about the way the data is collected and reported on; as one informant points out

> one of the problems with monitoring is that it's slow … they are given too long to put data in and then feeding back to them is slow, for that sort of stuff to be

> effective, or as effective as it could, to be useful [this process has to be quicker].

While this lack of timeliness of the feedback cycle can become an issue for government and mental health services, the reports do provide useful information and allow for comparison between different health and mental health services, because

> from a central [NSW Health] point of view, you can show what other areas are doing, you can compare.

At the same time as the usefulness of the data collection is pointed out by some, other informants talk about the limitation of the current evaluation, as reporting on data in itself does not measure client satisfaction or outcomes.

> There isn't a service responsibility or area responsibility [for policy implementation on domestic violence]; the responsibility is, to get the snapshot [evaluation report] in.

This issue of the focus being on providing data on the level of screening—rather than the quality of support provided—is echoed by another informant, who suggests that

> we know it's working, whether it really means a difference to clients, I don't know that, that's something that you might know on a local level.

One size fits all?

The entry points to mental health services are many and this is experienced as an impediment towards a universal approach to screening (a 'one-size-fits-all approach'). Some settings may not be as conducive to screening as others, such as at the crisis end of service provision.

> I think it's difficult to try and do screening in acute units, when people … are in an acute phase of their disease and how you get answers that you want, genuinely, I think it is very difficult to get medical officers involved, they … refused to come to training ….

Implementation within a system such as mental health, which comprises several different types of teams and settings, is also seen as

> complicated … [because] they have so many different teams, they have community teams; I mean you know six or seven different types of teams that you have to do this implementation through. So it's not automatically, like in maternity services, everybody gets screened, when they get booked in, or thereabouts.

Standardising assessment

The questions for routine screening have been integrated into mental health assessments by making them part of the 'MH-OAT', the 'Mental Health Outcome Assessment Tool' (NSW Health). Those key informants commenting on this fact see this as a major change for mental health services; however they also comment on the fact that reporting on domestic violence is not part of the feedback mental health services *need* to provide to the Centre for Mental Health (NSW Government). One informant suggests that next time MH-OAT is reviewed; it would be useful to integrate a feedback loop for this type of data being collected by mental health, so the information is available to government and specifically to the Centre for Mental Health.

Implement AND maintain

While the snapshot data collection shows an increase in sites at which routine screening has been implemented over the years, it is also thought that recently

> screening has dropped off a little bit, but there are still significant numbers being identified with dv ….

The issue of implementation and maintaining this work is also picked up by another informant who reflects on the fact that she initially thought that "implementation [works like this]—do it and eventually [you] walk away", however she has learned that it is important

> not just to implement, it's implement and maintain and that it [screening and working with domestic violence] is embedded everywhere.

Leadership

Informants suggest that leadership within organisations is a necessary part of implementation in order to develop implementation plans and to actually drive them; and management needs to support this work.

> … mental health were really persistent, there was some strong leadership there … the senior social worker and nurses—clinical nurse consultants— … the mental health managers agreed with it and thought it was a good idea.

Working with those who provide leadership within mental health services is seen as a way into mental health services.

> So in the beginning it's the CNC [clinical nurse consultant] and the social worker and psychologist [who] were … providing the leadership.

Implementation issues: sexual safety guidelines

Implementation of the sexual safety guidelines involves a multi-layered approach, which can be summarised as a requirement to develop local policy for each mental health service; a directive to develop local responses via local implementation committees (comprising staff from within and beyond mental health services and which include sexual assault service staff, consumers, nurses and other mental health staff, and an ECAV representative)[16]; and development and delivery of training[17]. Key informants are asked to comment on implementation issues relevant to this process, with an overview of these themes provided in the following section.

Whose mandate is implementation?

One factor that is a driver for the level of implementation undertaken in regard to the guidelines is the directive by the (then) Director of the Centre for Mental Health (NSW) as well as the Director-General of Health, who both express that it is compulsory to implement the guidelines on local levels. According to key informants the influence of the Director of the Centre for Mental Health (NSW Health), as well as that of policy officers and ECAV, were important when particular areas were uncooperative during implementation. The key informant quoted below highlights the issue of consistency in relation to implementation.

> I know that there isn't a take up everywhere and it does take dedicated workers who have done the training and who understand the issues to make whatever is created … either the guidelines visible and active or … whatever else is developed.

While other sections of the Department such as women's health units or those parts of the Department responsible for the areas of sexual abuse have an interest in the guidelines being implemented and monitored, these sections do not have a mandate to monitor implementation.

> We don't actually have responsibility to manage those guidelines, because they have a Centre for Mental Health.

It is suggested that some of the local implementation committees

> failed because they did not have a translator, these are complex issues.

[16] However not all areas had all those representatives and some did not have an ECAV representative on their local implementation group.
[17] Training was to be provided both centrally by ECAV as well as locally by Women's Health Units, which are part of Area Health Services.

In this case 'translator' refers to a staff member from ECAV being able to literally speak two different professional languages: that of mental health and that of sexual abuse (services). She furthermore points out that for some committees

> [it] took 18 months or two years before they spoke the same language.

This was the case, even when a staff member of ECAV was part of committees supporting this kind of work and providing a bridge between the different sectors ('the translator').

Monitoring

Inconsistencies in implementation also became apparent during the evaluation phase for the first guidelines (with the results directly feeding into the development of the second edition). As one key informant suggests, "some areas took it up more than others".

Integration or invisibility?

While the movement of issues of abuse into the policy arena is seen as a positive step by many, integration can also precipitate a certain level of invisibility of the issue, as is suggested by this key informant.

> It seems not to impress anybody in mental health anymore, if you say something about people's trauma histories, or if you name sexual abuse or domestic violence or child abuse as being significant factors in the lives of people with mental illness. So it feels like 20 years ago, maybe even 15 years ago … [abuse] was totally invisible, now it feels like there is a nod to it, but as if [there are] … not policy issues.

Through this process of integration of abuse into policy and service provision the 'novelty has worn off' and associated with this fact is a diminished focus on abuse, which is a contrast to the initial response to the guidelines, when

> [the] sexual abuse guidelines had actually made that issue visible in mental health facilities.

Training

Training about sexual abuse is delivered to staff of mental health services as well as consumer support workers[18]. The effort necessary to ensure attendance at training is described as a "huge amount of work" and that it was "very critical". It is believed that

[18] These are staff within mental health services who are or have been consumers themselves and who support other consumers.

without this effort levels of attendance at training would have been much lower. The training delivered to mental health services "covered the world of sexual abuse in three days". Advanced training for those who wished to build on the three-day training was also offered, as was training for sexual assault services on mental health issues by ECAV (all of these are still provided to date). It is believed that this multi-layered "training strategy has been very effective". Over several years, those providing training on sexual abuse have seen a shift within mental health services. It is believed by some that the issue of sexual abuse has actually moved much more into the centre of mental health organisations and that

> mental health doesn't see sexual abuse as unusual anymore, [it is] now core business.

According to key informants, while those teams working at the acute end of mental health (such as inpatient units and crisis teams) used to be hard to reach or engage in training, this has changed over the years and ECAV now delivers "training directly into acute admission" (psychiatric inpatient units and their staff).

Training is seen as integral to the successful implementation of the policy, as is suggested by this key informant.

> Developing policy only in complex areas is useless without training [because] you are asking a field [to undertake] enormous transformation.

Minimal resources

The lack of resources provided is raised as an issue by a number of key informants. According to one informant resources are "drip-fed … into the silos and then [they] expect us to collaborate …": this lack of resources is seen as a lack of opportunity to actually collaborate—as is required in order to work on local implementation strategies and committees. A lack of resources is also identified in relation to how difficult it had been at times to work with mental health services on these issues, and also that the

> mental health sector [has been] hard to engage, because of workload and resources.

While it appears that ECAV has been able to deliver plenty of training to mental health staff, according to another informant its reach is still limited, due to the minimal funding ECAV receives for this purpose.

> There was no heavy investment in training for mental health workers [hence] ECAV took some of that up, including tertiary education packages.

In summary, a variety of issues are associated with implementation of the domestic violence policy. These include the fact that mandatory screening assists with implementation and uptake across services. The move of abuse into the core of mental health service provision is aided by the introduction of this universal approach, and through this process a workforce development strategy has been introduced; other external developments also assist in moving abuse to the centre of mental health service provision. While training continues to be provided, there are also limitations to the training: while staff have been trained, they may still not feel confident in responding to expressed needs or indeed feel there is nowhere to refer to and hence do not take up screening for domestic violence. NSW Health's approach to implementation—which includes monitoring from the outset—seems to have been a successful way to (at least) gather data on levels of screening, without which key informants believe that the uptake of screening would be less. An approach of 'one size fits all' to responding to domestic violence through screening and a standardised assessment provides challenges, as it does not allow for local or service-specific approaches to the issue. Leadership by both those who develop and those who are involved in local implementation is needed for the successful development and implementation of the domestic violence policy.

Implementation issues for the sexual safety guidelines are somewhat different. While many may have an interest in ensuring that the guidelines are implemented, the mandate to oversee implementation lie solely with the Centre for Mental Health, and this is seen as a potential problem. Uptake of the policy and training varies between different mental health organisations. The integration of the issue of abuse into mental health policy, while seen as a positive step, can have also have the effect of making the issue less visible: the focus is gone; the issue is 'integrated'. The delivery of training is a time-consuming effort which requires plenty of work 'behind the scenes' to get staff to attend; however through the consistent provision of training by ECAV, those delivering the training have noticed a major shift in attitude and skills of mental health staff. The level of (minimal extra) resources provided to undertake implementation of the guidelines has an impact on the amount of training provided by ECAV and also the level of cross-sector collaboration between mental health services and specialist services.

Having provided an overview of the findings from the interviews held with key informants in NSW, with a specific focus on policy drivers, barriers and implementation issues for the domestic violence policy and procedures, the next

section will provide an overview of the findings of interviews with key informants in Victoria.

Victorian interviews

The focus of the interviews with Victorian key informants was to obtain their views of the level of policy guidance provided by the Victorian State Government to mental health services on the issue of abuse. The questions on the level of policy development were kept broad, rather than specifically focusing on current or past abuse—or abuse that occurs within mental health facilities. The document analysis—Study one—revealed that to date a ten year-old policy relevant to the issue exists. Among other issues, this refers to the need to address sexual abuse as part of clinical practice, as well as the provision of safety in psychiatric inpatient units for Victorian mental health services (Victorian Government Department of Human Services, 1997). While some other Victorian mental health policies include abuse to varying degrees, they lack comprehensive guidance and directives as how to implement, evaluate and report on policies to address abuse within mental health service provision. The document analysis shows a lack of specific policy documents addressing abuse issues.

Those informants who commented on Victoria's women's mental health policy were asked to provide information about implementation of policy addressing abuse. The interviews go on to investigate which barriers have affected the level of policy development and which barriers would need to be overcome if (further) policy was to be developed. The interview schedule also includes a question on informants' knowledge about how the issue of abuse made it on to the agenda (in case a key informant were to state that there is sufficient policy); however due to the lack of policy development in this area this question was not explored.

The following section describes informants' responses to the level of policy direction; implementation of policy issues; and the barriers to policy development.

Level of policy direction

Key informants suggest that there has been 'little' to 'no' policy guidance by the Victorian State Government to direct mental health services on issues of abuse. The following statements encapsulate the level of policy development in this area.

> Oh probably nil.

> Very little—do you want me to expand on that?

Those aligned with mental health are aware of Victoria's women's mental health policy (Victorian Government Department of Human Services, 1997); with the exception of two key informants, none of the other 'non-mental health informants' are aware of this policy. It is furthermore pointed out by those commenting on the policy, that it is rather old and outdated.

> It is quite old, I mean what the issues would be, the environment around it, even if the issues and the policy is still valid, it needs to be recast … it's been ten years, there has been [a] fairly big change, it would need to be revamped.

This informant states that while there has been some policy direction, it is relatively broad in focus.

> Well look it depends how you define it, I think in the broader sense the policy work is there—in that—the kind of policy framework is there around these issues, some of it's a little dated.

When further queried which policy is referred to it becomes apparent that other than the women's mental health policy from 1997, the informant cannot recall other relevant policy. The same key informant tries to ascertain if the latest Victorian Policy, published in 2002 (Victorian Government Department of Human Services, 2002a) includes addressing abuse when going on to say

> I'm just thinking of the more recent ones, like 'New Directions' … I don't think, I'm pretty sure that says nothing about abuse.

While this key informant believes there to be a lack of relevant policy, she also states that this is unlikely to be a deliberate act by state government:

> I don't think there's been any conscious decision not to do it, or conscious decision that it's not necessary [to develop policy in this area].

Other policies or policy-like documents mentioned by key informants are the Victorian Women's Health and Wellbeing Strategy (Victorian Government Department of Human Services, 2002b)—which is however not a mental health specific policy—and the report on a project determining the level of collaboration between mental health, family violence and sexual assault services (Mental Health Branch, 2006). Additionally some informants (who are with one exception are from mental health) are aware of a project being undertaken during 2007 by the Mental Health Branch on

'gender sensitivity and safety in psychiatric inpatient units'[19] (Mental Health and Drugs Division, 2008).

Implementation Issues

Those key informants familiar with the Victoria's women's mental health policy published in 1997 comment on several problems with its implementation.

Lack of implementation and accountability

Key informants report that there was no real implementation plan by state government beyond 1998 to implement the 'women's mental health policy'. The employment of twelve Women's Mental Health Consultants across the state, who each worked with several Area Mental Health Services during 1998, is seen as a state government short-term implementation strategy. All of those commenting on the implementation are critical of this short-term vision and saw those Women's Mental Health Consultants being able to achieve little change in twelve months. Those commenting on the limited implementation are particularly critical of the lack of accountability,

> … there was no expectation by head office to report back [about implementation of the policy or outcomes];
>
> … what were the outcomes—no loop to tie it back in.

Some key informants comment that reports about local implementation were sent to the Department of Human Services (Mental Health Branch); however no report about the implementation was ever released. Equally disappointing for some is the lack of resources attached to implementing this policy.

Another informant suggests that through the publication of the women's mental health policy issues of abuse are raised but are subsequently soon forgotten. She refers to the short-term implementation contributing towards a lack of focus, when she suggests that people think

> … lets get back to normal, when getting back to normal should mean having to keep doing that [implement policy] and that's how it drops off.

Barriers

Key informants are asked to comment on barriers that have hindered policy development and which would have to be overcome or worked with, were policy in

[19] The associated report was published after the interviews were conducted.

this area to be developed in the future. This section provides an overview of those findings.

Lack of drivers

Several informants speak about a lack of drivers, both from within the department as well as from the field: some comment on the lack of push by the sexual assault field for policy, while others suggest there has been no 'high-level authorisation' either within state government or across government. The lack of 'drive' or push for policy by the sexual assault sector is conceptualised by one informant as partly relating to the fact that, especially during the 1990s, the sexual assault sector tended to have a view that "… mental health issues were an outcome of sexual abuse". This view did not encourage cross-sector collaboration or advocacy for those with sexual abuse histories and mental illness. Another informant points out that other areas such as aged care have vocal external advocates (such as family members) who have pushed issues with state government to a greater degree than for the mental health. She suggests that state government has not experienced the same level of pressure in regards to the issue of abuse and the mental health sector. Connected to this issue is also the political 'noise' created by some incidents within aged care; she suggests that issues within aged care also came to light more prominently through

> a couple of spectacular failures of Commonwealth accreditation [of such facilities] that brought it into the face of the department. So again an external process that actually put it in our faces that there was something happening there, associated with high public risk and risk in other places.

A lack of focus by the Commonwealth on issues of abuse within mental health services is also mentioned; several key informants point to the fact that there has been no high-level focus on these issues for some time.

Lack of leadership

Lack of leadership is discussed by key informants as a contributing factor for this lack of policy development.

> I actually think it takes leadership, so you gotta have people, both within bureaucracy and policy, identifying the issue and get a move on … and have people in the mental health services that are actually advocating for it.

Leadership is needed in state government as well as 'on the ground', as this statement suggests.

> [It needs] people at the top who are actually on top of the research and can actually make policy [happen] … and are actually committed to doing it. But then you've also, at the same time, got to have the people who operate on the bottom who say 'these are issues' in our practice and we got to deal with them and have leadership in the middle to be able to negotiate all of that.

Linked with leadership is the need for knowledge about these issues by those who are in a position to influence policy, both within state government and in mental health services.

Biology versus social factors

Philosophical issues are also mentioned by key informants as one reason for a lack of policy development in this area. Some suggest that the biological model of mental health care—which largely excludes social factors as contributing or causal factors for the development of mental illness—provides no opportunity to include issues of abuse. This key informant points out that

> it's the way you define how people are, the explanations [of the] the emotional health and wellbeing of their behaviours. This is the mental illness, that's what's causing all this [their behaviour] so that automatically wipes out any other explanations.

There are philosophical issues that impact on any possible demand for policy development by the mental health sector. While all those interviewed for this study believe that a link between abuse and mental illness exists, it is pointed out that not all within the mental health sector share the same belief and hence would not ask government for direction to address abuse issues (i.e. approaches to working with those who have a mental illness AND an experience of sexual abuse), as they do not see it as relevant.

Another key informant points out that an attitude or philosophical stance within the sexual assault sector has kept that sector from making a connection with mental health—or asking for policy. This informant suggests that

> we were still very reluctant to think about those issues in a more developed sense, because we were caught up in that rhetoric almost, and in some of the feminist analysis that we've clung so tightly to, without thinking, reflecting on it, where it was pathologising in our view [to think about mental illness related to abuse].

The issue of a historically predominant biological view of mental illness versus a social model of health is mentioned as an obstacle; furthermore the

> traditional reductionist view of mental health, it's kind of diagnostically and individually driven and [the] individual is seen in isolation almost to society, the family; and so you are dealing with illness and diagnosis and therefore causal factors or social factors that correlate with diagnosis are not perceived, because it's entirely kind of individual [focused].

According to these key informants, this biological focus on illness can also lead to a lack of recognition that there are other factors that may need to be taken into account. This key informant points out that within a biological framework

> you are not treating the abuse; you are treating the anxiety, depression, whatever comes from it [the abuse].

Marginalisation: issues and people

Some speak about issues of abuse still constituting a 'marginalised' area of mental health; some also comment on the fact that those who work on these issues within clinical mental health services can in turn become marginalised. This key informant suggest that such staff can be seen as a

> marginalised whiner on some specialised topic, you know it takes people like me to try and make sure that doesn't happen. Trying to set it up so it's not going to happen, but you know it has happened many times in good faith. It's not integrated it can still become marginalised in the services, but if it's integrated it can disappear.

Alongside the marginalisation of those working on these issues, abuse can also be perceived as only a 'women's issue'; and while the majority of consumers with such experiences are women, being a victim/survivor of abuse—in particular childhood sexual abuse—is not only a women's issue, in particular within the mental health context. However, this reality is not necessarily perceived by all, as this informant suggests:

> There are a core of people who don't think gender-based issues as legitimate issues and I think that is very much associated with people's world views and … there is quite an emotional reaction to it ….

The following informant points out that a lack of analysis of gender and power issues underpin these attitudes.

> In terms of the things that relate to abuse or things that relate to, you know, that kind of broader gender and power and society [issue], that group of

> people is quite resistant to a specific service response, because that challenges their own world view.

Funder-provider split

Related to the criticism about the lack of implementation/strategy or accountability of the women's mental health policy (Victorian Government Department of Human Services, 1997) is the point made by informants that there is no mechanism by which sexual assault, if it occurs within mental health facilities, is reported to government. Some connect this lack of expectation by State Government to receive such reports as associated with the 'funder-provider split'; which "actively seeks to disengage from practice". The 'funder-provider split', according to this informant comes with problems.

> The more practice orientated detailed stuff no longer floats up to you, government no longer sees, and if it does see it, it sees it in anecdotes and in individuals—that makes it easy to dismiss—because of not actually seeing it at a system level in the same way.

This way of governing is not limited to the issues this research project is aiming to investigate but according to this informant is the way the Victorian state government works.

> The Victorian framework for policy: we sit here and have discussions …; we talk about quality of services more generally …. the government doesn't interfere, it sees what it wants to do—that the hospitals have a robust system … that's in the contract, it's the hospital's responsibility, it's meant to have a robust system for dealing with these things, not government.

What is the issue?

Identifying or naming the actual issue that policy is needed on—'issue identification'—is vital. This key informant suggests that generally most staff within mental health would agree that

> abuse issues are very important, yes they need to be assessed for, yes we need to ask survivors … no-one would think that you would disagree with that [the need to provide sensitive services].

She points out that this in itself does not contribute towards developing the need to ask for policy: people may ask

> … why do you need a policy on that, because no-one is disputing it [the issue/the need to provide services]?

This sentiment that there is no need for policy stands in stark contrast to the opinion of this key informant, who suggests that the quality of service provided is not sufficient.

> We all think we are doing the right thing, but people are doing the right thing in the wrong way.

While some policy exists it is suggested that broad 'motherhood' type statements do not identify 'how to work' on these issues or with consumers with such experiences.

Silos

The separateness of state government departments and their 'silo' mentality is mentioned by key informants as a contributing factor to the paucity of direction-setting in this area.

> There is the silos, obviously! That's family violence, that's that department, that's you know, child protection, that's the Office for Women, that's domestic violence; that obviously doesn't help.

The 'silo' mentality of government does not lend itself to cross-departmental collaboration, as this informant points out:

> … we haven't sat down and [have] not talked to each other.
>
> We could have been working so much better together.

When to involve other parts of the department—the timing of working collaboratively across 'silos'—is also raised as a factor that may be a barrier or at least complicate this work, as this key informant suggests.

> … at what point do you engage, and would that engagement at that time have made a difference? I guess everyone will say [you engage] 'all the way through' [the process].

Similarly the following key informant also comments on the issue of timing across government:

> … government is in silos as anyone else, so we've got domestic violence sections, we've got, you know, I don't know, CASAs … you know all of these bits all over the department … you know we've got then big policy, women's health kind of sitting over there, not necessarily connected to any operational components. If we think of family violence, you've got the whole protective services stuff, which is a really big arm into family violence, you know, so

> we've got all of these bits of government, and we don't always play together well.

It is a very crowded policy agenda

A busy policy agenda with competing interests and items that demand attention is mentioned as a potential barrier for future developments, as the following statement of a key informant suggests.

> There is the competition with the other potentially … good ideas or not good ideas, other necessary things to do. And in a way what gets up ... [is] a combination of … what 'absolutely must be done' to keep the system running and b) some things have these reasons—favoured by the government of the day. Or finally have to be managed because there is perhaps an effective sector industry lobby that they become a priority, because it's, you know, that sort of 'squeaky wheel and the oil' … it's an informal but competitive process for policy implementation.

This statement covers several potential barriers: firstly that of a crowded policy agenda and the associated competition of issues; secondly the fact that a focus on 'what absolutely has to be done' overtakes other (seemingly) less pressing issues; thirdly the fact that government and its ministers set policy agendas and this may change depending on the individuals taking up office; and fourthly lobbying by external drivers for certain issues, which influences the policy agenda or what makes it to the top of the agenda.

In summary, the interviews in Victoria provide insight into key informants' points of view about the level of policy development, implementation issues and information about barriers to policy development. There is agreement that little to no policy development has occurred in Victoria to direct mental health services on the issue of abuse, with the exception of a policy on women's mental health published in 1997, which includes abuse as one of several foci. The implementation of this policy lacks any strategy or resources beyond the first year; there was little accountability about its implementation progress within the first year and there has been none since then.

Key informants name a number of barriers that have led to the dearth of policy development, one being that of a 'lack of drivers' to push the issue with government both from within and state government. Connected to this lack of drivers is a lack of leadership, again within and outside bureaucracy. Another barrier is the focus on a biological view of mental illness, rather than a view which takes social factors into account. The likelihood of marginalisation of both the issue of abuse and those who work in this area is seen as an obstacle to increased policy development and

implementation of the (old) policy—with some suggesting abuse is seen as a women's issue and hence marginalised. The Victorian Government's approach to policy and implementation, characterised by the 'funder-provider' split, is seen as an overall barrier to government's awareness about issues as well as implementation of policy. A lack of identification of the actual issue that needs policy direction constitutes another barrier. The 'silo' mentality, both within government and between mental health services and other sectors, is seen as an impediment to policy development. Finally a crowded policy agenda is identified as yet another impediment for the development of policy.

Having presented the findings from NSW and Victoria, the following chapter provides the discussion of the findings and the conclusion.

Chapter 8: Discussion of findings

Introduction

The key questions for this study are to investigate

- ◊ if there are differences in the extent to which abuse and violence issues are included in mental health policy across jurisdictions
- ◊ what factors have enabled or hindered the development of policy guidelines for the prevention and remediation of violence and abuse for people with a mental illness
- ◊ what factors have enabled or hindered the implementation of strategies to prevent or remediate violence and abuse for people with a mental illness

This chapter provides a summary of the findings of Study one and Study two in relation to each of these key areas of the thesis, following the Australian Policy Cycle as the policy framework utilised for the study, with a particular focus on the steps of 'agenda setting' and 'implementation'.

Mental health services and policy in Australia and Victoria have undergone major changes since 'mental health care' was first conceptualised post-white-settlement. The beginning of such 'care' saw those with mental illness locked up alongside 'criminals'; they were then moved out of jails into institutions alongside those with alcohol addiction and people with intellectual disabilities. The next change saw those with mental illness being moved into large institutions, which was eventually seen as another form of incarceration—with no real opportunities to rejoin society or hope for recovery—and as an infringement of human rights, as people were still locked away from society. The most recent development in mental health care saw the closure of large institutions and the (re) integration of patients into society, with mental health care being provided within the community and in more recent times the inclusion of a focus on recovery. Recovery, as discussed earlier, provides a way of working with people with mental illness that encourages and supports them in 'making sense' of mental illness and (re) learning how to live a better life, notwithstanding the impact of mental illness on everyday life. However recovery constitutes a focus that provides hope, possibilities and encouragement to move beyond 'diagnosis' or 'becoming' the mental illness. Recovery is part of the mental health systems move, at least theoretically, from a purely medical model that favours a biological approach to conceptualising mental illness to the exclusion of other models of mental health care. The medical approach to mental illness, with its origins in biological reasoning for

mental illness, its origins and therefore treatment options has been challenged as early as the 1960s by those who expressed their dissatisfaction with such mental health care (anti-psychiatry movement). Recovery has become more and more the focus of current mental health care and policy; hence moving away from a view that those with mental illness will never be able to live a more integrated life within mainstream society.

Mirroring international developments, a greater focus on consumer rights and human rights of mental health service recipients has evolved and been strongly advocated by mental health professionals, policy makers, people with mental illness and their families. Abuse of human rights within the large institutions was (eventually) documented, if not necessarily acted upon: with the latest development within mental health care (the move into the community) the locus of such duty of care has shifted and become less clear. While those responsible for people with a mental illness in institutions did not necessarily protect them from abuse, it *was* clearly their duty of care to do so and to provide (at least theoretically) adequate support if such abuse occurred. In the late 20th and early 21st century only a few 'institution-type facilities' remain, with fewer longer-term wards, residential facilities and psychiatric inpatient units. It is less clearly defined where duty of care begins and where it ends, especially in relation to (preventing) abuse of those with mental illness or remediating previous abuse experiences. Human rights of people with mental illness is a contested area and much debate still needs to be had in order to clearly define what 'human rights' for people with mental illness really means. The right to choose treatment is clearly taken away from people when they become involuntary patients of a system that claims to support and protect them from (human rights) abuse from others. It is beyond the scope of this thesis to provide a more in-depth discussion of these issues, however it is necessary to point out that there is a lack of clarity at times as to whose rights policy and indeed the Mental Health Act is protecting: that of the person with mental illness (to be protected from— for example—abuse) or that of society (to be protected from those with mental illness). One area of human rights seems to gain more clarity, that of the need and right to feel safe within psychiatric wards and residential settings; it is unlikely that anybody would dispute that those with mental illness accessing such facilities ought to feel safe within these environments.

As has previously been argued in this thesis, the high incidence of childhood (sexual) abuse as well as abuse experienced during adulthood clearly points towards a need for mental health care providers to be both cognisant of such facts as well as proactive. Revictimisation rates of those with childhood abuse experiences are high and even higher for those with mental illness. Frequently revictimisation occurs within

psychiatric inpatient units or residential settings. Research studies provide ample evidence about the rate of abuse histories for women with mental illness being between 50 and 80%. The rate for men is as high as 40% for child sexual abuse. Most people, who have been abused, have had more than one such experience. It has equally been established that those with abuse histories make contact with mental health services earlier, more frequently and utilise crisis services of mental health care to a greater degree than those without abuse histories. It has furthermore been established that, unless asked, consumers tend not to spontaneously disclose abuse histories and that an integration of such an inquiry into routine assessment processes, when done in a skilled and sensitive way, provides an opportunity to assist in a number of ways. Inquiry about previous or current abuse provides opportunities for heightened awareness about increased likelihood of vulnerability and an increased need for addressing safety issues (especially for inpatient and residential settings); bringing to light links between abuse and mental illness as part of mental health care; and providing holistic mental health care, following a model of prevention and early intervention as part of a population health approach if not indeed providing 'trauma informed' mental health care.

At the same time, addressing violence and abuse in the era of deinstitutionalisation can be complex, requiring those providing care to be alert, skilled and able to provide such care in the least restrictive and most supportive way possible, maintaining a sensitive balance between human rights and the request for freedom from abuse, and people's self-determination. Those involved in mental health care may need to address difficult questions such as "does holding down a person to inject them with medication" constitute human rights abuse? If the person has a history of being abused by an intimate partner and has been subjected to physical violence, do these factors need consideration when undertaking to 'hold someone down' to inject them? If those admitted to psychiatric inpatient units have a right to feel free from being subjected to violence and (sexual) abuse from others, do they have a right to ask to be relocated if they do not feel safe (enough)? These are difficult questions and practice issues, which are not likely to be addressed in a philosophical way or through discussion within busy inpatient units among those providing mental health care. Staff of mental health services may find themselves weighing up risk versus protection, as well as freedom versus infringement of such freedom, when aiming to address abuse or aiming to provide the least possible restrictive environments balanced with a need for protection, as suggested above.

In the era of community-based mental health services, taking those complexities into account, it could be expected that governments provide clear guidance on the

prevention of (further) abuse of those with mental illness in order to provide a systemic, systematic and coordinated response to (for example) the above discussed dilemmas and protecting those who are often referred to as 'the most vulnerable people in society. Internationally much work has been undertaken to remediate and prevent abuse of those with mental illness (as discussed in the literature review); compared with those international developments, less work has occurred in Australian states with the exception of NSW.

Study one found that major differences exist between the states of NSW and Victoria: while abuse is addressed in mental health policy in NSW, Victoria lacks such focus on systematic strategies to prevent and reduce the impact of abuse. NSW's policies are accompanied by implementation strategies and resources for such implementation. Data collection for routine screening of domestic violence provides information on screening levels across the state of NSW over the course of several years. In contrast Victoria does not only lack specific policies in this area, but the only relevant policy document—an outdated Women's Mental Health Policy—has been left untouched through a lack of an implementation strategy and resource allocation since 1999. Mental health policy in Victoria has addressed abuse issues in an inconsistent and less specific way than NSW: while the issues do somewhat feature in Victorian mental health policy documents, they are characterised by lack of guidance, resources and implementation strategies. The policy guidance that does exist, solely relates to women with mental illness and how to respond sensitively to an experience of sexual abuse (without any information how to do this or what 'sensitively' means); with few exceptions, family violence issues are not addressed and neither are issues of (sexual) abuse of men with mental illness and how to assist them. While Victorian policy appears to have drawn on available research and some of the policy documents recognise issues such as causal links, high prevalence rates, revictimisation, and safety issues for inpatient units, they lack real guidance for mental health services.

In comparison, policy in NSW is quite specific in the way it directs mental health services to screen for domestic violence; and to provide safety within psychiatric inpatient units, while acknowledging the high prevalence rate of sexual abuse. The NSW state government provides support and resources for implementation—which includes development of strategies delivered by government (ECAV). Victoria not only lacks such a workforce development strategy, there is no government department that is responsible for such workforce development. These differences between NSW and Victoria are also alluded to by key stakeholder interviews (Study

two), who talk about the lack of policies in Victoria and the development and implementation of policies in NSW.

This next section provides a discussion of findings relevant to agenda setting in both NSW and Victoria.

Agenda setting

As stated earlier, the step of 'agenda' setting (identifying an issue) was of particular interest to this research study, considering that an issue has to make it onto the agenda if policy was to be developed, this is a vital step in policy formation, even if other steps in the cycle are left out (such as consultation or implementation strategies). Agenda setting, the first step in the Australian Policy Cycle (Bridgman & Davis, 2004) enables a closer look at which issues make the agenda and what the contributing factors (enablers/drivers) for this to occur are. This step also provides a way of looking at the reasons why some issues fail to make the agenda, inclusive of barriers to agenda setting.

Agenda setting in NSW

Agenda setting in this area of policy in NSW is characterised by a number of drivers (enablers): clear 'issue clarification', the identification of the need for a universal response, leadership, external and internal drivers, and the identification of solutions with the possibility of implementing those solutions with minimal extra resources.

A number of 'enablers' (drivers) assisted in setting the agenda in this area in NSW. One such driver is the existence of a previous policy on domestic violence which could be built upon (New South Wales Health Department, 1993). The fact that those with such experiences present at any type of service, and the consequent need to provide a 'universal', consistent and systematic approach is another enabler according to key informants in NSW. Leadership provided by bureaucrats and key individuals and in general by the NSW State Government's Department of Health are drivers for both documents (New South Wales Health, 2004). The prospect that a state government department, the Education Centre Against Violence (ECAV), was to provide ongoing education, training and support towards implementation of both initiatives with a guarantee that the associated implementation strategy was to be undertaken at minimal additional cost is seen as a clear driver towards getting the issues onto the policy agenda. At the same time local Women's Health Units also have a mandate to implement the domestic violence policy, hence assisting ECAV with local implementation.

‘Issue identification’ is part of agenda setting: once an issue is clearly identified it has—at least theoretically—more chance to ‘make’ the agenda. The NSW study by Davidson (Davidson, 1997) clearly identified an issue—abuse of women within psychiatric services—as one worthy of making the agenda. This study identified a ‘duty of care’ issue and highlighted state government’s responsibility to protect those in its care. This study was a catalyst for the development of the policy on sexual safety for NSW mental health services. The study raised the issue of safety or lack of safety for women in psychiatric inpatient units—which correlates with the seminal work on the human rights of people with mental illness by the Human Rights and Equal Opportunity Commission (1993c). The inquiry documented abuse of women within psychiatric settings and recommended that these issues needed to be addressed.

External developments, such as work undertaken by WHO (1997, 2002a) and VicHealh (VicHealth, 2004) have also been utilised by those providing leadership in NSW as ‘drivers’ towards the development of policy in NSW. The research study by Davidson also constitutes such an external driver. The identification of an issue (problem) was combined with suggestions towards a solution as well as the possibility of how the solution can be provided at minimal extra cost; these are clearly drivers towards policy development. Bridgman and Davis (Bridgman & Davis, 2004) suggest that external drivers impact on policy formation, including legal shifts—in the case of NSW the changes to child protection legislation—as well as international developments. Concurrently, those writing on policy development also suggest that if an issue is presented alongside with a solution (we show you how you can solve this issue), then it is more likely to be taken up by those with the power to say ‘yes’ or ‘no’ to an issue being addressed through policy. Additionally, In the case of NSW external drivers also include national and state initiatives which have been utilised by leaders within and outside bureaucracy to identify an issue and propose options for solutions.

The availability or lack of resources also influence which issues make the policy agenda. On the one hand those involved in developing the domestic violence policy quite clearly state that no additional resources were available and therefore a solution was developed that would not need (much) extra funding—routine screening. While resources were obtained from federal government to undertake the pilot on routine screening, there were no costs to the NSW government. The evaluation results contributed towards the inclusion of routine screening in the policy (Irwin & Waugh, 2001). Bridgman and Davis, as well as other writers on policy, state that an issue is more likely to make it onto the agenda, if minimal or no costs or resources are involved in implementing the policy.

Davidson's study on women's experiences of abuse experienced within psychiatric settings not only showed an issue of great concern, it provided the opportunity for those outside government to bring it to the attention of government and alert government officials to a potentially politically volatile situation. Bridgman and Davis suggest that "pressure groups try to attract attention for some serious problem, but often must wait until a dramatic event and media coverage carries it on to the policy agenda" (2004, p. 41). While the media was not involved in this process, the results of the study could have easily come to the attention of the media. The pressure group—in this case, the NSW Women and Mental Health Network—did not focus on a specific event, rather they presented several events that had already occurred but had not been made public prior to the publication of the study.

Government is more likely to take up an issue as part of its policy agenda, if a solution goes hand in hand with problem identification, as "policy makers prefer issues that offer plausible solutions. Some intractable problems cannot be avoided, but it is easier to sell a topic … where resolution seems possible. Few politicians are drawn to issues promising certain failure" (Bridgman & Davis, 2004, p. 41). The NSW research did not only identify a problem but included recommendations providing solutions at minimal cost. The existence of a government body (ECAV) that provides expertise, local support and training as part of the implementation process is a comprehensive package towards contributing to provision of a solution at minimal cost.

Internal drivers—those within NSW Health—include key staff who worked with external pressure groups to get sexual safety onto the agenda. Some of those staff also had a good understanding of the issues of sexual abuse prior to becoming bureaucrats. Their leadership and expertise includes an ability to 'push' the issue up the policy line, to educate those in power to understand the issues involved, and an ability to work with external (pressure) groups.

The move towards directing mental health services to play an active role in the provision of care that takes abuse experiences into account when providing care to people with mental illness constitutes a shift away from a purely 'biological' model of care. In this way, NSW government points out that there is a need, not only for protection of those with mental illness, but also that issues of abuse play a role in people's mental health and that it is indeed the responsibility of mental health services to address these. This constitutes a step towards a more integrated system of mental health care, one which makes a concerted effort to focus on the 'psycho-social' part of 'bio-psycho-social' mental health care.

Lack of agenda setting in Victoria

Lack of policy direction on the issue of abuse in Victoria is connected to a lack of drivers as well as barriers that impede policy development. Barriers include a lack of 'high level' authorisation within state government; lack of leadership within as well as outside government; lack of direction from the Commonwealth, as well as a lack of lobbying from external pressure groups such as the sexual assault sector or concerned key stakeholder groups. These have all contributed towards a lack of agenda setting. The dominance of a biological focus of mental health care (versus mental health care that provides a more balanced 'bio-psycho-social' approach) which excludes issues of a 'social' nature such as abuse, is a barrier that has not been tackled in this area of policy work in Victoria. The marginalisation of abuse, often perceived as a 'women's issue', and connected to this sentiment the (potential) marginalisation of those who work in this area, are seen yet as other stumbling blocks. Lack of cross-departmental coordination or initiatives within state government are further barriers which have contributed towards a lack of direction in this area.

A number of barriers that are responsible for the dearth of policy development in Victoria in this area can be linked to the Australian Policy Cycle and its steps in policy development (Bridgman & Davis, 2004). A clearly identified issue, leadership and 'high level authorisation' are clearly needed when aiming to influence the policy agenda (Colebatch, 2006). Victoria lacks all of these elements, there is no clearly defined issue that has been brought to the attention of policy makers, the state lacks leadership in the area of abuse and mental illness (within and beyond government) and there is no 'high level' authorisation to work on these issues.

This comparison between NSW and Victoria is characterised by the existence of drivers and clarity of issue identification in NSW versus a lack of these in Victoria. Research studies undertaken in these states have had different impact on policy development: Parsons refers to the need to make "a link … between the trigger and a grievance or problem which then transforms the issue into an agenda item" (Parsons, 1995, p. 128). Purely identifying a problem may not be enough, as was the case in Victoria. The study undertaken in NSW clearly connects policy makers with a (potential) grievance, that of mental health services being unsafe for their clients—as well as the issue of human rights (protecting them from abuse) for those accessing mental health services—and points to the responsibility of those providing such services to ensure a safe environment. Colebatch suggests that policy development "is not simply an aggregation of the decisions of ministers of health, but encompasses beliefs about health …" (Colebatch, 2004, p. 113); the recognition that

violence is indeed a health and *mental health issue* (at least on a state government level) constitutes a driver towards policy development in this area. In contrast to those developments, lack of such recognition by state government has contributed towards the dearth of policy in Victoria in this area. As discussed earlier this marked difference between NSW and Victoria seems to be one way of expressing a move towards a less 'medical' (biologically focussed) model of mental health care in NSW as opposed to one that relies predominately on a biological explanation and treatment of mental illness as is the case in Victoria.

In summary, agenda setting in NSW was supported by a number of drivers, including some such as lack of resource allocation that potentially could have been barriers; which were, through good leadership, turned into advantages (developing a universal response). Strong leadership that utilises external developments to argue for the need for policy development is another factor that has contributed towards policy development. In contrast, Victoria lacks leadership in this area; barriers which were worked with and indeed (even if only partly) overcome in NSW remain hindrances in Victoria today. Victoria lacks clarity about the actual issue(s), therefore no clear strategies to address those (ill-identified) issues can be provided and there is no specific body such as ECAV or the Women's Health Units, which could take on the implementation (hence additional resources would be needed).

Implementation

In NSW the policies discussed in this study have been implemented and maintained over a number of years; in contrast Victoria had a one-year implementation strategy for its women's mental health policy during 1998.

The implementation strategies of both NSW policies have been enabled, coordinated and delivered by ECAV on a statewide basis. For the implementation of routine screening Women's Health Centres provide additional local implementation strategies and training. The fact that 'screening for domestic violence' has become mandatory for health and mental health services, and its adoption as part of core business of service provision has aided implementation. Short-term implementation is not enough in itself, there is a need to go to the next step of maintenance. This process is supported by the continuation of training provided by ECAV and by the data collection requested by NSW Health. While both training and data collection can assist implementation and monitoring, leadership within organisations has also been essential in order to implement and maintain the policies.

While implementation of policies in NSW may not be consistent across the state, the implementation phases for both policies have formed part of policy development. The implementation of the policy on sexual safety for psychiatric inpatient units consists of multiple layers: the instruction by NSW state government for mental health services to develop local policy; for these to undertake this and other work via local implementation committees; and the development and delivery of training. Implementation has been facilitated through the existence of ECAV (with minimal extra resources); in turn, the existence and work by ECAV has contributed to the continuing implementation (and maintenance) of the policy across the state of NSW.

The knowledge that no or only minimal extra resources would be available for the implementation of policies also meant that policy needed to be developed which asked people to 'do things differently' rather than do something completely new or additional to current practice: this is the case for both NSW policies. This cultural change within mental health service provision constitutes a move away from an overly biological model of care towards a more integrated model that takes social dimensions of people's lives increasingly into account. While it may be still a long way from providing 'trauma-informed' care, those mental health professionals willing to engage in change processes in order to address issues of abuse within mental health care can rely on policies which can assist organisations and the people within them to take a closer step towards such care. Mental health care that takes other issues into account and aims to address them within its model of care, cannot but contribute towards recovery for people with mental illness, if recovery is seen as a process of integrating experiences (mental illness and others) into one's life in order to live a more satisfying life, being able to manage the manifestation of mental illness but not being ruled by it.

While those in NSW who work on a statewide level are able to recognise positive changes over the years, such as an increase in uptake of training and screening, those working on local implementation through Women's Health Units point out that the uptake is not consistent, and that resources need to be provided for maintenance (rather than just implementation). While informants are nearly unanimous that sexual assault/sexual safety and domestic/family violence receive heightened attention in mental health services, it is also clear that there is still much work to be done to adequately support consumers who have had those experiences. It has furthermore not been possible to establish how the policies under discussion here have impacted on individual consumers accessing mental health services.

In contrast to developments in NSW, Victoria had a short-term implementation strategy for its women's mental health policy. The employment of women's mental health consultants for one year[20] only has meant that implementation of the policy and its subsection on abuse has been left to individual mental health services. While the policy includes recommendations towards implementation, in reality lack of assistance by the Department of Human Services has meant a lack of implementation and no coordination across Victoria. More than ten years after the development of the women's mental health policy it is impossible to obtain information about the level of implementation during the first year of the policy (or beyond). If the ideology of recovery is followed and life-events play an integral part to people's recovery as is suggested in the literature and approach to recovery, then it is vital that underlying (or contributing) issues and factors to the development of mental illness such as abuse are brought to light, connections are made and solutions for integration are provided to those accessing mental health services. Clearly 'recovery from' mental illness cannot exclude aspects that have contributed to the development of such illness, or the process addresses only part of the whole picture.

Key informants in Victoria identify a lack of leadership as one of the reasons why there has been little work done in this area, as well as this constituting one of the barriers that need to be overcome if a stronger focus on issues of abuse were to occur in Victoria. Colebatch suggests that "giving directions is one of the ways in which people demonstrate leadership" (Colebatch, 2002, p. 114). Lack of direction is noticeable through the lack of an implementation strategy beyond the initial twelve months.

Even though a statewide approach to implementation is lacking, it would still be possible for individual mental health services to take up the issue of abuse within their policy and service development activities. A number of barriers are identified by key informants as to why this has not occurred in Victoria. They include the above-mentioned lack of leadership; as well as the biological focus of mental health care, which does not recognise the link between abuse and mental illness (as has been established by research studies). Furthermore no resources have been provided in Victoria for implementation strategies.

Lack of attention to implementation of the policy—combined with a lack of resource provision to implement and/or maintain Victoria's women's mental health policy—is not specific to this area of policy or to mental health; rather it is the legacy of the political climate and changes of the 1990s. During this time the Victorian state

[20] With the exception of three women's mental health consultants who continue to be employed part-time in three different Area Mental Health Services in Victoria.

government adopted a ‘funder-provider’ split, which separates state government from provision of services or being linked to service provision. This ‘funder-provider’ split (and with it a move to a contractual model which is focused on output) does not so much focus on quality of health or mental health care as much as the number of people seen or the episodes of care provided and not necessarily *how* care is provided (Alford & O'Neill, 1994). While the women’s mental health policy (Victorian Government Department of Human Services, 1997) includes suggestions about what and how to implement the policy, it is in some way naïve or perhaps deliberate in some of its suggestions—which are unrealistic without further service development, resources and a statewide approach to implementation. In contrast to the Victorian contractual model, NSW did not undergo such dramatic changes. The extensive consultation process during the development (review) of the domestic violence policy, as discussed by informants, demonstrated the NSW Government’s approach to inclusive consultation, with its attempt to integrate various views and its aim of ownership by those who had been part of the process. Boxelaar et al suggest that the Australian “public policy process … is changing towards a more interactive, collaborative model, where governments seek to develop partnerships with civil society and private sector organizations to manage complex policy changes” (Boxelaar, Paine, & Beilin, 2006, p. 113). It appears that NSW has at least partially adopted this model.

While it is difficult to measure the level of implementation of the policies in NSW and some key informants suggested that implementation is inconsistent and could be done more thoroughly, Study two provides evidence that the statewide coordinated approach has gone some way towards a comprehensive implementation strategy, even if there are regional differences. The availability of statewide and local units that assist in implementation and even in maintenance of the policies has meant that a large number of mental health services have (to various degrees) adopted both domestic violence and sexual abuse/safety as core issues with the aid of local implementation strategies and workforce (culture) change. This move towards treating abuse as ‘core’ issue cannot be underestimated; as has been stated previously this move constitutes a movement towards broader integration and focus on aspects of people’s lives which go beyond biological factors determining their mental health. By contrast in Victoria lack of a coordinated implementation beyond the first year of the women’s mental health policy, combined with a lack of resource allocation and/or availability of training bodies, has meant that implementation has been ad hoc and undertaken on a local and individual service level (if at all) rather than on a statewide and coordinated level.

In summary, the existence (in the case of NSW) and the lack of policy (in Victoria) have implications on a number of levels. An evaluation consisting of feedback by those accessing mental health services, and the opinions and experiences of those providing care and treatment, would provide thorough evidence about the successes, failures or lack of policy implementation in NSW and Victoria. However it is possible (at least theoretically) to draw some conclusions about the impact of the different situations in the two states. While the NSW state government has clearly moved the issue of abuse to centre stage and therefore has made 'working with', 'responding to abuse' and 'providing sexual safety' a core issue for mental health services, no such move has occurred in Victoria. While differences in the level of policy implementation have been pointed out by key stakeholders in NSW, the fact that state government sets policy direction on these issues provides those working within mental health services with a mandate and some degree of power to demand that clinical practice should include good (best) practice when responding to those with abuse histories—and should indeed increase their safety. In Victoria, in comparison, those aiming at influencing clinical practice in this area rely on internal drivers (managers and interested individuals) to influence clinical practice, without being able to draw on state government direction or even acknowledgement of the fact that abuse constitutes a core issue and should be addressed within clinical mental health practice. These differences in policy are likely to influence practice; it is furthermore highly likely that this lack of policy direction in Victoria leads to a high degree of inconsistency in work practice in relation to 'responding to' and 'supporting' those with mental illness who have histories of abuse.

It is likely that those with a diagnosed mental illness who access public mental health services in NSW and those who access services in Victoria receive quite different treatment and services in response to histories of abuse, corresponding to state government policy or lack of it. In Victoria the high level of inconsistency is likely to provide those accessing mental health services with an inconsistent response to their abuse histories. They are likely to be confronted by a service system that has a greater focus on the biological aspect of mental illness; and they are likely to be confronted with a service system that ignores the impact of abuse on mental health (illness) and is hence out of step with mental health care that has a 'bio-psycho-social' approach to care.

The differences between the two states also reflect variation in the uptake of a move towards a 'rights-based approach' to mental health care. While key informants did not explicitly talk about the work that has occurred in NSW as informed by a human rights framework, it is highly likely that the focus on human rights was influential. The

approach NSW has taken indeed mirrors a human rights approach to mental health care, which also takes abuse, prevention of abuse and the amelioration of the impact of such abuse into the core business of mental health care. It was as early as 1991 that the human rights of those with mental illness were given international attention by the publication of the United Nations' 'Principles for the protection of persons with mental illness' (United Nations, 1991), which was closely followed by the 'National Inquiry into the Rights of People with Mental Illness' (HEROC, 1993c) in Australia. These publications provide an overall framework of principles and recommendations when addressing issues of abuse (HEROC, 1993c).

Limitations of the study

This study has several limitations. Firstly the interviews with key informants capture a relatively small number of twenty-one individuals, when a larger cohort of key informants could enable issues pertaining to the development, implementation, maintenance and evaluation of relevant policies to be explored more broadly. The study could have involved multiple states, rather than just a comparison between Victoria and NSW; it could have included a comparison with other models of policy implementation, namely that of Queensland and Western Australia. Interviews with clinical directors and managers of mental health services, and their perceptions and experiences of the implementation of those policies discussed (or the need for such policy, as may be the case in Victoria) would have provided an 'on the ground' impression of the impact of policy on mental health services. Equally, interviews with clients/consumers of mental health services would provide another view of policy and its implementation, and obtaining information about the level and quality of service provision to those who have experienced abuse would contribute towards understanding whether policy and its implementation has actually made a difference (for example in NSW). The data gathering method for the second study constitutes a qualitative approach and interviews were undertaken, which has limitations in scope. A mixed method of interviews and surveys would provide greater volume of information and cover other areas which time-limited interviews cannot address.

Implications for future studies

Abuse and violence are serious issues within the general community and within mental health care. Internationally this seriousness has been acknowledged through work that moves abuse into the centre of mental health service provision, acknowledging the (long-term) impact on health and development of mental illness and the need to look further than biology to explain and respond to mental illness. Worldwide a range of interventions have occurred, including policy, guidelines,

training, separation of women and men in psychiatric inpatient units, routine screening for histories of abuse and ascertaining levels of vulnerability.

Future studies could research the actual impact of routine screening such as that undertaken in NSW, including asking questions of consumers about their experience of this intervention. Those 'delivering the policy' (for example routine screening) could be asked about the reach and scope of policy implementation and factors assisting or hindering it. A study of managers of mental health services that compares NSW and Victoria could explore issues of policy direction provided by state government (NSW) and how a lack of such guidance (in Victoria) impacts on work in this area. Some advocate for trauma-specific mental health services, which provide holistic treatment, cognisant of the impact of such trauma. Future studies could look at the differences between such services and mainstream mental health services and aim to ascertain if it is possible to integrate trauma-informed practice into current mental health services, and the changes that would need to occur to undertake such work.

Conclusion

Family violence and sexual abuse are significant issues within society in Australia and internationally and are more prevalent and of even greater significance for those with mental illness. Research provides evidence that abuse is linked with a number of short and long-term health and mental health impacts; abuse constitutes a causal or contributing factor for the development of mental illness. Abuse has been linked to depression, anxiety, an increase in suicidality, bipolar disorder, eating disorders, borderline personality disorder, post traumatic stress disorder, and psychosis. Research also provides evidence about the correlation between the severity and frequency of abuse with the severity and chronicity of adverse mental health outcomes. While in the general population an experience of abuse during childhood increases the likelihood for revictimisation in adulthood, the increase of such likelihood is even higher for those with mental illness. The burden of disease created by abuse is significant for the individual and for society in general, with the health (including mental health) impact being the greatest financial burden (of all financial burdens) for the individual and society; this is even higher for the population of those with mental illness.

Those with a history of abuse and a diagnosed mental illness come into contact with mental health services earlier and access emergency services more frequently than those without such history and a diagnosed of mental illness. It has been established that consumers of mental health services tend not to spontaneously disclose their

abuse histories unless they are asked; and mental health clinicians tend not to ask about abuse unless they are guided to do so.

The need for policy, organisational and workforce development strategies to address abuse issues within mental health services has equally been established; as has the need for a coordinated approach to policy, its implementation and associated workforce development. It has been stated elsewhere, that it is not enough to develop policy documents, which end up on bookshelves without having any impact on service provision; implementation processes need to form part of policy development, unless policy becomes a political vehicle which has no real 'teeth.

The implications of the findings of this study for mental health services in Victoria are significant. Study one and Study two provide evidence about the lack of policy guidance in this area of work in Victoria, which leaves it mostly up to individual mental health services to find their own ways of working with issues of abuse—if they do so at all. This lack of policy guidance and lack of expectation of cultural change cannot but contribute to an inconsistency in professional responses to those consumers that access mental health services and have histories of abuse (if indeed mental health clinicians ask them about abuse or respond to reported abuse). This lack of policy direction on abuse and violence in relation to mental illness by the Victorian State Government contributes towards an inconsistency of service provision not only between services but also within services, leaving it up to chance if a consumer will be seen by a staff member who has a good understanding of issues of abuse and the capacity for a therapeutic response, or who has little or no understanding and/or skills in this area of clinical work. Concurrently the lack of policy direction does not fit with the promotion of the 'recovery' model that mental health services apply across the state of Victoria; if a substantial part of people's life does not get addressed as part of treatment and care, it is questionable how well someone can recovery and how much mental health services are indeed able to assist those with such experiences towards their recovery.

Victoria only partially follows international developments in policy to address abuse and mental illness within mental health care; neither has the state worked towards preventing such abuse from occurring for those with mental illness and/or within mental health services. This lack of direction setting, including a lack of provision of resources towards policy implementation, stands in contrast to other recent Victorian developments, such as the Victorian Dual Diagnosis Strategy (Victorian Government Department of Human Services, 2007a) and the Victorian FaPMI[21] Strategy

[21] Families where a Parent has a Mental Illness

(Victorian Government Department of Human Services, 2007b), which include implementation strategies, resources and feedback mechanisms, though lacking evaluation processes.

A comprehensive state government direction on abuse and mental health service provision would provide a policy and an implementation strategy which would include (for example) a five-year implementation plan; it would also promote the concept that abuse is indeed core business for mental health services and therefore needs to be addressed on all levels. This would constitute a shift away from a biological focus of mental health care and the integration of the 'psycho-social' into the 'bio-psycho-social' mental health care that has been promoted (at least theoretically) for some time. Policy should include a mandate for a routine inquiry about past and current abuse (both family violence and sexual abuse) and strategies to address abuse issues. The implementation strategy would include a workforce development strategy, which could be carried out through an injection of funds to current training providers associated with mental health services, such as the Mental Health Training Clusters or The Bouverie Centre. Implementation strategies would include an evaluation of the policy, providing data for future review and adaptation of the policy. A statewide policy combined with an implementation strategy is likely to attract the interest of researchers, as has recently occurred with the Victorian FaPMI Strategy.

It seems timely that Victoria step up to the challenge of recognising and indeed addressing the major issue of abuse in the lives of those with mental illness, just as other states, countries and sectors have done, and to then respond through the constructive policy process described above.

Appendices

Appendix A: Consent form and participant information sheet

CONSENT FORM

Project Title: ABUSE ISSUES AND MENTAL HEALTH POLICY – A (DIS) CONNECTION?

Senior Investigator: PROF HAL SWERISSEN
A/Dean
FACULTY OF HEALTH SCIENCES
LA TROBE UNIVERSITY

Researcher: ANGELINA SABIN FERNBACHER
PROFESSIONAL DOCTORATE STUDENT
FACULTY OF HEALTH SCIENCES
LA TROBE UNIVERSITY

This research project aims to understand the breadth of inclusion (or exclusion) of abuse issues (family violence and sexual abuse) within mental health policy as expressed through state government direction setting for mental health services. The project is particularly interested in the different degree of policy direction and implementation between NSW and Victoria and the contributing factors to this difference.

The results of this research will be made available through conference presentations and journal articles.

The results of this project will appear in a thesis to be written by Ms Sabin Fernbacher, in journal publications and in presentations at conferences, it will not be possible to identify you through any of these publications.

Any questions regarding this project titled 'Abuse Issues and Mental Health Policy – A (Dis) Connection?' may be directed to the senior Investigator, Prof Hal Swerissen, A/Dean Faculty of Health Sciences, La Trobe University on the telephone number (03) 9479-1743.

You have the right to withdraw from active participation in this project at anytime and further, to demand that data arising from your participation are not used in the research project provided that this right is exercised within four weeks of completion of your participation in the project. You are asked to complete the "Withdrawal of Consent Form" or to notify the investigator by e-mail or telephone that you wish to withdraw your consent for your data to be used in this research project.

I …… have read and understood the information above, and any questions I have asked have been answered to my satisfaction. I agree to participate in this project, realising that I may withdraw at any time. I agree that research data collected during the project may be included in a thesis, presented at conferences and published in journals, on condition that my name is not used.

NAME OF PARTICIPANT (in block letters):
……

Signature: …… Date: ……

NAME OF SENIOR INVESTIGATOR (in block letters): PROF HAL SWERISSEN

Signature: …… Date ……

NAME OF RESEARCHER (in block letters): A. Sabin FERNBACHER

Signature: …… Date ……

Participant Information Sheet

RE: ABUSE ISSUES AND MENTAL HEALTH POLICY – A (DIS) CONNECTION?

This research project aims to understand the breadth of inclusion (or exclusion) of abuse issues (family violence and sexual abuse) within mental health policy as expressed through state government direction setting for mental health services. The project is particularly interested in the different degree of policy direction and implementation between NSW and Victoria and the contributing factors to this difference.

This research is being conducted as part of the requirements for Ms Sabin Fernbacher Professional Doctorate Thesis in Public Health; Prof Hal Swerissen, A/Dean Faculty Health Sciences is supervising the project.

If you agree to participate in this project, you will be asked to participate in an individual, semi structured interview at a venue convenient to you (such as your workplace). In some circumstances interviews can be arranged to be held over the phone. Interviews will take no longer than 60 minutes. Questions will cover queries about the Australian policy cycle and how issues of abuse have or have not made it onto the policy agenda. You will be asked about your professional opinion and to reflect on circumstances that may have supported or hindered the development and implementation of such policies.

Current or previous employees of state government (NSW and Victoria) and other key informants, who are able to comment on policy development and implementation issues, will be approached to participate in this research project and approximately 24 people will be interviewed. Participation is voluntary and your confidentiality will be maintained; no personal information will be collected about you. Attached you will find a copy of the consent form for the study which has further details. If you have any questions or to indicate your willingness to participate please contact me at your earliest convenience by phone on 0406051739 or email: asfernbacher@studentslatrobe.edu.au

Notes will be taken during the interview and the interview will be taped, the student researcher will consequently take more notes while listening to the tapes. Both sources of data (tapes and hard copies of transcriptions) will be stored at the research student's home in a locked filing cabinet during the course of the study. Upon finalising the study tapes and transcripts will be

stored in a locked filing cabinet at La Trobe University by the supervisor; according to University policy these records will be destroyed after five years.

The results of this research will be made available through the thesis to be written by Ms Sabin Fernbacher, in journal articles and in presentations at conferences; it will not be possible to identify you in any of these reports.

Any questions regarding this project may be directed to the Investigators Prof Hal Swerissen, A/Dean Faculty of Health Sciences, La Trobe University on the telephone number (03) 9479-1743 or Ms Sabin Fernbacher (student) on 0406051739.

If you have any complaints or queries that the investigator has not been able to answer to your satisfaction, you may contact the Secretary, Faculty Human Ethics Committee, Faculty of Health Sciences, La Trobe University, Victoria 3086, ph 9479-3583.

You have the right to withdraw from active participation in this project at anytime and, further, to demand that data arising from your participation are not used in the research project provided that this right is exercised within four weeks of the completion of your participation in the project. You are asked to complete the 'Withdrawal of Consent Form' or to notify the investigator by email or telephone that you wish to withdraw your consent for your data to be used in this research project.

Sincerely,

A. Sabin Fernbacher
(Student Researcher)
asfernbacher@studentslatrobe.edu.au

Prof Hal Swerissen
(Research Supervisor)
hswerissen@latrobe.edu.au

Appendix B: Ethics approval

La Trobe University
Faculty of Health Sciences
MEMORANDUM

TO: Professor Hal Swerissen School of Public Health

SUBJECT: *Reference:* **FHEC07/59**

Student or Other Investigator: A. Sabin Fernbacher

Title: **Abuse Issues and Mental Health Policy - (Dis) Connections**

DATE: 31 May, 2007

The Faculty Human Ethics Committee (FHEC) has considered and approved the above project. You may now proceed.

Please note that Informed Consent forms need to be retained for a minimum of 7 years. Please ensure that each participant retains a copy of the Informed Consent form. Researchers are also required to retain a copy of all Informed Consent forms separately from the data. The data must be retained for a period of 5 years.

Please note that any modification to the project must be submitted in writing to FHEC for approval. You are required to provide an annual report (where applicable) and/or a final report on completion of the project. A copy of the progress/final report can be downloaded from the following website:
www.latrobe.edu.au/rgso/forms-resources/forms/ethic-prog-final.rtf.

Please return the completed form to The Secretary, FHEC, Faculty of Health Sciences Office, La Trobe University, Victoria 3086.

A copy of this memorandum is enclosed for you to forward to the student(s) concerned.

Natalie Humphries

Natalie Humphries
Secretary
Faculty Human Ethics Committee
Faculty of Health Sciences

Appendix C: Schedule of interview questions for NSW and Victoria

1. What is your understanding about the link between abuse and mental illness?
   (How much of a link, are they aware of research data)

2. What do you think has the policy response been in NSW to issues of abuse and mental illness?
   (This can cover things that I am not aware of, acknowledge this to interviewee.)

3. Do you know how the issue of abuse got onto the policy agenda in NSW?

4. Are you aware of any individuals or groups who were influential in the development of a government response?
   Do you know how they influenced government to take up these issues?

5. What were the barriers that had to be overcome for these policies to be developed?

6. What are the issues in regards to implementing these policies?
   (What has worked well, not so well? Has the implementation of the guidelines & policies been effective? How have they come to their conclusion?)

7. Is there anything else you would like to add?

Interview Questions Victoria

1. What is your understanding about the link between abuse and mental illness?
    a. (How much of a link, are they aware of research data)

2. What do you think has the policy response been in Victoria to issues of abuse and mental illness?
    a. (This can cover things that I am not aware of, acknowledge this to interviewee.)

3. (If 'there has been a response') Do you know how the issue of abuse got onto the policy agenda in Victoria?
    a. (What contributed to developing policy?)

4. (If 'little has been developed') What has contributed towards the lack of policy development?

5. (If yes) Are you aware of any individuals or groups who were influential in the development of a government response?
    a. Do you know how they influenced government to take up these issues?

6. What were the barriers that had to be overcome (or would have to be overcome) for these policies to be developed?

7. (If 'there has been a response') What are the issues in regards to implementing these policies?
    a. (What has worked well, not so well? Has the implementation of the guidelines & policies been effective? How have they come to their conclusion?)

8. Is there anything else you would like to add?

Appendix D: Commonwealth Mental Health Policies

Year	Title
1991	Mental Health Statement of Rights and Responsibilities: Report of the Mental Health Consumer Outcomes Task Force
1991(?)	Directions. Vision and New Development in Psychiatric Services
1992	Burdekin Report: Human Rights and Equal Opportunity Commission Report of the National Inquiry into the Human Rights of People with Mental Illness.
1992	National Mental Health Policy: endorsed by all Australian health ministers National Mental Health Plan: first five-year plan Medicare Agreement Act 1992
1996	National Standards for Mental Health Services National Mental Health Report: Third Annual Report, covering 1994–95
1998	Second National Mental Health Plan 1998–2003: Second Five-year plan National Information Priorities & Strategies
1999	Mental Health Promotion and Prevention National Action Plan 1998–2003
1999	The Mental Health of Australians
2000	National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 A population health model for the provision of mental health care Outcomes and indicators, measurement tools and databases for national action plan for promotion, prevention and early intervention for mental health.
2002	National Mental Health Report: covering changes in Australia's mental health services under the first two years of the second National Mental Health Plan 1998–2000
2003	Third National Mental Health Plan 2003–2008
2003	National Practice Standards for the Mental Health Workforce
2005	National Safety Priorities

Appendix E: Victorian Mental Health Policies

Year	Title
1991(?)	Directions: Vision and new developments in psychiatric services.
1992	Strategic Directions for Public Psychiatric Services in Victoria. Continuing Victoria's Reform of Psychiatric Services
1993	Psychiatric Hospital and Community Service Review. The Current Status of the Victorian Psychiatric Service System.
1993	Victoria's Health Reforms: Psychiatric Services. Discussion Paper.
1996	General Adult Community Mental Health Services. Guidelines for Service Provision.
1996	Victoria's Mental Health Service. The Framework for Service Delivery. Better Outcomes Through Area Mental Health Services.
1997	Victoria's Mental Health Service. Tailoring Services to meet the Needs of Women
	The protocol for clinical review for Area Mental Health Services 1997–2003
1998	Victoria's Mental Health Service. The Framework for Service Delivery. Better Outcomes Through Area Mental Health Services.
2002	New Directions for Victoria's Mental Health Services. The Next Five Years.
2002	The protocol for clinical review for Area Mental Health Services 1997–2003
2005	Victoria's Implementation of the National Standards for Mental Health Services
2004	Victorian strategy for safety and quality in public mental health services (2004–2008)
2004	Caring Together. An action plan for carer involvement in Victorian public mental health services.
2005	Victoria—public hospitals and mental health services. Policy and funding guidelines 2005–2006
2005	Victoria's Implementation of the National Standards for Mental Health Services. Progress Report
2005	Review of the 2003–04 Victorian surveys of consumer and carer experience of public mental health services.

Reference list

ABS (1996). *Women's safety Australia*. Canberra: Commonwealth of Australia.

ABS (2003). Information paper: sexual assault information development framework. Canberra: Commonwealth of Australia.

ABS (2004a). *Australian Women's Safety Survey*. Retrieved August, 31, 2005, 2005, from http://www.abs.gov.au/Ausstats/abs@.nsf/0/46ea7c5b824d2940ca256bd0002840df?OpenDocument

ABS (2004b). *Sexual Assault in Australia: a statistical overview*. Canberra: Commonwealth of Australia.

ABS (2005). *Personal safety survey 2005*. Canberra: Commonwealth of Australia.

Access Economics. (2004a). *The cost of domestic violence to the Australian economy: part I*. Canberra: Commonwealth of Australia.

Access Economics. (2004b). *The cost of domestic violence to the Australian economy: part II*. Canberra: Commonwealth of Australia.

Agar, K., & Read, J. (2002). What happens when people disclose sexual or physical abuse to staff at a community mental health centre? *International Journal of Mental Health Nursing, 11*, 70-79.

Agar, K., Read, J., & Bush, J.-M. (2002). Identification of abuse histories in a community mental health centre: The need for policies and training. *Journal of Mental Health, 11*(5), 533-543.

Alford, J., & O'Neill, D. (Eds.). (1994). *The contract state. Public management and the Kennett Government.* Melbourne: Deakin University Press.

American Association of Colleges of Nursing. (1999). *Violence as a public health problem. Position paper*. Retrieved 09/07/05, 2005, from http://www.aacn.nche.edu/Publications/positions/index.htm

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Psychiatric Disorders, vol 3*. Washington, D.C.: American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition.* Washington: American Pschiatric Association.

Amnesty International. (2004). *It's in our hands. Stop violence against women.* London: Amnesty International.

Arata, C. (1999). Repeated sexual victimization and mental disorders in women. *Journal of Child Sexual Abuse, 7*(3), 1.

Astbury, J. (2002). Intimate partner violence finally a 'legitimate' public health issue. *Australian and New Zealand journal of Public Health, 26*(5), 409-411.

Australian Bureau of Statistics. (1996). *Women's safety Australia*. Canberra: Commonwealth of Australia.

Australian Bureau of Statistics. (2003). *Information paper: sexual assault information development framework*. Canberra: Commonwealth of Australia.

Australian Bureau of Statistics. (2004a). *Australian Women's Safety Survey*. Retrieved 31/08/2005, 2005, from http://www.abs.gov.au/Ausstats/abs@.nsf/0/46ea7c5b824d2940ca256bd0002840df?OpenDocument

Australian Bureau of Statistics. (2004b). *Sexual Assault in Australia: a statistical overview*. Canberra: Commonwealth of Australia.

Australian Bureau of Statistics. (2005). *Personal safety survey 2005*. Canberra: Commonwealth of Australia.

Australian Health Ministers. (1991). *Mental health statement of rights and responsibilities*. Canberra: Commonwealth of Australia.

Australian Health Ministers. (1992a). *National Mental Health Plan*. Canberra: Commonwealth of Australia.

Australian Health Ministers. (1992b). *National mental health policy*. Canberra: Commonwealth of Australia.

Australian Health Ministers. (1998). *Second National Mental Health Plan.* Canberra: Mental Health Branch, Commonwealth Department of Health and Family Services.

Australian Health Ministers. (2003). *National Mental Health Plan 2003-2008*. Canberra: Commonwealth of Australia.

Australian Institute of Criminology. (2005). *Crime Facts Info, No 105: Trends in recorded sexual assault*. Retrieved 08/09/2005, 2005, from http://www.aic.gov.au/publications/cfi105.html

Australian Institute of Health and Welfare. (2005). Female SAAP clients and children escaping domestic and family violence 2003-04. AIHW Bulletin No. 30. Canberra: AIHW.

Banyard, V. L., Williams, L. M., & Siegel, J. A. (2002). Retraumatization among adult women sexually abused in childhood: Exploratory analyses in a prospective study. *Journal of Child Sexual Abuse, 11*(3), 19.

Barrett, S., & Fudge, C. (Eds.). (1981). *Policy and action.* London: Methuen.

Bloch, S. & Singh, B. S. (1997). *Understanding troubled minds*. Melbourne, Australia: Melbourne University Press.

Boxelaar, L., Paine, M., & Beilin, R. (2006). Community engagement and public administration: of silos, overlays and technologies of government. *Australian Journal of Public Administration, 65*(1), 113-126.

Bridgman, P., & Davis, G. (2003). What use is a policy cycle? Plenty if the aim is clear. *Australian Journal of Public Administration, 62*(2), 65-70.

Bridgman, P. & Davis, G. (2004). *The Australian policy handbook* (3rd ed.). Crows Nest, NSW: Allen & Unwin.

Briere, J. (1989). *Therapy for adults molested as children: beyond survival*: Springer Publishing Co.. 1989; 219 p.

Briere, J. (1992). Child Abuse Trauma: Theory and Treatment of Lasting Effects: Sage.

Briere, J. (2001). New Directions for Mental Health Services, Using Trauma Theory to Design Service Systems.

Briere, J. (2002). The Psychological Trauma Clinic at LAC + USC Medical Center. Retrieved 9/05/2005, 2005

Briere, J., & Jordan, C. E. (2004). Violence against women: outcome complexity and implications for assessment and treatment. *Journal of Interpersonal Violence, 19*(11), 1252-1276.

Briere, J., Woo, R., McRae, B., Foltz, J., & Sitzman, R. (1997). Lifetime Victimization History, Demographics, and Clinical Status in Female Psychiatirc Emergency Room Patients. *The Journal of nervous and mental diesease, 185*(2), 95-101.

Briere, J., & Zaidi, L. Y. (1989). Sexual abuse histories and sequalae in female psychiatric emergency room patients. *American Journal of Psychiaty, 146*(12), 1602-1606.

Briere, J. N., & Elliott, D. M. (1994). Immediate and long-term impacts of child sexual abuse. *The Future of Children, 4*(2), 54-69.

Briggs, L., & Joyce, P. R. (1997). What determines post-traumatic stress disorder symptomatology for survivors of childhood sexual abuse? *Child Abuse & Neglect, 21*(6), 575-582.

Butzel, J., Talbot, N., Duberstein, R., Houghtalen, R., Cos, C., & Giles, D. (2000). The relationship between traumatic events and dissociation among women with histories of childhood sexual abuse. *The Journal of nervous and mental diesease, 188*(8), 547-549.

Campbell, J., Sullivan, C. M., & Davidson, W. S. (1995). Women who use domestic violence shelters: changes in depression over time. *Psychology of Women Quarterly, 19*, 237-255.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331.

Campbell, J. C., Kub, J. E., & Rose, L. (1996). Depression in Battered Women. *Journal of the American Medical Women's Association., 51*(3), 106-110.

Cascardi, M., Mueser, K. T., DeGiralomo, J., & Murrin, M. (1996). Physical aggression against psychiatric inpatients by family members and partners. *Psychiatric Services, 47*, 531-533.

Cascardi, M., O'Leary, K. D., & Schlee, K. A. (1999). Co-ocurrence and correlates of posttraumatic stress disorder and major depression in physically abused women. *Journal Of Family Violence, 14*(3), 227-249.

Cavanagh, M.-R., Read, J., & New, B. (2004). Sexual Abuse Inquiry and Response: A New Zealand training programme. *New Zealand Journal of Psychology., 33*(3), 137-144.

Chief Psychiatrist. (2005). Community treatment order guidelines. Melbourne: Mental Health Branch, Government Department of Human Services Victoria.

Christensen, R. C., Hodgkins, C. C., Garces, L. K., Estlund, K. L., Miller, M. D., & Touchton, R. (2005). Homeless, mentally ill and addicted: the need for abuse and trauma services. *Journal of Health Care for the Poor and Underserved, 16*(4), 615-621.

Chung, D., Kennedy, R., O'Brien, B., & Wendt, s. (2000). *Home safe home. The link between domestic and family violence and women's homelessness.* Canberra: Parnterships Against Domestic Violence.

Cobb, R. W., & Elder, C. D. (1972). Participation in American politics. The dynamics of agenda-building. Boston: Allyn and Bacon Inc.

Coker, A., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H., et al. (2002). Physical and mental health effects of intimate partner violence for men and women. *Amercian Journal of Preventive Medicine, 23*(4), 260-268.

Colebatch, H. (Ed.). (2006). Beyond the policy cycle: the policy process in Australia. Sydney: Allen and Unwin.

Colebatch, H. K. (1998). *Policy*. UK: Buckingham: Open University Press.

Colebatch, H. K. (2002). *Policy* (second edition ed.). Berkshire, UK: Open University Press.

Colebatch, H. K. (2004). Review essay interpretive policy analysis. *Australian Journal of Public Administration, 63*(3), 113-121.

Commonwealth Department of Community Services and Health. (1989). National Women's Health Policy. Advancing women's health in Australia. Canberra: Australian Government Publishing Service.

Commonwealth Department of Health and Aged Care. (1999). *Mental health promotion and prevention national action plan*. Canberra: Commonwealth of Australia.

Commonwealth Department of Health and Aged Care. (2000). *Promotion, prevention and early intervention for mental health-a monograph*. Canberra: Commonwealth of Health and Aged Care, Mental Health and Special Programs Branch.

Commonwealth Department of Health and Ageing. (2002). National mental health report 2002: seventh report. Changes in Australia's Mental Health Services und the First Two Years of the Second National Mental Health Plan 1998-2002. Canberra: Commonwealth of Australia.

Commonwealth Mental Health Branch. (2005). Mental illness: the facts. Canberra: Department of Health and Aged Care.

Cox, M. (1995a). The good practices in women's mental health project. In R. Sorger (Ed.), *Research issues in women's mental health* (pp. pp 20-28). Melbourne: Healthsharing women's resource collective.

Cox, M. (1995b). *Good practices in women's mental health.* Melbourne: Healthsharing women's resource collective.

Creedy, D., Nizette, D., & Henderson, K. (1998). A framework for practice with women survivors of childhood sexual abuse. *Austrialian New Zealand Journal of Mental Health Nursing, 7*(2), 67-73.

Cusack, K. J., Frueh, B. C., & Brady, K. T. (2004). Trauma history screening in a community mental health center. *Psychiatric Services, 55*(2), 157-162.

Daniels, K. (2005). Intimate partner violence & depression: a deadly comorbidity. *Journal of Psychosocial Nursing & Mental Health Services, 43*(1), 44.

Danielson, K. K., Moffitt, T. E., Caspi, A., & Silva, P. A. (1998). Comorbidity between abuse of an adult and DSM-III-R mental disorders: evidence from an epidemiological study. *The American Journal of Pschiatry, 155*(1), 131-133.

Davidson, J. (1997). Every boundary broken. Sexual abuse of women patients in psychiatric institutions. Sydney: Women and Mental Health Inc.

Davidson, J. R., Hughes, D. C., George, L. K., & Blazer, D. G. (1996). The association of sexual assault and attempted suicide within the community. *Archives of General Psychiatry, 53*(6), 550-555.

Davidson, L., King, V., Garcia, J., & Marchant, S. (2001). What role can the health services play? In J. e. Taylor-Browne (Ed.), *What works in reducing domestic violence? A compehensive guide for professionals.* (pp. 95-122). London: Whiting & Birch.

Dax, E. C. (1961). Asylum to community. The development of the mental health hygiene service in Victoria, Australia. Melbourne: F. F. Cheshire.

Day, T. (1995). The health-related costs of violence against women in Canada: the tip of the iceberg. London, Ontario, Canada.

Denzin, N. K., & Lincoln, Y. S. (2000). Introduction. The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (Vol. 2nd, pp. 1-28). Thousand Oaks: Sage Publications.

Denzin, N. K., & Lincoln, Y. S. (2005a). Introduction. The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005b). *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, USA: Sage Publications.

Department of Health. (2000). Domestic violence: a resource manual for health care professionals. London: Department of Health.

Department of Health. (2001). Responding to family & domestic violence. A guide for health care professionals in Western Australia. Perth, Australia.

Department of Health. (2008). Briefing 162 Implementing national policy on violence and abuse. London: The NHS Confederation.

Department of Health, M. H., Health & Social Care Standards & Quality Group,. (2003a). *Mainstreaming gender and women's mental health. Implementation guide.* London: Department of Health.

Department of Health, M. H., Health & Social Care Standards & Quality Group,. (2003b). *Women's mental health: into the mainstream. Strategic development of mental health care for women.* London: Department of Health.

Department of Health Western Australia. (1998). Guidelines for developing protocols on intervention and management of family and domestic violence for hospitals in Western Australia. Perth: Government of Western Australia. Department of Health.

Department of Health Western Australia. (1999). Accompanying resource manual for family and domestic violence protocols for hospitals in Western Australia. Perth: Government of Western Australia, Department of Health.

Department of Human Services/Mental Health Branch. (2004). *Mental illness: the facts*. Retrieved 28/04/2005, 2005, from http://www.health.vic.gov.au/mentalhealth/illnesses/facts.htm

Department of Victorian Communities. (2005). *Changing lives: a new approach to family violence in Victoria*. Melbourne: State of Victoria.

Dienemann, J., Boyle, E., Baker, D., Resnick, W., Wiederhorn, N., & Campbell, J. (2000). Intimate partner abuse among women diagnosed with depression. *Issues in Mental Health Nursing, 21*(5), 499-513.

Difede, J., Apfeldorf, W., Cloitre, M., Spielman, L., & Perry, S. (1997). Physical and sexual abuse during childhood and development of psychiatric ilnesses during adulthood. *Journal of Nervous & Mental Disease, 185*(8), 522-524.

Dinwiddie, S., Heath, A., Bucholz, K., Madden, P., Slutske, W., Bierut, L., et al. (2000). Early sexual abuse and lifetime psychopathology: a co-twin control study. *Psychological Medicine, 30*(1), 41-52.

Domestic Violence & Mental Health Policy Initiative. (2002). *Intensive trauma training and implementation program*. Retrieved 11/03/2004, 2004, from Http://www.dvmhpi.org/Trainings.htm

Domestic Violence and Incest Resource Centre. (2001). *Childhood sexual abuse:information for adults who have experienced abuse as a child*. Retrieved 31/08/2005, 2005, from http://www.dvirc.org.au/publications/Incest.htm

Domestic Violence and Incest Resource Centre. (2003). *What is child sexual abuse? Rethinking what we know.* Melbourne.

Easteal, P. (1994). Violence Against Women in the Home: How Far Have We Come? How Far to Go? *Family Matters, 37*(April 1994), 86-93.

Education Centre Against Violence. (2008). *Training for mental health workers.* Retrieved 11/02/2008, 2008, from http://www1.health.nsw.gov.au/ecav/index.asp?pg=11&s=PJ

Ellason, J. W., & Ross, C. A. (1997). Childhood trauma and psychiatric symptoms. *Psychological Reports, 80*(2), 447-450.

Elliott, D. M., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma denied: prinicples and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461-477.

Everett, B., & Gallop, R. (2001). The Link Between Childhood Trauma and Mental Illness. Effective Interventions for Mental Health Professionals. Thousand Oaks: Sage Publications.

Everett, S. (2003). The policy cycle: democratic process or rational paradigm revisited? *Australian Journal of Public Administration, 62*(2), 65-70.

Fallot, R. D., & Harris, M. (2002). The Trauma Recovery and Empowerment Model (TREM): conceptual and practical issues in a group intervention for women. *Community Mental Health Journal, 38*(6), 475-485.

Family Violence Prevention Fund. (2004). National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. San Francisco: The Family Violence Prevention Fund.

Fernbacher, S. (2005). *NAMHS partnership project report.* Melbourne: Northern Area Mental Health Service.

Fernbacher, S. (2006). *NAMHS partnership project report.* Melbourne: Northern Area Mental Health Service.

Fernbacher, S. (2007). *NAMHS partnership project report.* Melbourne: Northern Area Mental Health Service.

Flitcraft, A. (1996). Synergy: Violence Prevention, Intervention, and Women's Health. *Journal of the American Medical Women's Association., 51*(3), 75-76.

Flood, M., & Pease, B. (2006). The factors influencing community attitudes in relation to violence against women: a critical review of the literature. Paper three of the Violence Against Women Community Attitudes Project. Melbourne: VicHealth.

Fontana, A., & Frey, J. H. (2006). The interview: from neutral stance to political involvement. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 696-727). Thousand Oaks, USA: Sage Publications.

Fossey, E. (2001). Psychosocial rehabilitation. In B. Singh & G. Meadows (Eds.), *Mental Health in Australia* (pp. 37-39). South Melbourne: Oxford University Press.

Frueh, B., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., et al. (2005). Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting. *Psychiatric Services Vol 56(9) Sep 2005, 1123-1133*.

Ganley, A. L. (1998). Improving the health care response to domestic violence: a trainer's manual for health care providers. San Francisco: The Family Violence Prevention Fund.

Gearon, J. S., Kaltman, S. I., Brown, C., & Bellack, A. S. (2003). Traumatic life events and PTSD among women with substance use disorders and schizophrenia. *Psychiatric Services, 54*(4), 523-528.

Gerlock, A. (1999). Health impact of domestic violence. *Issues in Mental Health Nursing, 20*(4), 373-385.

Gold, S. N., Lucenko, B. A., Elhai, J. D., Swingle, J. M., & Sellers, A. H. (1999). A comparison of psychological/psychiatric symptomatology of women and men sexually abused as children. *Child Abuse & Neglect, 23*(7), 683-692.

Golding, J. (1999). Intimate partner violence as a risk factor for mental disorder: a meta analysis. *Journal Of Family Violence, 14*(2), 99-132.

Golding, J. (2002). Inscribed Bodies: Health impacts of childhood sexual assault. *Medscape General Medicine, 4*(4).

Goodman, L. A., Johnson, M., Dutton, M. A., & Harris, M. (1997). Prevalence and impact of sexual and physical abuse in women with severe mental illness. In M. Harris & C. L. Landis (Eds.), *Sexual abuse in the lives of women diagnosed with severe mental illness* (Vol. 2, pp. 277-299). Amsterdam: Harwood Academic Publishers.

Goodman, L. A., Rosenberg, S. D., Mueser, K. T., & Drake, R. E. (1997). Physical and sexual assault history in women with serious mental illness: prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin, 23*(4), 685-696.

Goodman, L. A., Salyers, M. P., Mueser, K. T., Rosenberg, S. D., Swartz, M., Essock, S. M., et al. (2001). Recent victimization in women and men with severe mental illness: prevalence and correlates. *Journal of Traumatic Stress, 14*(4), 615-632.

Government Printer. (1963). Mental Health Act 1959; an act to amend the law relating to mental health and for other purposes.

Graham, C. (1994). Certified Truths. Women who have been sexually assaulted-their experience of psychiatric services. Melbourne: South East Centre Against Sexual Assault.

Hague, G. (1998). Inter-Agency work in domestic violence in the UK. *Women's Studies International Forum, 21*(441-9).

Hague, G. (2001). Multi-agency initiatives. In J. e. Taylor-Browne (Ed.), *What works in reducing domestic violence? A comprehensive guide for professionals.* (pp. 275-305). London: Whiting & Birch.

Hall, L. A., Sachs, B., Rayens, M. K., & Lutenbacher, M. (1993). Childhood physical and sexual abuse: their relationship with depressive symptoms in adulthood. *Image: Journal of Nursing Scholarship, 25*(4), 317-323.

Harris, M. (1997). Modifications in service delivery for women diagnosed with severe mental illness who are also survivors of sexua abuse trauma. In M. Harris & C. L. Landis (Eds.), *Sexual abuse in the lives of women diagnosed with serious mental illness* (Vol. 2, pp. 3-20). Amsterdam: Harwood Academic Publisher.

Harvey, C., Meadows, G., & Singh, B. (2001). Mental disorder in Australia. In Graham Meadows & B. Singh (Eds.), *Mental health in Australia. Collaborative community practice*. Melbourne: Oxford University Press.

Hawthorne, D., Mc.Kenzie, A., & Dawson, J. (1996). *Critical Admissions. A study of family violence, physical and sexual abuse in a psychiatric in-patient population.* Melbourne: Psychiatric Nursing Research Institue, Royal Park Hospital.

Healy, B. (2003). Policy reform in the psychiatic sector. In P. Liamputong & H. Gardner (Eds.), *Health, social change & communities* (pp. 100-116). Melbourne, Australia: Oxford University Press.

Heenan, M., & Murray, S. (2006). *Study of reported rapes in Victoria 2000-2003. Summary research report.* Melbourne: Office of Women's Policy, Department for Victorian Communities.

Heffernan, K., & Cloitre, M. (2000). A comparison of posttraumatic stress disorder with and without borderline personality disorder among women with a history of childhood sexual abuse. Etiological and clinical characteristics. *The Journal of nervous and mental diesease, 188*(9), 589-595.

Herman, J. (1992). *Trauma and recovery.* New York, USA: Basic Books.

Herman, J. L., Perry, C., & van der Kolk, B. A. (1989). Childhood Trauma in Borderline Personality Disorder. *The American Journal of Psychiatry, 146*(4), 490.

Hoff, L. A. (1994). Violence issues: an interdisciplinary curriculum guide for health professionals. Ottawa, Canada: Public Health Agency of Canada.

Hogwood, B. W., & Gunn, L. A. (1983). *Policy analysis for the real world*. London: Oxford University Press.

Home Office. (2005). Domestic violence: break the chain multi-agency guidance for addressing domestic violence. London: Home Office.

Howard, C. (2005). The Policy Cycle: A Model of Post-Machiavellian Policy Making? *Australian Journal of Public Administration, 64*(3), 3-13.

HEROC. (1993a). Human rights and mental illness. Report of the national inquiry into the human rights of people with mental illness. Volume 1. Canberra: Australian Government Publishing Service.

HEROC. (1993b). Human rights and mental illness. Report of the national inquiry into the human rights of people with mental illness. Volume 2. Canberra: Australian Government Publishing Service.

HEROC. (1993c, 02 / 12 / 2001). *National inquiry into the human rights of people with mental illness*. Retrieved 17/02/2006, 2006, from http://www.hreoc.gov.au/disability_rights/inquiries/mii.htm

Humphries, R. (2008). Involuntary patients.

Huntington, N., Moses, D. J., & Veysey, B. M. (2005). Developing and implementing a comprehensive approach to serving women with co-occuring disorders and histories of trauma. *Journal of Community Psychology, 33*(4), 395-410.

Irwin, J., & Waugh, F. (2001). Unless they're asked. Routine screening for domestic violence in NSW health. Sydney: NSW Health Department.

Jennings, A. (2004). *Models for developing truama-infromed behavioral health systems and trauma specific services*. Alexandria, VA, USA: National Association of State Mental Health Program Directors and the National Technical Assistance Center for State Mental Health Planning.

Jennings, A., & Ralph, R. O. (1997). *In their own words*. Augusta, Maine, USA: Department of Mental Health, Mental Retardation and Substance Abuse Services.

Jones, L., Highes, M., & Unterstaller, U. (2001). Post-traumatic stress disorder in victims of domestic violence: a review of the research. *Trauma, violence and abuse, 2*(2), 99-119.

Kessler, R. C., Molnar, B. E., Feurer, I. D., & Appelbaum, M. (2001). Patterns and mental health predictors of domestic violence in the United States: results from the National Comorbidity Survey. *International Journal of Law & Psychiatry, 24*(4-5), 487-508.

King, C. M. (1998). Changing women's lives. The primary prevention of violence against women. In J. Campbell (Ed.), *Empowering surviviors of abuse. Health care for battered women and their children.* (pp. 177-194). Thousand Oaks, California.: Sage.

La Trobe University. (2006). La Trobe University handbook for candidates and supervisors for Masters degrees by research and Doctoral degrees: La Trobe University.

Laing, L. (2000). *Progress, trends and challenges in Australian responses to domestic violence*. Sydney: Australian Domestic & Family Violence Clearinghouse.

Leonard, S., Steiger, H., & Kao, A. (2003). Childhood and adulthood abuse in bulimic and nonbulimic women: prevalences and psychological correlates. *International Journal of Eating Disorders, 33*(4), 397-405.

Leverich, G. S., McElroy, S. L., Suppes, T., Keck, P. E., Denicoff, K. D., Nolen, W. A., et al. (2002). Early physical and sexual abuse associated with an adverse course of bipolar illness. *Society of Biological Psychiatry, 51*, 288-297.

Lewis, M. (1988). *Managing madness: psychiatry and society in Australia 1788-1980*. Canberra: Australian Government Publishing Service.

Lia-Hogberg, B., Kragthorpe, C., Schaffer, M., & Hill, D. L. (2001). Community interdisciplinary education to promote partnerships in family violence prevention. *Family and Community Health, 24*(1), 15-27.

Liamputtong, P., & Ezzy, D. (2005). *Qualitative research methods* (Second ed.). Melbourne: Oxford University Press.

Liamputtong Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods. A health focus.* South Melbourne: Oxford University Press.

Llewellyn, G., Sullivan, G., & Minichiello, V. (1999). Sampling in qualitative research. In V. Minichiello, G. Sullivan, K. Greenwood & R. Axford (Eds.), *Handbook for research methods in health sciences* (pp. 147-199). Sydney: Pearson Education Australia.

Lupton, B. (1999). Content analysis. In V. Minichiello, G. Sullivan, K. Greenwood & R. Axford (Eds.), *Handbook for research methods in health sciences.* (pp. 449-461). Sydney: Pearson Education Australia.

Mason, J. (2002). *Qualitative researching* (2nd ed.). London: Thousand Oaks.

Matsunga, H., Walter, H., McConaha, C., Plotnicov, K., Pollice, C., Radhika, R., et al. (1999). Psychopathological characteristics of recovered bulimics who have a history of physical or sexual abuse. *The Journal of nervous and mental diesease, 187*(8), 472-477.

May, B., Rakhlin, D., Katz, A., & Limandri, B. (2003). Are abused women mentally ill? *Journal of Psychosocial Nursing & Mental Health Services, 41*(2), 21.

McDermott, F., & Meadows, G. (2007). Understanding mental disorder. In B. Singh & G. Meadows (Eds.), *Mental health in Australia. Collaborative community practice.* (pp. 4-7). Melbourne: Oxford University Press.

McLean, L. M., & Gallop, R. (2003). Implications of Childhood Sexual Abuse for Adult Borderline Personality Disorder and Complex Posttraumatic Stress Disorder. *Am J Psychiatry, 160*(2), 369-371.

Meadows, G. (2007). Conceptual models used in mental health practice. Familiar models in overview. The medical model. In B. Singh & G. Meadows (Eds.), *Mental health in Australia. Collaborative community practice.* Melbourne: Oxford University Press.

Meadows, G., Singh, B., & Grigg, M. (2007). The national mental health strategy. In G. Meadows, B. Singh & M. Grigg (Eds.), *Mental health in Australia. Collaborative community practice.* (pp. 69-75). South Melbourne: Oxford University Press.

Mental Health and Drugs Division. (2008). *The gender sensitivity and safety in adult acute inpatient units project. Final report.* Melbourne: State of Victoria, Deparment of Human Services.

Mental Health and Special Programs Branch. (2000). National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000. A joint Commonwealth, State and Territory Initiative under the Second National Mental Health Plan. Canberra: Commonwealth of Australia.

Mental Health Authority. (1968). Personalities of the past. *Mental Health Services Review, 5*, 7.

Mental Health Branch. (2005, 07/11/2005). *Program Management Circulars*. Retrieved 16/03/2006, 2006, from http://www.health.vic.gov.au/mentalhealth/pmc/index.htm

Mental Health Branch. (2006). *Building partnerships between mental health, family violence and sexual assault services. Project report.* Melbourne: Victorian Government Department of Human Services, Mental Health Branch.

Mental Health Branch/Department of Human Services. (2007a). Gender sensitivity and safety in adult acute mental health inpatient units. Melbourne: Mental Health Branch, Department of Human Services.

Mental Health Branch/Department of Human Services. (2007b). Gender sensitivity and safety in adult acute mental health inpatient units. Melbourne: Mental Health Branch/Department of Human Services.

Middleton, W. & Higson, D. (2004). Establishing and running a trauma and dissociation unit: a contemporary experience. *Australasian Psychiatry, 12*(4), 338-346.

Minichiello, V., Fulton, G., & Sullivan, G. (1999). Posing qualitative research questions. In V. Minichiello, G. Sullivan, K. Greenwood & R. Axford (Eds.), *Handbook for research methods in health sciences* (pp. 35-56). Sydney: Pearson Education Australia.

Minichiello, V., Madison, J., Hays, T., Courtney, M., & St John, W. (1999). Qualitative interviews. In V. Minichiello, G. Sullivan, K. Greenwood & R. Axford (Eds.), *Handbook for research methods in health sciences* (pp. 395-418). Frenchs Forrest, NSW: Prentice Hall.

Ministry of Health. (1998). Family violence. Guidelines for health sector providers to develop practice protocols. Wellington, New Zealand.

Ministry of Health. (2001). DHB toolkit. Interpersonal violence. To reduce violence in interpersonal relationships, families, schools and communities. Wellington, New Zealand.

Molnar, B., Berkman, L., & Buka, S. (2001). Psychopathology, childhood sexual abuse and other childhood adversities: relative links to subsequent suicidal behaviour in the US. *Psychological Medicine, 31*(6), 965-977.

Molnar, B., Buka, S., & Kessler, R. (2001). Child sexual abuse and subsequent psychopathology: Results from the National Comorbidity Survey. *American Journal of Public Health, 91*(5), 753.

Moracco, K., Brown, C., Martin, S., Chang, J., Dulli, L., Loucks-Sorrell, M., et al. (2004). Mental health issues among female clients of domestic violence programs in North Carolina. *Psychiatric Services, 55*(9), 1036-1040.

Morrow, M. (2002). *Violence and trauma in the lives of women with serious mental illness.* Vancouver, Canada: British Columbia Centre of Excellence for Women's Health.

Morrow, M. (2003). *Mainstreaming women's mental health - building a canadian strategy*. Vancouver: British Columbia Centre of Excellence for Women's Health.

Morrow, M. & Chappell, M. (1999). *Hearing women's voices. Mental health care for women*. Vancouver, Canada: British Columbia Centre of Excellence for Women's Health.

Morrow, M., & Varcoe, C. (2000). Violence against women. Improvign the health care response. A guide for health authorities, health care managers, providers and planners. Vancouver: Ministry of Women's Health. Women's Health Bureau, Government of British Columbia.

Mouzos, J. & Makkai, T. (2004). Women's experience of male violence, findings form the Australian component of the International Violence Against women survey. Canberra: Australian Institute of Criminology.

Mrazek, P. J. & Haggerty, R. J. (Eds.). (1994). Reducing the risks for mental disorders: frontiers for preventive intervention research. Washington: National Academy Press.

Muenzenmaier, K., Meyer, I., Struening, E., & Ferber, J. (1993). Childhood abuse and neglect among women outpatients with chronic mental illness.[see comment]. *Hospital and Community Psychiatry, 44*(7), 666-670.

Mullen, P. & Flemming, J. (1998). Long-term effects of child sexual abuse. *Issues in Child Abuse Prevention No 9, 9*.

Mullen, P., Romans-Clarkson, S., Walton, V., & Herbison, P. (1988). Impact of sexual and physical abuse on women's mental health. *The Lancet, 1*, 841-845.

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, P. (1993). Childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry, 163*, 721-732.

Musick, J. (1994). Patterns of institutional sexual assault. *Response: to violence in the family and sexual assault, 7*(3), 1-2, 10-11.

National Advisory Council on Violence Against Women. (2001). *Toolkit to end violence against women*: National Advisory Council on Violence Against Women.

National Assembly of Wales. (2001). *Domestic violence: a resource manual for health carer professionals in Wales.* Cardiff, UK: National Assembly of Wales.

National Health and Medical Research Council. (1997). *Depression in young people. Clinical practice guidelines*. Canberra: Commonwealth of Australia.

National Mental Health Strategy Evaluation Steering Committee - for the Australian Health Ministers Advisory Council. (1997). *Evaluation of the second national mental health strategy*. Canberra: Mental Health Branch, Commonwealth Department of Health and Family Services.

National Mental Health Working Group. (1997). *National Standards for Mental Health Services*. Canberra: Commonwealth of Australia.

National Mental Health working group. (2005). *National safety priorities in mental health: a national plan for reducing harm.* Canberra: Health Priorities and Suicide Prevention Branch, Department of Health and Ageing, Commonwealth of Australia.

Neame, A., & Heenan, M. (2003). *What lies behind the hidden figure of sexual assault? Issues of prevalence and disclosure.* Melbourne: Australian Centre for the Study of Sexual Assault.

Nelson, B. J. (1984). Making an issue of child abuse: political agenda setting for social problems. Chicago: University of Chicago Press.

Neuman, W. L. (2003). Social research methods. Qualitative and quantitative approaches. Boston: Pearsons Education.

Neumann, D. A. (1994). Long-term correlates of childhood sexual abuse in adult survivors. *New Directions in Mental Health Services, 64*(Winter 1994), 29-38.

Neumann, D. A., Houskamp, B. M., Pollock, V. E., & Briere, J. (1996). The long-term sequelae of childhood sexual abuse in women: a meta-analytic review. *Child Maltreatment, 1*(1), 6-16.

New South Wales Government. (2003). Policy and Procedures for identifying and responding to domestic violence. Sydney: NSW Department of Health.

New South Wales Health. (2004). Guidelines for the promotion of sexual safety in NSW mental health services. Sydney: NSW Department of Health.

New South Wales Health Department. (1993). Domestic Violence Policy. Sydney: NSW Health Department.

New York State Office for the Prevention of Domestic Violence. (2000). *Domestic violence intervention: a guide for health care professionals.* New York: State of New York. Office for the Prevention of Domestic Violence.

Nibert, D., Cooper, S., & Crossmaker, M. (1989). Assaults against residents of a psychiatric institution: Residents' history of abuse. *Journal of Interpersonal Violence, 4*(3), 342-349.

NSW Department of Health. (2004). Routine screening for domestic violence program. Snapshot report 1. North Sydney.

NSW Department of Health. (2005). *Routine screening for domestic violence program. Snapshot report 2*. North Sydney: NSW Department of Health.

NSW Department of Health. (2007). Routine screening for domestic violence program. Snapshot report 3 November 2005, snapshot 4 November 2006. Sydney, Australia: NSW Department of Health.

NSW Health. *Mental Health Outcome & Assessment Tools*. Retrieved 18/06/2007, 2007, from http://www.cs.nsw.gov.au/MHealth/default.htm

NSW Health. (2005). Identifying and responding to domestic violence. Sydney, Australia: NSW Health.

NSW Health Department. (1999). Guidelines for the promotion of sexual safety in NSW mental health services.: NSW Health Department.

Office for the Prevention of Domestic Violence, N. Y. (2000). *Domestic violence intervention: a guide for health care professionals.* Retrieved 24/06/2005, 2005

Office for Women. (2006). *Women's saftey agenda-elimination of violence*. Retrieved 01/10/2006, 2006, from http://ofw.facs.gov.au/womens_safety_agenda/index.htm

Office of Psychiatric Services. (199?). *Directions. Vision and new development in psychiatric services*. Melbourne: Office of Psychiatric Services, Health Department of Victoria.

Office of Psychiatric Services. (1992). Policy and Strategic Directions for Public Psychiatric Service in Victoria. Continuing Victoria's reform of Pscychiatric Services. Melbourne: Office of Psychiatric Services, Health Department of Victoria.

Office of the Chief Psychiatrist. (2003). *Annual report 2003. Office of the Chief Psychiatrist*. Melbourne: Victorian Government Department of Human Services.

Office of the Chief Psychiatrist. (2004). *Annual report 2004. Office of the Chief Psychiatrist*. Melbourne: Mental Health Branch, Victorian Government Department of Human Services.

Office of Women's Policy. (2005a, 14/02/2007). *Personal safety survey 2005 summary overview*. Retrieved 05/02/2008, 2005, from http://www.abs.gov.au/AUSSTATS/

Office of Women's Policy. (2005b). *Women's safety strategy 2002-07. Progress report November 2005*. Melbourne: Department of Victorian Communities.

Olsen, A., & Epstein, M. (2001). The consumer of mental health services. Consumers and services. In G. Meadows & B. Singh (Eds.), *Mental health in Australia. Collaborative community practice.* (pp. 138-140). South Melbourne: Oxford University Press.

Paolucci, E. O., Genuis, M. L., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *Journal of Psychology, 135*(1), 17-36.

Parsons, W. (1995). Public policy. An introduction to the theory and practice of policy analysis. Aldershot, UK: Edward Elgar.

Peleikis, D., Mykletun, A., & Dahl, A. (2002). The relative influence of childhood sexual abuse and other family background risk factors on adult adversities in female outpatients treated for anxiety disorders and depression. *Child Abuse & Neglect, 28*(1), 61.

Polkinghorn, D. E. (1998). Phenomenological research methods. In R. S. Valle & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology: exploring the breadth of human experience* (pp. 41-60). New York: Plenum.

Pressman, J. L., & Wildavsky, A. (1984). Implementation. How great expectations in Washington are dashed in Oakland; or why it's amazing that federal programs work at all. This being a sage of the economic development administration as told by two sympathetic observers who seek to build morals on a foundation of ruined hopes. (3rd ed.). Berkley, USA.: University of California Press.

Psychiatric Services Branch. (1995). *Responding to allegations of sexual assault*. Retrieved 17/03/2006, 2006, from http://www.health.vic.gov.au/mentalhealth/archive/pmc/assault.htm

Psychiatric Services Branch. (1996). General adult community mental health services. Guidelines for service provision. In *Victroia's mental health service: the framework for service delivery* (pp. 25-33). Melbourne: Victorian Government Department of Human Services.

Psychiatric Services Division. (1994). *Victoria's Mental Health Services: the framework for service delivery*. Melbourne: Department of Victorian Government Department of Health and Community Services.

Psychiatric Services Division, (1996). Victoria's mental health service : the framework for service delivery : better outcomes through area mental health services.

Psychiatric Services Unit. (1993). Psychiatric hospital and community service review. The current status of the Victorian Psychiatric Service System. Melbourne: Victorian Government Department of Health & Community Services.

Queensland Government, Q. H. (2004). responding to sexual assault and promoting sexual safety within Queensland Health inpatient mental health services. Brisbane: Queensland Health.

Quirk, A., Lelliott, P. & Seale, C. (2004). Service users' strategies for managing risk in the volatile environment of an acute psychiatric ward. *Social Science & Medicine, 59*(12), 2573-2583.

Raphael, B. (2000). A population health model for the provision of mental health care. Canberra: Commonwealth of Australia.

Read, J. (1997). Child abuse and psychosis: a literature review and implications for professional practice. *Professional psychology: research and practice., 28*(5), 448-456.

Read, J. (1998). Child abuse and severity of disturbance among adult psychiatric inpatients. *Child Abuse & Neglect, 22*(5), 359-368.

Read, J., Agar, K., Argyle, N., & Aderhold, V. (2003). Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychology and Psychotherapy, 76*, 1-22.

Read, J., Agar, K., Barker-Collo, S. & Davies, E. (2001). Assessing Sucidality in Adults: Integrating childhood trauma as a major risk factor. *Professional psychology: research and practice., 32*(4), 367-372.

Read, J., & Fraser, A. (1998a). Abuse histories of psychiatric inpatients: to ask or not to ask? *Psychiatric Services, 49*, 355-359.

Read, J., & Fraser, A. (1998b). Staff response to abuse histories of psychiatric inpatients. *Australian and New Zealand Journal of Psychiatry, 32*, 206-213.

Read, J., Hammersley, P. & Rudegair, T. (2007). Why, when and how to ask about childhood abuse. *Advances in Psychiatric Treatment, 13*, 101-110.

Read, J., Mosher, L. R. & Bentall, R. P. (Eds.). (2004). *Models of madness.* East Sussex, UK: Brunner-Routledge.

Redford, J. (2001). Are sexual abuse and bulimia linked? *Physician Assistant, 25*(3), 21.

Repper, J., & Perkins, R. (2003). *Social inclusion and recovery: a model for mental health practice.* Edingburgh, New York: Bailliere Tindall.

Roberts, G. L., Lawrence, J. M., Williams, G. M. & Raphael, B. (1998). The impact of domestic violence on women's mental health. *Australian and New Zealand Journal of Public Health, 22*(7), 796.

Rogers, A. & Pilgrim, D. (2005). *A sociology of mental health and illness.* Maidenhead, UK: Open University Press.

Salasin, S. E. (2005). Evolution of women's trauma-integrated services at the Substance Abuse and Mental Health Services Administration. *Journal of Community Psychology, 33*(4), 379-393.

Sayce, L. (2000). From psychiatric patient to citizen. Overcoming discrimination and social exclusion. Basingstoke, New York: Macmillan: St Martin's Press.

Schofield, M., & Jamieson, M. (1999). Sampling in quantitative research. In V. Minichiello, C. M. Sullivan, K. Greenwood & R. Axford (Eds.), *Handbook for research methods in health sciences.* (pp. 147171). Syndey, Australia: Pearson Education Australia.

Shelley, M. (2007). Training for Queensland inpatient mental health services. In S. Fernbacher (Ed.). Melbourne.

Silk, K. R., Lee, S., Hill, E. M., & Lohr, N. E. (1995). Borderline personality disorder symptoms and severity of sexual abuse. *The American Journal of Psychiatry, 152*(7), 1059-1064.

Singh, B. (2007a). Australian psychiatry through the twentieth century. In G. Meadows & B. Singh (Eds.), *Mental health in Australia. Collaborative community practice* (pp. 53-54). South Melbourne: Oxford University Press.

Singh, B. (2007b). Community services ascendant for almost have a century. In G. Meadows, B. Singh & M. Grigg (Eds.), *Mental health in Australia. Collaborative community practice.* (pp. 67-69). South Melbourne: Oxford University Press.

Singh, B. (2007c). Conceptual models used in mental health practice. Specific models in focus. In B. Singh & G. Meadows (Eds.), *Mental health care in Australia. Collaborative community practice.* Melbourne: Oxford University Press.

Singh, B. (2007d). The global perspective. In B. Singh & G. Meadows (Eds.), *Mental health in Australia. Collaborative community practice* (pp. 42-50). South Melbourne: Oxford University Press.

Singh, B. (2007e). The global perspective. In G. Meadows, B. Singh & M. Grigg (Eds.), *Mental health in Australia. Collaborative community practice.* (pp. 51-62). Melbourne, Australia: Oxford Press.

Singh, B., Benson, A., Weir, W., Rosen, A., & Ash, D. (2007). History of mental health services in Australia. In G. Meadows, B. Singh & M. Grigg (Eds.), *Mental health in Austrlia. Collaborative community practice* (pp. 65-69). South Melbourne: Oxford University Press.

Singh, B., & Fossey, E. (2007). The National Mental Health Strategy. In G. Meadows & B. Singh (Eds.), *Mental health in Australia. Collaborative community practice.* (pp. 57-59). South Melbourne: Oxford University Press.

Spataro, J., Mullen, P. E., Burgess, P. M., Wells, D. L., & Moss, S. A. (2004). Impact of child sexual abuse on mental health: Prospective study in males and females. *British Journal of Psychiatry, 184*(5), 416-421.

Spielvogel, A., & Floyd, A. K. (1997). Assessment of trauma in women psychiatric patients. In M. Harris & C. L. Landis (Eds.), *Sexual abuse in the lives of women diagnosed with serious mental illness* (Vol. 2, pp. 39-64). Amsterdam: Harwood Academic Publishers.

Stoller, A. & Arscott, K. W. (1955). *Report on mental health facilities and needs in Australia*. Canberra: Australian Government Publishing Service.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: grounded theory procedures and techniques.* (2nd ed.). Thousand Oaks: Sage Publications.

Symonds, R. (2003). *Family and domestic violence telehealth development unit project.* Perth, Australia: Department of Health. Government of Western Australia.

Taft, A. (2003). *Promoting women's mental health:the challenges of intimate/domestic violence against women.* (No. Issues Paper 8). Sydney: Australian Domestic and Family Violence Clearinghouse.

Tan, C., Basta, J., Sullivan, C. M. & Davidson, W. s. (1995). The role of social support in the lives of women exiting domestic violence shelters: an experimental study. *Journal of Interpersonal Violence, 10*, 437-451.

The Family Violence Prevention Fund. *History of legislation to address health care and domestic violence*. Retrieved 08/07/05, 2005, from http://endabuse.org/programs/display.php3?DocID=317

The Family Violence Prevention Fund. (2004a). *The domestic violence screening, treatment and prevention act*. Retrieved 08/07/05, 2005, from http://endabuse.org/programs/printable/display.php3?DocID=315

The Family Violence Prevention Fund. (2004b). National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. San Francisco: The Family Violence Prevention Fund.

Thompson, K., Crosby, R., Wonderlich, S., Mitchell, J., Fredlin, J., Demuth, G., et al. (2003). Psychopathology and sexual trauma in childhood and adulthood. *Journal of Traumatic Stress, 16*(1), 35-38.

Tobin, D. L. & Griffing, A. S. (1996). Coping, sexual abuse, and compensatory behavior. *International Journal of Eating Disorders, 20*(2), 143-148.

Ullman, S. E. & Brecklin, L. R. (2002). Sexual assault history and suicidal behavior in a national sample of women. *Suicide & Life Threatening Behavior, 32*(2), 117-130.

United Nations. (1991). *Principles for the protection of persons with mental illness and the improvement of mental health care*. Retrieved 18/02/2006, 2006, from http://www.ohchr.org/english/law/principles.htm

Urbis Keys Young. (2004). *National framework for sexual assault prevention*. Canberra: Department of the Prime Minister and Cabinet. Office of the Status of Women.

Van Meter, D. & Van Horn, C. (1975). The policy implementation process: a conceptual framework. *Administraion and Society, 6*, 445-488.

VicHealth. (2004). *The health costs of violence. Measuring he burden of disease caused by intimate partner violence.* Melbourne: Victorian Health Promotion Foundation, Department of Human Services.

Victorian Community Council Against Violence. (2004). Identifying and responding to family violence: a guide for mental health clinicians in Victoria. Melbourne: Victorian Community Council Against Violence.

Victorian Government. (2002). Women's Safety Strategy: A Policy Framework. Melbourne.

Victorian Government. (2005). *Dual diagnosis.* Retrieved 31/05/2006, 2006, from http://www.betterhealth.vic.gov.au/bhcv2/bhcpdf.nsf/ByPDF/Dual_diagnosis/$File/Dual_diagnosis.pdf

Victorian Government Department of Human Services. (1997). *Victoria's Mental Health Services tailoring services to meet the needs of women*. Melbourne, Australia.: Aged, Community and Mental Health.

Victorian Government Department of Human Services. (2002a). *New directions for Victoria's mental health services.* Melbourne, Australia: Mental Health Branch.

Victorian Government Department of Human Services. (2002b). *Victorian women's health and wellbeing strategy. Policy statement and implementation framework 2002-2006*. Melbourne: Women's Health and Wellbeing Strategy. Policy and Strategic Projects Division. DHS.

Victorian Government Department of Human Services. (2007a). Dual diagnosis key directions and priorities for service development. Melbourne, Australia: Victorian Government Department of Human Services.

Victorian Government Department of Human Services. (2007b). Families where a parent has a mental illness. A service development strategy. Melbourne.

Victorian Women and Mental Health Network. (2008). *Nowhere to be safe*. Melbourne: Victorian Women and Mental Health Network.

Warshaw, C. & Barnes, H. (2003, 04/03). *Domestic violence, mental health & trauma: researh highlights*. Retrieved 13/07/05, 2005, from http://www.dvmhpi.org/Publications.htm

Warshaw, C. & Ganley, A. L. (1998). Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers. San Francisco: The Family Violence Prevention Fund.

Warshaw, C., Gugenheim, A. M., Moroney, G., & Barnes, H. (2003). Fragmented services, unmet needs: building collaboration between the mental health and domestic violence communities. *Health Affairs, 22*(5), 230-234.

WHO. (1997). *Violence against women. A priority health issue.* Geneva: Family and Reproductive Health. World Health Organzation.

WHO. (1999). Strengthening mental health promotion, WHO fact sheet no 220. Geneva: World Health Organization.

WHO. (2002a). World report on health and violence. Geneva: WHO.

WHO. (2002b). *World report on violence and health: summary*. Geneva: World Health Organization.

WHO. (2004). Preventing violence. A guide to implementing the recommendations of the World report on violence and health. Geneva: WHO.

Wile, J. (1997). Inpatient treatement of psychiatric women patients. In M. Harris & C. L. Landis (Eds.), *Sexual abuse in the lives of women diagnosed with serious mental illness* (Vol. 2, pp. 109-136). Amsterdam: Harwood Academic Publishers.

Women's Aid. (2004, 2004). Health and domestic violence-good practice guidelines. Principles of good practice for working with women experiencing domestic violence. Guidance for mental health professionals. Retrieved 25/06/2005

Wyshak, G. (2000). Violence, mental health, substance abuse -- problems for women worldwide. *Health Care for Women International, 21*(7), 631-639.

Yeatman, A. (Ed.). (1998). *Activism and the policy process*. St Leonards, NSW, Australia: Allen & Unwin.

Young, M., Read, J., & Barker-Collo, S. (2001). Evaluating and overcoming barriers to taking abuse histories. *Professional psychology: research and practice., 32*(4), 407-414.

Zlotnick, C., Mattia, J., & Zimmerman, M. (2001). Clinical features of survivors of sexual abuse with major depression. *Child Abuse & Neglect, 25*(3), 357-367.