

THE GENDER-SENSITIVE CARE PROJECT: EXPLORING SEXUAL VIOLENCE IN PSYCHIATRIC INPATIENT UNITS

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ABSTRACT

Sexual violence is a major global public health issue. There are strong associations between sexual violence victimisation and mental illness, with one in three women presenting at mental health services have experienced domestic violence, including sexual violence. Women often report feeling disempowered and re-victimised while in psychiatric inpatient units, especially in mixed-gender wards. The biomedical model has been the dominant model of care in psychiatric inpatient units. Recent years have seen a global movement towards gender-sensitive and trauma-informed models of care for those with mental illness. To date, there is limited extant research focused on understanding health professionals' experiences and practices of these care models.

This research aimed to understand how trauma-informed care or gender-sensitive care is experienced and enacted by health professionals' for women victim-survivors of sexual violence across acute psychiatric inpatient units. To address this aim, the research was divided into two phases and four research questions. The first phase answered research questions one and two through a scoping review of the literature. The first research question explored health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings. The second research question explored health professionals' awareness of the gendered impacts of trauma and how this impacts the care provided.

The second phase included a qualitative case study, including stakeholder interviews, observations, and document analysis. The second phase answered research questions three and four. The third research question explored health professionals' perceptions of providing care for women who are victim-survivors of sexual violence in psychiatric inpatient units. The fourth research question explored health professionals' experiences in providing care for women who are victim-survivors of sexual violence in psychiatric inpatient units. The researcher also conducted a policy review of current mental health and violence against women policy and procedures to understand the context of health professionals' experiences and practices.

The findings of these studies are presented in three peer-reviewed published articles. The findings suggest that trauma-informed and gender-sensitive care are inconsistently understood and enacted in practice. A more comprehensive care model, which is gender-trauma and-violence informed, is suggested to address the identified barriers in acute psychiatric inpatient units. This research contributes to improving care provision for women who are victim-survivors of sexual violence during their admissions to psychiatric inpatient units.

DECLARATION

I, Carol Marie O'Dwyer, do hereby declare:

1. This thesis comprises only my original work towards the degree of Doctor of Philosophy, except where indicated in the preface,
2. That due acknowledgement has been made to all materials used, and
3. This thesis does not exceed the word limit of 100,000 words (excluding tables, maps, bibliography, and appendices).

PREFACE

This research was supported by a scholarship from the Melbourne Social Equity Institutes (MSEI), which provided money for my stipend and ‘top-up fund’ including publication fees, conference registrations and travel.

As part of this thesis are three journal articles that answer the thesis research questions. The author was responsible for writing the ethics applications, conducting recruitment and data collection. The author also led the data analysis and drafted all three papers. All article co-authors contributed to the study design, analysis and interpretation of the data, and critically reviewed and edited the articles prior to publication.

The following peer reviewed papers have been published in academic journals:

Chapter 4

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Chapter 6

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National

- O'Dwyer, C., Tarzia, L., Fernbacher, S., & Hegarty, K. (March 2017). A gender-sensitive care approach in mental health for women victim-survivors of sexual violence. Poster presentation at the *Trauma 2017 Conference*: Melbourne, Australia.
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- The Doctoral Academy convened by the Melbourne Social Equity Institute in 2018.
- The Mental Health PhD Program, University of Melbourne from 2018-2020.
- Associate Scholar with Safer Families, Centre for Research Excellence, University of Melbourne from 2018-2020.
- Member of the Australian Psychological Society 2015-ongoing.
- Committee Member of Women's Mental Health Network Victoria 2017-ongoing.

Proofreading

Dr. Ann-Maree Duncan proofread this thesis for spelling and grammatical errors in accordance with Guidelines for the Editing of Research Theses by Professional Editors.

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DEFINITIONS

The language used in the thesis comes from the domestic violence sector and the mental health sector.

Consumer

People who identify as having a living or lived experience of mental illness, irrespective of whether they have a formal diagnosis, who have accessed mental health services and/or received treatment (State of Victoria, 2018–19).

Complex trauma

Complex trauma describes exposure to multiple traumas. It also refers to the impacts of that exposure. Complex trauma is usually interpersonal i.e. occurs between people and involves ‘being or feeling’ trapped. Complex trauma is often planned, extreme, ongoing and/or repeated, and often has more severe, persistent and cumulative impacts. It involves challenges with shame, trust, self-esteem, identity and regulating emotions. It often involves different coping strategies, including alcohol and drug use, self-harm, over- or under-eating, over-work etc and affects emotional and physical health, wellbeing, relationships and daily functioning (Blue Knot Foundation, 2020).

Domestic violence

A set of violent or intimidating behaviours usually perpetrated by current or former intimate partners, where a partner aims to exert power and control over the other, through fear. Domestic violence can include physical violence, sexual violence, emotional abuse and psychological abuse (Australian Institute of Health and Welfare, 2019).

Family violence

In Victoria, family violence has long been the preferred term used to describe abusive behaviours, including sexual abuse, by an intimate partner against their current or former partner and her children (State of Victoria, 2014-16; Yates, 2020).

Gender-based violence

Gender based violence is both a cause and consequence of gender inequality, and has been recognised as a form of discrimination, on the basis of sex and gender. This form of discrimination seriously inhibits women's ability to enjoy and exercise their human rights and fundamental freedoms (UN General Assembly, 1993).

Gender sensitivity

The ability to recognise differences between genders and the appreciation of the need to attend to these differences in service planning and practice. Furthermore, it acknowledges different perceptions, experiences and interests arising from the gendered differences of social positions and access to mental health care (Department of Health, 2011b).

Gender-sensitive care

Gender-sensitive care considers individuals and the context in which care takes place, including interpersonal context and the gender of the health professionals. It encourages personal reflection about one's own experience and practice, and avoids gender stereotypes and assumptions (Miers, 2002).

Gender sensitive practice

Practice that recognises and responds to the differences, inequalities and specific needs of men and women and acts on this awareness (Department of Health, 2011a).

Health professional

A health professional is a person working in a clinical capacity within a health setting including nurses, doctors, midwives, social workers and other allied health professionals (Australian Institute of Health and Welfare, 2016). The term 'staff' is used interchangeably with health professional, attributed to the same meaning.

Intimate partner violence

Violent or intimidating behaviours perpetrated by a current or cohabiting partner, boyfriend, girlfriend or date (Australian Institute of Health and Welfare, 2019).

Mental disorders

A broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others (World Health Organization, 2019).

Mental health

A state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (World Health Organization, 2018).

Mental illness

A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory, excluding intellectual disability (Victorian State Government, 2014).

Partner violence

Violent or intimidating behaviours perpetrated by a current or former cohabiting partner. See also domestic violence and intimate partner violence (Australian Institute of Health and Welfare, 2019).

Restrictive Interventions

Restrictive interventions involve the use of bodily restraint, including physical and mechanical restraint, and seclusion (Victorian State Government, 2014).

Severe Mental Illness (SMI)

Is a term used in the UK to refer to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and bipolar disorder are often referred to as an SMI (Heller, Roccoforte, Hsieh, Cook, & Pickett, 1997).

Sexual assault

Sexual assault can include rape, attempted rape, aggravated sexual assault (assault with a weapon), indecent assault, penetration by objects, forced sexual activity that did not end in

penetration, and attempts to force a person into sexual activity (Australian Bureau of Statistics, 2017).

Sexual threat

Sexual threats are threats of a sexual nature, made face to face, where a person believed it was able and likely to be carried to (Australian Bureau of Statistics, 2017).

Sexual violence

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or acts against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work (World Health Organization, 2013).

Trauma

Trauma occurs when an individual experiences an event (or repeated events) such as sexual assault, physical injury, or the threat of death that they are unable to prevent, stop, or psychologically process (Reeves, 2015).

Trauma-informed care

Trauma-informed care seeks to create safety for patients by understanding the effects of trauma, and its close links to health and behaviour (Quadara, 2015).

Violence against women

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (UN General Assembly, 1993).

Victim-survivor

The term victim is a legal definition, typically referring to someone who has recently experienced a sexual assault. The term survivor is a term of empowerment, typically referring to someone who is going through or has gone through the recovery process (Sexual Assault Kit Initiative, 2020).

ABBREVIATIONS

AMHS	Area Mental Health Service
VAW	Violence against women
SV	Sexual violence
IPV	Intimate partner violence
DV	Domestic violence
FV	Family violence
GBV	Gender-based violence
GSC	Gender-Sensitive Care
GSS	Gender sensitivity and safety guideline
NPT	Normalisation Process Theory
TIC	Trauma-Informed Care
TVIC	Trauma-and-Violence-Informed Care

CHAPTER 1. INTRODUCTION

1.1 Overview

Sexual violence is experienced by one in five women in Australia (Australian Bureau of Statistics, 2016), and by 35% of women worldwide (Oram, Khalifeh, & Howard, 2017). It is perpetrated mainly by men against women (World Health Organization, 2013a) and usually by someone known to them, including an intimate partner (Australian Bureau of Statistics, 2012). Young women, aged 15-34 are most vulnerable, accounting for more than half (53%) of all police-recorded female sexual assault victims (Australian Bureau of Statistics, 2018). Concerningly, rates of sexual violence have remained stable over the last decade (Australian Bureau of Statistics, 2016). Violence against women is more likely to be repeated and involve abusive and controlling behaviours that intimidate, belittle and control the victim (Webster et al., 2018; Howard, Trevillion, & Agnew-Davies, 2010). Furthermore, women who have experienced one type of gender-based violence often experience other types of gendered-violence in their lifetime, including child sexual abuse, domestic violence, sexual assault, and stalking (Cox, 2016; Rees et al., 2011).

Violence against women results in significant health issues. It is the leading contributor to death, disability, and illness in Victorian women aged between 15-44 years (Ayre, Lum On, Webster, Gourley, & Moon, 2016; Victorian Health Promotion Foundation, 2004). Research shows that sexual violence can contribute to mental health problems and can exacerbate already existing mental illness (Jonas et al., 2014; Rees et al., 2011). Approximately 65% of women experience anxiety or fear in the 12-months after an incident of sexual assault (Australian Bureau of Statistics, 2017). Sexual violence is also associated with substance misuse, anxiety, depression, post-traumatic stress disorder (PTSD), eating disorders, and symptoms of psychosis and suicidal behaviour (Australian Institute of Health and Welfare, 2019; Bebbington et al., 2011; Bundock et al., 2013; Jonas et al., 2014; Oram, Trevillion, Feder, & Howard, 2013; Rees et al., 2011; Trevillion, Oram, Feder, & Howard, 2012; Watts & Zimmerman, 2002; K. Webster, 2016). These mental health difficulties as a result of

experiencing sexual violence can persist across the life course and well after the violence has finished (Moulding, Franzway, Wendt, Zufferey, & Chung, 2020; K. Webster, 2016).

The relationship between sexual violence and mental health is complex and bi-directional (Khalifeh, Moran, et al., 2015; World Health Organization, 2017). Women who are receiving mental health support are at a higher risk of experiencing partner violence than women who do not have a diagnosis of these mental health disorders (Howard et al., 2010; Trevillion et al., 2014). This exposure to multiple and repeated forms of violence characteristic of partner violence, in addition to traumatic health problems and psychosocial challenges, can result in complex trauma (Salter et al., 2020). In Australia, women with complex trauma experiences are a significant but often forgotten group of victim-survivors of gender-based violence (Salter et al., 2020). Their unmet needs increase the risk of further and ongoing victimisation compounding trauma-related mental illness (M. Salter, 2017). Disregarding these complexities can lead to further harm, ongoing victimisation, and re-traumatisation from health providers and institutions supposed to provide support (Warner, 2009; Watson, 2020). Acute mental health units can be places of institutional harm and oppression that further compound women's trauma experiences. Institutional harm and oppression can occur through involuntary treatment and the use of restrictive practices such as restraint and seclusion (Watson, 2020). Furthermore, there is often a lack of communication and cross-referrals between mental health and sexual violence services despite often seeing the same women (A Quadara, 2015). There is a clear need for a holistic service model (Hegarty, 2017) that includes models of involuntary mental health care that are not traumatising (Salter et al., 2020).

Woman-centred care is recommended for victim-survivors to prioritise their mental health needs, including safety, minimisation/prevention of harm, women's perspective, humane, holistic, informative, and empowering care (World Health Organization, 2017). In Australia, attempts have been made to implement trauma-informed care (Harris & Fallot, 2001) and gender-sensitive care (Department of Health, 2011a) in the mental health system to support those with trauma histories. However, implementation has had its challenges due to a lack of consensus on a clear definition and broad principles of trauma-informed care (Hopper, Bassuk, & Olivet, 2010). Staff challenges include individual perceptions and attitudes, and change fatigue (Garside, 2004; Muskett, 2014). At a systems level, there has been a lack of clarity on the implementation direction in acute psychiatry (Watson, 2020), impeded by the hierarchy of the mental health system (Bills & Bloom, 1998) and funding issues (Cumming, 2011). Health

systems change is challenging (May & Finch, 2009; May et al., 2007; Myall et al., 2020) and needs political will to promote improvements in the health system's response to violence against women (World Health Organization, 2017). Furthermore, developments in mental health care also need to be supported by research and a robust evidence base. To date, despite the real need, there is a paucity of research into gender-sensitive and trauma-informed care in mental health care, particularly in acute psychiatrist settings (Muskett, 2014; Wilson, Hutchinson, & Hurley, 2017). This is a significant gap in the literature. In the next section, the researcher reflects on their experiences of gender-based violence, mental illness, institutions and services contributing to this research.

1.2 Reflections as a Researcher

In my final years of high school, I volunteered at a long term secure psychiatric unit for adults, who predominantly had a diagnosis of intellectual disability. Once a week in an expansive grey room with fluorescent lights, we would play recreational games and chat with the residents who were often dressed in their nightclothes in the middle of the day. It was not uncommon for women to carry around dolls and tell us stories about their babies. Volunteering here was my first recollection of observing the impact of institutional trauma and abuse. I do not doubt that this experience added to my decision to pursue undergraduate study in psychology and sociology. A few years later, while completing my undergraduate degree, I began casual work as a disability support worker. Coincidentally, I supported many of the residents I had met in the psychiatric unit transition from institutional care to community care. During this transition, file notes reported a long history of chemical, mechanical, and physical restraint. It also outlined institutional trauma and abuse, including sexual violence perpetrated by staff and other residents. This further insight set the course of my pursuit to support people, particularly women, who are at greater risk of violence and abuse.

Since then, during my career, training, and life experiences, I have met many women across diverse and varied mental health settings, including private practice, the disability sector, adult and youth mental health, inpatient, and forensic mental health service. Many of these women had trauma histories, including childhood abuse, domestic and family violence, and/or sexual violence. As a Clinical Psychologist, I was impassioned to understand how I could develop my skills, particularly as understanding trauma and violence was very limited in my clinical

psychology training. Furthermore, reports from clients on their traumatising experiences during admissions to psychiatric inpatient units, reinforcing my need to understand how mental health services support women with a trauma history. This interest led to my current research area and my continued professional development in trauma, violence, and mental illness. Finally, my personal experiences as a woman and those of my female friends, who have their own gender-based violence experiences, strengthens my fight in this area. My personal and professional experiences have undoubtedly influenced my practice and research. I am aware that these are my experiences, and there are many diverse and intersectional experiences of trauma, violence, and mental illness.

1.3 Research Aim

As I have outlined above, my experiences, coupled with the extant research in acute psychiatric inpatient care for victim-survivors of sexual violence, have fostered this research. The aim of this research was to understand how trauma-informed care or gender sensitive care is provided and enacted for women victim-survivors of sexual violence across acute psychiatric inpatient units. This aim is addressed by gaining further knowledge on health professionals' experiences of providing trauma-informed or gender-sensitive care in acute psychiatry. This overarching aim was addressed through the following research questions:

1. What is the current state of knowledge on health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings?
2. What is health professionals' awareness of the gendered impacts of trauma, and how does this impact the care they provide?
3. What are healthcare professionals' experiences and perceptions in providing care for women who are survivors of sexual violence in psychiatric inpatient units?
4. How is Gender-Sensitive Care (GSC) enacted across acute psychiatric inpatient units for women survivors of sexual violence?

1.4 Contribution of the thesis

This thesis makes several significant contributions to understanding trauma-informed care and gender-sensitive care for health professionals working in acute psychiatric units. Firstly, it reviews the limited extant research of health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings. It also highlights the need to understand the gendered impacts of trauma in acute psychiatric inpatient settings. Secondly, this thesis expands this knowledge through an in-depth qualitative case study analysis of health professionals' experiences of providing care in psychiatric settings to women survivors of sexual violence. Thirdly, it develops novel typologies of health professionals' experiences influenced by gender, level of experience, training, and adherence to the biomedical model. Fourthly, this thesis provides an in-depth understanding using Normalisation Process Theory (NPT) to explore how health professionals within a mental health organization across four different psychiatric inpatient units implement gender-sensitive care in practice. Finally, a gender, trauma, and violence informed care model is suggested, supported by policy and future research. Ultimately, the hope is that this thesis' findings have the potential to improve the care provided to women survivors of sexual violence and facilitate the implementation of a model of care that is gender-sensitive and trauma-and violence-informed in acute psychiatric inpatient settings.

1.5 Thesis Outline

This thesis with publication is divided into eight chapters with three peer-reviewed publications. Chapter 2 explores the background context of practice and research that informs this research's rationale and aims, and identifies the gap in the literature. Chapter 3 describes the theory and methodology, including qualitative case study design, data collection, and data analysis processes.

Chapters 4, 6, and 7 include peer-reviewed published articles. Chapter 4 is a scoping literature review exploring health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings. It also explores staff awareness of the gendered impacts of trauma and how this effects the care they provide. Chapter 5 outlines the policy landscape, from international to local level, that informs the empirical research. Chapter 6 explores health

professionals' perceptions of caring for women who are survivors of sexual violence in psychiatric inpatient units. Chapter 7 explores how health professionals enact Gender-Sensitive Care (GSC) across acute psychiatric inpatient units for women survivors of sexual violence.

Chapter 8 presents an overview and synthesis of the research findings and strengths and limitations of the research. It also presents implications for practice, policy, and suggestions for future research to build on the research findings. This chapter also includes an overall conclusion of the research. References and Appendices follow the final chapter.

1.6 Chapter Summary

This chapter introduces the prevalence of sexual violence, complexity, and bidirectional impacts of gender-based violence and mental illness for women. It shows that these experiences are further impacted by the limitations of the mental health service system, in addition to the paucity of research into trauma-informed and gender-sensitive care in acute psychiatric inpatient settings. The researcher has reflected on their experiences leading to this research topic's conception, followed by the research aim. The contributions of this thesis and an overall outline was provided. The next chapter provides a broader and more in-depth background of the practice and research that contributed to this research.

CHAPTER 2: BACKGROUND

2.1 Overview

This chapter provides a broad contextual background for this research. It describes a brief historical overview of the perceptions of women with mental illness. The relationship between sexual violence and mental health services is then outlined. This is followed by the various models and frameworks that inform the current mental health system. The research context is then outlined. Finally, the gaps, aims, scope, and research questions of this study are included.

2.2 Women and Mental Health

Women have long been portrayed as dysregulated and irrational. Women have been reported to experience ‘hysteria’ (from Greek hysterikos, meaning ‘of the womb’), a heterogeneous group of symptoms, including erratic emotions accompanied by seizures, paralysis, choking, and mutism since 1990 BC (Novais, Araújo, & Godinho, 2015). Early philosophers described the womb as a separate being or animal that lived within a woman and could cause health issues by wandering around her body, disturbing other organs (Thompson, 2012). From the early 20th century, the ‘father of psychiatry,’ Emil Kraepelin, described hysteria as a clash between instinct and volition. This informed psychoanalytic developments that emphasized hysteria and psychopathology more generally (Decker, 2004). Freud’s psychoanalytic theory initially suggested that hysterical symptoms were associated with hidden trauma or a series of traumas. However, he later abandoned this theory and instead emphasized the role of sexual fantasies, including penis envy and oedipal complex, in the development of a variety of neuroses and illnesses. These theories minimise the disclosures of sexual abuse as mere fantasies. This perception of women as ‘hysterical’ continues to influence attitudes, inform diagnostic labels and medical treatments of women with mental illness (Dinsdale & Crespi, 2017; Novais et al., 2015).

This minimising of women's sexual violence experiences continued following the move to mixed-gender wards in psychiatric care (Henderson & Reveley, 1996). This occurred from the 1960s following the deinstitutionalisation movement (Henderson & Reveley, 1996). Initial concerns were reported in the UK from 1963, followed by staff reporting sexual harassment and rape of consumers from the 1980s (Copperman & Knowles, 2006). In Australia, the 'Burdekin Report' highlighted the frequency of sexual assaults on women in inpatient settings and the stigma, negative attitudes, and responses they received due to having a mental illness (Human Rights and Equal Opportunity Commission, 1993). Despite these early reports, it was not until the 1990's that some countries, including the UK, began to move back to single-sex wards (Brunt, 2008). This reform transpired following a survey of inpatient care consumers. This survey uncovered concerns about lack of freedom, undesirable staff attitudes, limited staff availability, safety, boredom, and gender issues (Sainsbury Centre for Mental Health, 2001). Consequently, the UK National Health Service executive set out to abolish mixed-gender inpatient accommodation by 2002 (Ramsay, 2005).

However, in Australia, most psychiatric inpatient settings continue to have mixed-gender wards (Kulkarni & Galletly, 2017; Kulkarni et al., 2014). Women-only corridors and lounges were incorporated into mixed-gender wards in the early 2000s (Kulkarni & Galletly, 2017; Kulkarni et al., 2014). At this time, issues were raised about mixed-gender wards. Most alarmingly, two-thirds of women inpatients reported feeling unsafe, experiencing harassment, intimidation, or abuse in mixed wards and reported unsatisfactory management of sexual assault allegations (Clarke & Victorian Women's Mental Health Network, 2008). The provision of women-only spaces was recommended, including gender-specific sleeping areas (Clarke & Victorian Women's Mental Health Network, 2008). Following this, the Gender Sensitivity and Safety Guideline and associated literature review was developed in 2011 (Department of Health, 2011a, 2011b), which promoted the need for gender-responsive acute inpatient psychiatric units. Subsequently, funding was provided by the Department of Health and Human Services to modify adult acute inpatient units to create female-only corridors or wings and lockable bedrooms within mixed settings (Department of Health & Human Services, 2017; Kulkarni et al., 2014). Despite this progress of women-only corridors, recent figures show 80% of the reports of sexual harassment and sexual assaults in mental health settings were made by women in acute psychiatric inpatient units in Victoria (The Mental Health Complaints Commissioner, 2018). More than 75% of perpetrators were co-consumers, and 83% of these perpetrators were male (The Mental Health Complaints Commissioner, 2018).

Even today, women with mental illness are among the groups less likely to be believed when reporting sexual violence (L. Kelly, 2010), contrary to the reality of minimal false allegations (Weiser, 2017).

2.3 Sexual Violence and Mental Health Services

Sexual violence and mental illness frequently co-occur (Australian Institute of Health and Welfare, 2019; Bebbington et al., 2011; Bundock et al., 2013; Jonas et al., 2014; Oram et al., 2013; Rees et al., 2011; Trevillion et al., 2012; Watts & Zimmerman, 2002; K. Webster, 2016). Therefore it is alarming that sexual violence and mental health services are often isolated from each other (Hegarty, 2017; A Quadara, 2015). This siloing of services results in a lack of collaboration and a lack of awareness of the care needs of victim-survivors of sexual violence (Hughes, Lucock, & Brooker, 2019). Globally, almost half (40%) of individuals accessing sexual assault services are also known to mental health services (Bicanic, Snetselaar, De Jongh, & Van de Putte, 2014; Brooker & Durmaz, 2015; Zilkens et al., 2017). One in three women presenting at inpatient or outpatient mental health services have experienced domestic/family violence, including sexual violence (Oram et al., 2013). However, sexual violence is commonly unreported or not identified by mental health professionals (Chandra, Deepthivarma, Carey, Carey, & Shalinianant, 2003; Howard et al., 2010; Örmon, Sunnqvist, Bahtsevani, & Levander, 2016). Mental health professionals tend not to ask about sexual violence due to personal discomfort and feeling ill-equipped to respond to disclosures (McLindon & Harms, 2011). This lack of inquiry contributes to barriers of identifying sexual violence experiences among mental health consumers.

Positively, this underreporting seems to be decreasing with improvements in appropriate identification of sexual assault occurring in some countries. For instance, a recent study suggested an increase in sexual violence identification by women mental health professionals in Auckland, New Zealand (Sampson & Read, 2017). This improvement was associated with the roll-out of a training program that included: role plays on when and how to ask about sexual violence; how to respond to disclosures; use of assessment forms with specific abuse and neglect questions; and a change in service culture with an increased focus on identifying trauma (Sampson & Read, 2017). Women who have experienced sexual violence are increasingly seeking advice and support from health professionals (Australian Bureau of Statistics,

2012; Khalifeh, Oram, Trevillion, Johnson, & Howard, 2015) and welcome direct questioning and acknowledgment of their experiences from these professionals (Trevillion et al., 2014).

In Australia, mental health services are making attempts to improve their responses and care for victim-survivors of sexual violence (Muskett, 2014; Wilson et al., 2017). However, there is still much progress to be made (Victorian Mental Illness Awareness Council, 2013). Significant changes are required to address violence against women adequately, at both the health systems and health professional levels (Chapman & Monk, 2015; García-Moreno et al., 2015). Mental health services must provide a gender-sensitive, safe, and woman-centred response that offers coordination and continuity of care between services (García-Moreno et al., 2015; Khalifeh, Oram, et al., 2015; Rees et al., 2011). Mental health services must understand the gender processes associated with inequality for women, including cultural norms, gender disadvantage, patriarchal attitudes, inequality, discrimination, stereotyping, sexualisation, sexual harassment, family violence, economic disadvantage, and marginalisation of women's need (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; World Health Organization, 2012, 2013a). It is also essential to understand the current models and frameworks used by Australia and Victoria's mental health system, the setting for this thesis to improve future systems. These are described in the next section.

2.4 Models and Frameworks of the Mental Health System

The biopsychosocial model has been applied to health care since the late 1970s, in response to the biomedical model that dominated the last century (Álvarez, Pagani, & Meucci, 2012; Engel, 1977). The biomedical model is based on three common assumptions: that all illnesses have a single underlying cause; disease or pathology is always the single cause; and removal or attenuation of the disease will result in a return to health (Wade & Halligan, 2004). However, the biomedical model has been criticised for its reductionist approach as it does not consider the broader cultural, psychological and social factors that often contribute to 'illness' (Wade & Halligan, 2004). The biopsychosocial model was developed to highlight biological, psychological, and social factors in understanding health and illness (Engel, 1980; Gatchel, 2004; Wade & Halligan, 2004). It set out to challenge psychiatry's credibility as part of the medical field and promoted the inclusion of psychosomatic medicine and psychological study (Engel, 1977). The development of the biopsychosocial model coincided with the argument for

more significant consideration of the social context and ecological systems of life experiences' (Bronfenbrenner, 1979).

Despite its ideology, the biopsychosocial model has been criticised for several reasons. These criticisms include its lack of philosophical coherence, insensitivity to consumers' subjective experience, not adhering to its roots of general systems theory, and creating an eclectic and vague model (Benning, 2015). Furthermore, most concerning is the suggestion that the integration of the bio, psycho, and social perspectives are more of an illusion rather than reality (Benning, 2015). It is suggested this latter view results from the influence of the pharmaceutical industry on professionals, research, and teaching institutions (Beder, Mosher, & Gosden, 2004; Read, 2008; Shooter, 2005). The President of the American Psychiatric Association distinctly warned "If we are seen as mere pill pushers and employees of the pharmaceutical industry, our credibility as a profession is compromised. As we address these Big Pharma issues, we must examine the fact that as a profession, we have allowed the bio-psycho-social model to become the bio-bio-bio model" (Sharfstein, 2008, p. 3)

In the past two decades, several frameworks and models (Table 1) have been developed to address consumers' holistic needs within the mental health system. These include the recovery-oriented framework (Department of Health and Ageing, 2013), which is now well-established in mental health care in Australia. Trauma-informed care (SAMHSA, 2014), and trauma-and-violence-informed care (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015), have been adopted from the USA and Canada. More locally, gender-sensitive care (Department of Health, 2011b). and Safewards (Bowers et al., 2015) has been rolled out state-wide by the Department of Health and Human Services in Victoria. These frameworks and models will be explored in more detail below as context for the setting of the research.

Recovery-oriented Framework

The Australian and Victorian Mental Health System utilises the recovery-oriented framework (Department of Health and Ageing, 2013). This approach considers the perspective of the individual, family, and community in treating mental ill-health. The recovery-oriented framework is contextualised by culture, privilege or oppression, history, and the social determinants of health, and it has been used for the past two decades. Significantly, this framework is based on these principles: the uniqueness of the individual; real choices; attitudes

and rights; dignity and respect; partnership and communication; and evaluating recovery. Recovery-oriented service provision prioritises service users' hopes and goals relating to their ability to manage their illness and treatment (personal and clinical recovery). Social and functional dimensions of living, gender, age, and developmental stages are essential in recovery (Department of Health and Ageing, 2013; Lloyd, Turner, Lloyd, & Turner, 2008). However, there is no mention of violence against women or trauma within the recovery-oriented framework.

Trauma-informed Care

Trauma-informed care was developed almost two decades ago (Harris & Fallot, 2001) to address mental illness and violence in the Women, co-occurring Disorders, and Violence Study (WDVS). Trauma-informed care was designed as a service provision which can be integrated into any human service organisation (Harris & Fallot, 2001). It recommends several criteria for adopting services at both the organisational and clinical levels (Harris & Fallot, 2001). It is based on the following principles: safety; trustworthy and transparency; peer support and mutual self-help; collaboration and mutuality; empowerment, voice and choice; and cultural, historical, and gender issues. It aims to avoid re-traumatising consumers or staff working within the service settings. The ethos of trauma-informed care, "safety first" and "do no harm" (Fallot & Harris, 2009, p. 2), guide the three fundamental pillars of safety, connections, and managing emotions (Bath, 2008). Trauma-informed care places violence against women and trauma at the fore and has only more recently included gender to its guiding principles (SAMHSA, 2014).

Trauma-and-Violence-Informed Care

Trauma-and violence-informed care (TVIC) is an approach that aims to improve policies and practices through understanding the impact of trauma and violence on victims' lives and behaviours (Ponic, 2016). Four principles underpin TVIC: understand trauma, violence, and its impacts on peoples' lives and behaviours; emotionally and physically safe environments; choice, collaboration, and connection; strengths-based and capacity-building. It intentionally emphasises the ongoing and historical intersection between interpersonal and structural forms

of violence, compounding the negative impacts of trauma (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015; Wathen et al., 2010). TVIC promotes emotional, physical, and cultural safety for all regardless of whether they have disclosed a trauma history or not. It posits that trauma and violence should be conceptualised on a continuum by all services to reduce re-traumatisation. It provides different organisational and policy strategies that are direct and facilitate implementation at the individual and service provider levels. TVIC greatly considers safety, violence and trauma, however it could be more gender aware.

Gender-Sensitive Care

Similar to trauma-informed care, gender-sensitive care is a framework that operates at both the organizational and clinical levels. Gender-sensitive care is recommended to support diverse populations, including women with mental illness and trauma histories (Department of Health, 2011b). It considers how trauma, social, cultural, familial, and financial factors (Judd, Armstrong, & Kulkarni, 2009) interplay with gender in the context of service provision (Department of Health, 2011a). It is based on the following ideas: safety and responsiveness; people's lived experiences and their particular needs; physical, sexual, and emotional safety; service-specific factors such as design, workforce development, local policies, and procedures; that women and men may experience mental health issues differently. The gender-sensitivity and safety guideline also operates at a systems level (Department of Health, 2011b). It includes the environment, management and leadership, direct contact staff, practitioner support, referral pathways, information sharing, protocols and policies, and community linkages (Department of Health, 2011a). Gender sensitive care focuses more broadly on gender and trauma, however there is limited inclusion of violence or structural forms of violence.

Safewards Model

More recently, Safewards is a care model that originated in the UK and was adopted by the Victorian government in September 2016. The objective of the Safewards model is to reduce conflict and containment within mental health services. It is based on six domains: staff team or internal structure; physical environment; outside hospital; the patient community or patient-patient interaction; patient characteristics, symptoms, and demography; and the regulatory

framework of external structures. The model attempts to identify and address the causes of behaviours in staff and patients that may result in harm, such as violence, self-harm, or absconding, and reduce the likelihood of this occurring (Bowers et al., 2014; Bowers et al., 2015). Attempting to reduce violence and ensure safety is essential to reduce traumatisation and re-traumatisation in mental health settings. However, there is no consideration for gender or violence against women described within this model.

Table 1 outlines some shared principles outlined in the models mentioned above and frameworks. Positively, there appears to be broad consideration for safety, trauma, uniqueness, collaboration, and choice and governance at the system, organisational and individual levels. However, as Table 1 shows, the principles of gender and violence against women remain on the periphery of mental health. Moreover, there is even less consideration for attitudes, dignity, and respect within these models and frameworks.

Table 1. Shared principles in the current models and frameworks of mental health care.

	Recovery	Trauma-informed care	Trauma-and-violence informed care	Gender-sensitive care	Safewards
Safety		✓	✓	✓	✓
Trauma		✓	✓	✓	
Violence			✓		✓
Gender		✓		✓	
Uniqueness	✓	✓	✓	✓	✓
Collaboration & Choice	✓	✓	✓		✓
Peer Support		✓			✓
Attitudes	✓				
Dignity/Respect	✓				
Capacity building			✓	✓	
Governance/ Monitoring	✓			✓	✓

These principles have been collated and combined from the recovery-oriented framework (Department of Health and Ageing, 2013), trauma-informed care (SAMHSA, 2014), trauma-and-violence informed care (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015; Wathen et al., 2010), gender-sensitive care (Department of Health, 2011b), and Safewards (Bowers et al., 2014; Bowers et al., 2015). The next section provides an overview of the current research context for mental health and sexual violence, building on this background context.

2.5 Research Context

As shown above, over the past two decades, practices and models of care in the Australian mental health have struggled to address gender-based violence within the mental health system. From a research context, there have been three key projects completed in Australia in this area; *Women's Input into Trauma-Informed Systems of care in health settings study (the WITH*

Study) (Hegarty, 2017); the *Preventing gender-based violence in mental health inpatient units* (Watson, 2020); and *"A deep wound under my heart": Constructions of complex trauma and implications for women's wellbeing and safety from violence* (M Salter et al., 2020). These projects have been funded by the Australia National Research Organisation for Women's Safety (ANROWS). Each project identified key findings to improve the service system for women who have experienced gender-based violence. Hegarty et al. (2017) found a complex interrelationship between mental health and sexual violence experiences. Watson et al. (2020) found that women in mental health inpatient units experience many forms of gender-based violence and are not safe in mixed-gender or even gender-specific spaces. Furthermore, trauma-informed care is not consistently embedded in the service provision, and gender-based violence can also be experienced through institutional violence and coercion, including restraint and seclusion. Salter et al. (2020) found that complex trauma is inconsistently and poorly defined in Australian public policy. There is an incongruence between health professionals' understanding of complex trauma, and the fragmented service system does not address the multiple needs of women with complex trauma. Furthermore, gendered stereotypes and stigma about women's health can impact service provision across a range of sectors. Overall, the service provision should include holistic, wrap-around, and place-based supports that are culturally grounded and appropriate (Hegarty, 2017; Watson, 2020; Salter et al., 2020).

Collectively, these projects' findings and recommendations are fundamental to improve practice and models of care in Victoria. They recommend a whole of government commitment to the implementation of trauma and violence-informed practice across sectors, including women-centred issues (Hegarty, 2017; Watson, 2020; Salter et al., 2020). These recommendations suggest a focus on empowerment of women, the recognition of restrictive interventions as a form of gender-based violence and responding sensitively to disclosures (Hegarty, 2017; Watson, 2020). Researchers also identify the need for additional education and resources for practitioners. At the service level, there is a need for women-only settings, public policy and frameworks that support complex trauma and gender-based violence, continued data collection from services, and monitoring of service provision (Hegarty, 2017; Watson, 2020; Salter et al., 2020). These projects provide an influential base for developing the current mental health system to meet the needs of victim-survivors' of gender-based violence. It is also essential to hear from health professionals on their experiences of providing care for those who have experienced gender-based violence and complex trauma. It is particularly crucial for those working in acute mental health settings due to the intersection of complex needs, high potential

for re-traumatisation due to restrictive practices, power dynamics, and structural barriers. The next section illustrates the gaps in current research in this area.

2.6 The Gaps

The significant bi-directional impact of sexual violence and mental illness for women is clear (Australian Institute of Health and Welfare, 2019; Bebbington et al., 2011; Bundock et al., 2013; Jonas et al., 2014; Oram et al., 2013; Rees et al., 2011; Trevillion et al., 2012; Watts & Zimmerman, 2002; K. Webster, 2016). Feeling disempowered and re-victimised in psychiatric inpatient units is a commonly reported experience for women consumers, especially in mixed-gender wards (Judd et al., 2009). There is a need for gendered mental health research to address violence against women (Howard, Ehrlich, Gamlen, & Oram, 2017). Attempts by mental health and human service agencies in Australia to implement gender-sensitive and trauma-informed care has been challenging, as outlined in Chapter 1. These challenges are due to issues such as a lack of an agreed definition and guidance on implementation, siloing of services, funding, and societal attitudes. There is also the need for increased commitment from governments to implement gender-sensitive and trauma-informed care. This implementation strategy should include the development of consistent policies and procedures, and the improvement of organisational culture (Fernbacher, 2008; A Quadara, 2015; The Mental Health Complaints Commissioner, 2018). There is also an underdeveloped systems approach to implementing gender-sensitive care (Judd et al., 2009; Miers, 2002), specifically in clinical psychiatric settings (Maatta, 2009).

There is limited research that examines the effectiveness of organisation and systems models of gender-sensitive and trauma-informed care (A Quadara, 2015; Reeves, 2015). The evaluations that have been completed in trauma-informed care tend to focus on the individual and practice level or proxy indicators such as a reduction in seclusion and restraint practices/incidents to suggest changes in organisational practice (Muskett, 2014; Rivard et al., 2003; Wright, Woo, Muller, Fernandes, & Kraftcheck, 2003). Research has been completed on gender-sensitive care, predominately in the USA, regarding veterans (deKleijn, Lagro-Janssen, Canelo, & Yano, 2015), forensic populations (Archer, Lau, & Sethi, 2016), and primary health care (Meyer, Womack, & Gibson, 2016). However, there is limited research in gender-sensitive

care explicitly relating to mental health inpatient settings (Bills & Bloom, 1998; Kulkarni et al., 2014). There is also limited research on the psychological safety of consumers who are victims of sexual violence or those who have been assaulted during an inpatient admission (Cole, 2003; Gallop, Engels, DiNunzio, & Napravnik, 1999; Phillips, 2011). Of the available research, positive outcomes for implementing trauma-informed care for treatment and cost-effectiveness in mental health have been shown (Clark & Power, 2005; Domino, Morrissey, Nadlicki-Patterson, & Chung, 2005; Morrissey et al., 2005). A reduction in violence and self-harm and an increase in discharge rates were found when trauma-informed care principles were implemented into a psychiatric inpatient unit (Bills & Bloom, 1998). The outcomes of gender-sensitive care are unknown due to the paucity of research currently available.

2.7 Aims and Scope

This project aims to fill some of the gaps outlined above by exploring psychiatric inpatient care provided to women who have experienced sexual violence and mental illness. Specifically, it seeks to understand health professionals' experiences of providing trauma-informed care or gender-sensitive care, and how it is enacted across four different psychiatric inpatient units within a Mental Health Service in Victoria. As discussed earlier, gender-based violence is a broad and complex area. This research focuses on sexual violence and the care provided in a specific mental health setting due to the bidirectional impact.

2.8 Research Questions

The overarching aim will be explored through the following research questions:

1. What is the current state of knowledge on health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings?
2. What is their awareness of the gendered impacts of trauma, and how does this impact the care they provide?
3. What are healthcare professionals' experiences and perceptions in providing care for women who are survivors of sexual violence in psychiatric inpatient units?
4. How is Gender-Sensitive Care (GSC) enacted across acute psychiatric inpatient units for women survivors of sexual violence?

2.9 Chapter Summary

This chapter provided an overview of the mental health system's historical context through practice, models, and research. It specifically explored the historical and continued impact of the negative perceptions of women with mental illness who are victim-survivors of sexual violence within the mental health system. Following this, a description of the mental health system models and frameworks, including their shared principles, was outlined. An analysis of the research context of mental health and sexual violence in Australia was provided, which leads to the identified gaps in current understanding. The chapter concludes with an outline of the aims and scope of this research study. The next chapter outlines the theory and methodology used to answer these four research questions.

CHAPTER 3: THEORY AND METHODOLOGY

3.1 Overview

In this chapter, a description of the research design, including the epistemological perspectives and the design framework of phase one and phase two, is provided. Phase one and phase two are then described separately, including the data collection and analysis methods of each phase. The description of phase two also includes information about the recruitment strategy, ethical considerations, and rigour including positionality and reflexivity.

3.2 Epistemological and Ontological Perspective

This study's design, interpretation of the data, and the conclusions drawn are all informed by the author's perspective on both the social construction of meaning and feminist theory. Research is guided by the researcher's beliefs and feelings about the world, including the questions asked and the lens they are interpreted through (Denzin & Lincoln, 2008). The philosophical framework is congruent with the researcher's perspectives as a woman and clinical psychologist with experience working in the mental health field. Constructivist feminist approaches are appropriate when health research aims to better understand women's mental health experiences (Doucet, Letourneau, & Stoppard, 2010). An outline of how social constructivist feminist theory applies to this research design is described below.

Social Constructivist Feminist Approach

Social constructivism aims to understand how people construct and reconstruct meaning (Guba & Lincoln, 1994). As a result, meanings are varied and multiple, causing the researcher to look for the complexity of perspectives (Creswell & Garrett, 2008). It states that meaning is constructed socially and conventionally through the engagement with the world and established historical and social 'institutions' (Crotty, 1998; Guba & Lincoln, 1994). In addition to

institutions, culture and gender provide us with a lens on how to view, make meaning and ignore things in the world we are born into (Crotty, 1998; Doucet et al., 2010; Geertz, 1973). Ultimately social constructivists believe people construct their reality based on their current perspectives; the truth is relative to the individual and may change over time (Doucet et al., 2010). Feminist theorists see gender as the central organising principle by which women are subordinated (Bryson, 2016; Cornwall & Rivas, 2015). Feminist theory posits that gender is constructed from a patriarchal society that places the male gender in a more powerful and privileged position than the female gender (Baird, Mitchell, & Baird, 2014). Feminist research advocates for a change in the social, political, and health policies that impact women's lives (Parker & McFarlane, 1991; Wigginton & Lafrance, 2019).

Together with feminist theory (Bryson, 2016), social constructivism supports the understanding of how health professionals construct and reconstruct meaning (Guba & Lincoln, 1994). It presents multiple, holistic, competing, and often conflicting realities depending on gender and professional background (Lincoln, 1990). It encourages the researcher to explore varied, multiple, and complex perspectives (Creswell & Garrett, 2008). It provides a strong theoretical foundation to understand how a mental health service and the health professionals working within this institution construct meaning about the care they provide to women victim-survivors of sexual violence. Furthermore, it provides an understanding of the power imbalance that leads to the oppression of women's perspectives, which commonly occurs in mental health settings (Holloway & Galvin, 2016; Holloway & Wheeler, 2010). Researchers must recognise the active role they play in the data collection and interpretation of research findings (Schwandt, 1994), and thereby these findings are unavoidably value-laden (Guba & Lincoln, 1989). The researcher's positioning is outlined at the end of this chapter to explain how values and perspectives have influenced the research findings. In the next section, the two phases of this thesis's research design are described and an outline of the scoping literature review and case study design used is provided.

3.3 Research Design

A qualitative design with two phases of research was used. The two phases each corresponded to two research questions and allowed for flexibility for each phase's results to stand alone while still contributing to an overall understanding of mental healthcare for victim-survivors

(Figure 1). The results of each of these phases were published in three peer-reviewed journals (see Chapters 4, 6, and 7). The rationale, data collection, and data analysis of each phase will be outlined in this chapter. Phase one will be described in the next section.

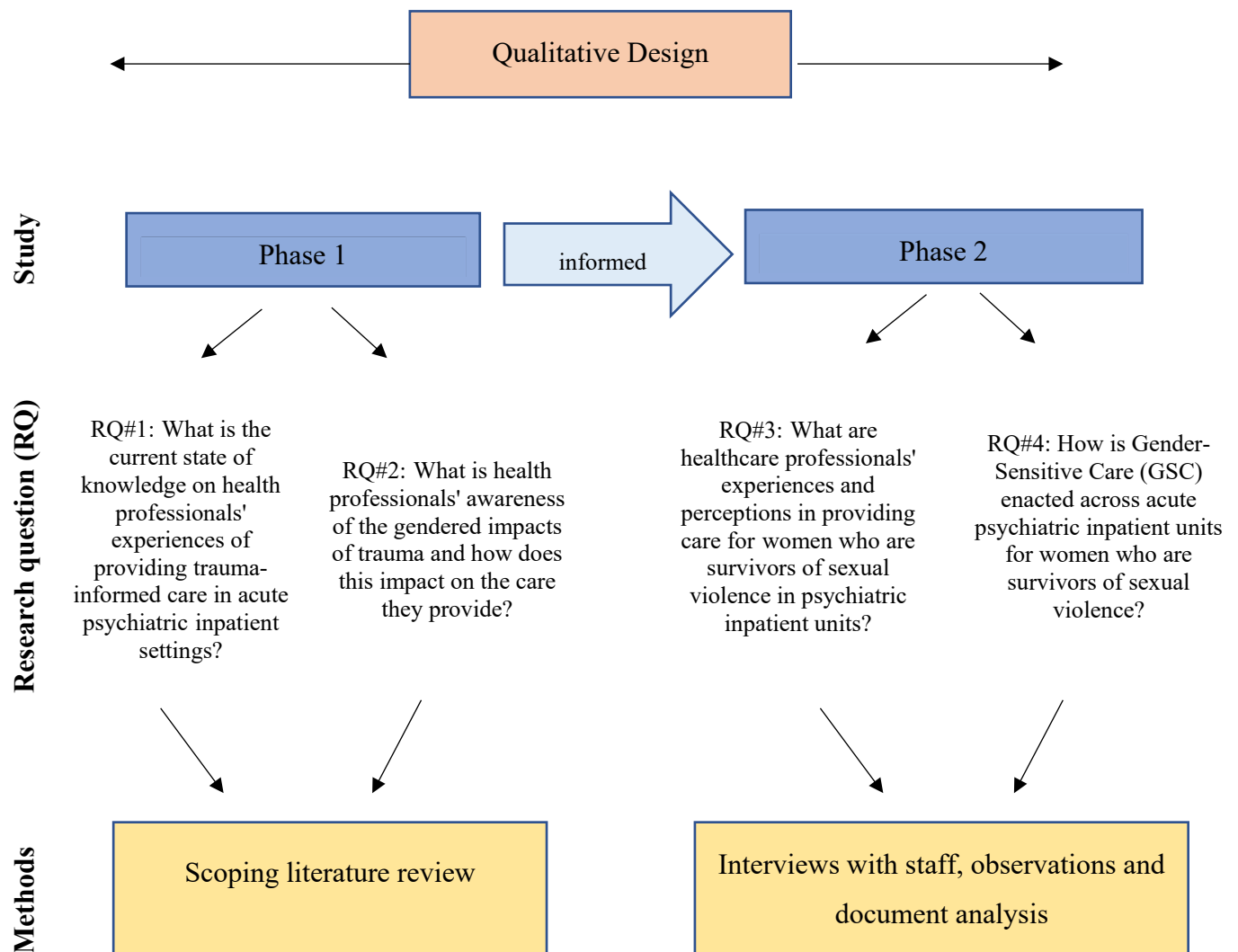


Figure 1. Summary of research phases, research question and methodology.

3.4 Phase One-Scoping Literature Review Methodology

The first phase's research questions were: 'What is the current state of knowledge on health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings?' and 'What is health professionals' awareness of the gendered impacts of trauma, and how does this impact the care they provide?' A scoping review of the literature was conducted to answer these research questions.

Rationale

The scoping literature review has become increasingly popular as a knowledge synthesis method to advance practice and research through the consolidation of evidence. A scoping literature review aims to inform practice, programs, and policy by providing direction to future research priorities (Arksey & O'Malley, 2005). This aim makes scoping literature reviews well placed to answer a range of questions in both emerging and established health research (Colquhoun et al., 2014). In emerging areas, the scoping literature review methodology permits the collating of diverse study methodologies of published articles (Colquhoun et al., 2014). A scoping review methodology has been strengthened in recent times through a five-step process (Arksey & O'Malley, 2005; Levac, Colquhoun, & O'Brien, 2010) and a quality assessment for included studies (Daudt, van Mossel, & Scott, 2013). A description of how this methodology was utilized will be outlined in the next section.

Scoping Literature Review Data Collection

A five-stage scoping review methodology was used (Arksey & O'Malley, 2005; Levac et al., 2010). This methodology requires identifying the research question(s), identifying relevant studies, study selection, charting the data, and collating and summarising and reporting the results. These stages were conducted iteratively to ensure all relevant articles were included and are described in detail below.

A search strategy was used (Peters, Godfrey, McInerney, Soares, Khalil, & Parker, 2015) to answer the two research questions from phase one. The searches were conducted in March 2018, using filters to include the English language only and a time frame of 20 years (January

1998-March 2018). A 20-year time frame was applied as trauma-informed care began emerging as a new model of care provision around 2000. The initial search included an analysis of the words contained in the title and abstract of retrieved papers and the index terms used to describe the articles across MEDLINE and CINAHL to identify additional search terms to use. The second search employed all keywords and index terms, grouped under search topics, across PsycINFO, Embase, PsychARTICLES, PubMed, and Cochrane Library. The reference lists of all identified reports and articles were searched for additional studies, in addition to snowballing and contacting authors. Each keyword search topic was searched independently and then the topics were combined with ‘AND’ (Appendix 1). The titles and abstracts of the articles were reviewed manually to determine whether they met the inclusion criteria.

The author and three supervisors were involved in determining the scoping review questions and inclusion and exclusion criteria (Table 2). Once agreed upon, two researchers (CO'D and LT) applied the inclusion and exclusion criteria to all citations title and abstract, and identified those meeting the research aim. After the initial selection, full texts were obtained and reviewed independently. In the case of uncertainty regarding the inclusion of articles based on review of abstracts, full texts were reviewed by each researcher until consensus was agreed upon. A third researcher (KH) reviewed any articles where there was disagreement.

Table 2. Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Qualitative or mixed-method empirical studies reporting primary data published in peer-reviewed scientific journals.	Studies that exclusively focused on nonacute mental health settings (e.g. community, forensic and rehabilitation) due to the differences in scope and context of care
Participants had to include staff working within acute psychiatric inpatient settings.	Staff and consumer data presented together.

A total of 1,046 studies were yielded from electronic databases and hand searches once duplicates were removed (Figure 2 below). This number was reduced to 38 articles once the inclusion criteria were applied to titles and abstracts. The full text of these 38 articles was reviewed, and 32 were excluded as they did not meet inclusion criteria. Two further articles were added after reviewing the reference lists of included studies. A custom-designed template was used to record extracted information from the final eight identified articles (Appendix 2).

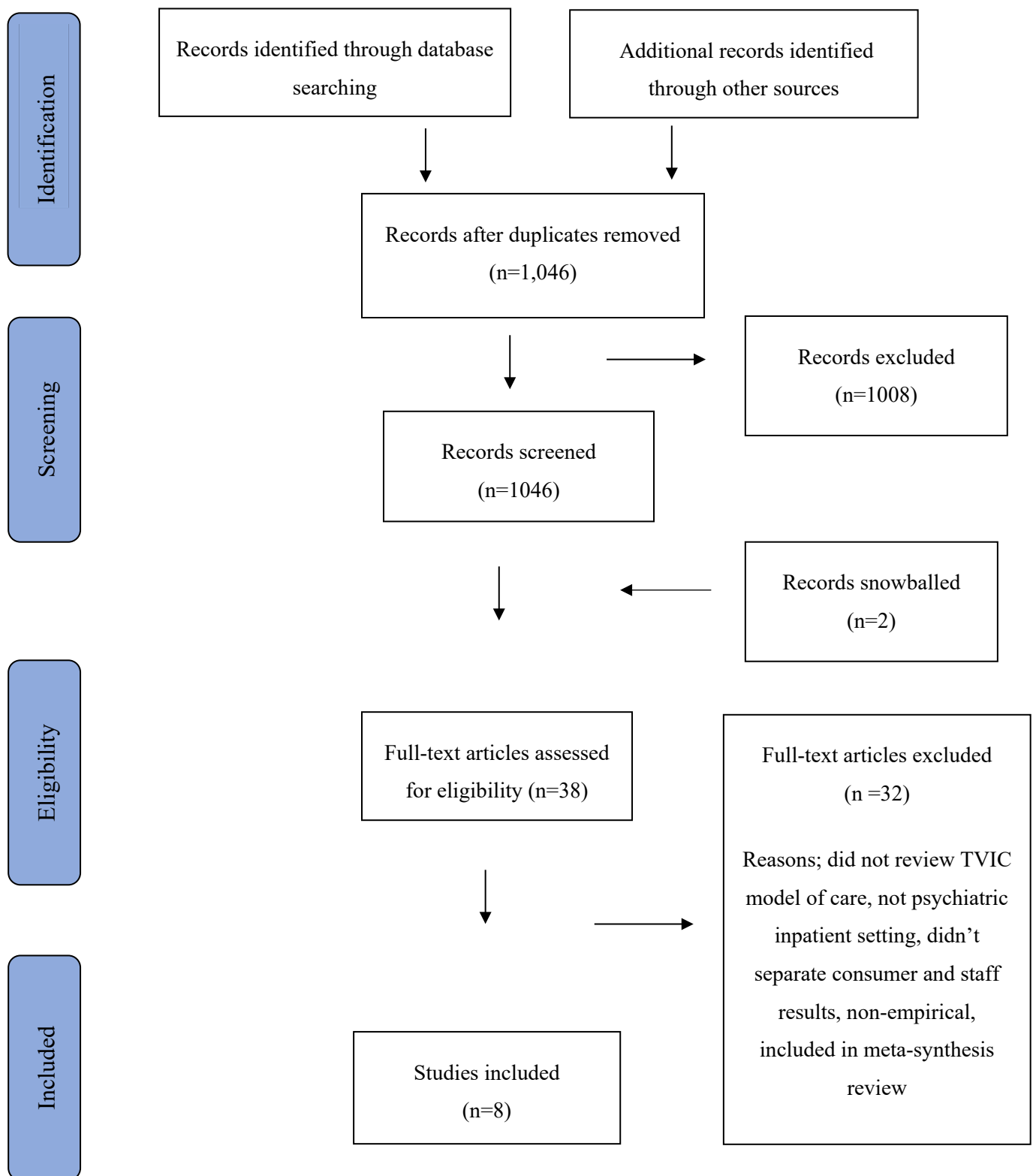


Figure 2. PRISMA Flow diagram of completed search.

Updated Scoping Review Search

As the initial scoping review search was carried out in 2018, a more recent review was conducted on the 4th of May 2020 to scan for any recent publications. This search was conducted using the previously used search terms on the five databases (Table 2) in the original scoping literature review. This search's dates were narrowed to January 2018, when the initial search was completed, until May 2020. The authors' peer-reviewed publications of this thesis were identified through the database search and were excluded during screening. The original exclusion and inclusion criteria were also applied. A total of 268 results were yielded, and the titles were reviewed. Following this, 18 abstracts were reviewed; one article met the criteria (Isobel, Gladstone, Goodyear, Furness, & Foster, 2020).

Scoping Literature Review Data Analysis

Qualitative content analysis was used to analyse the articles included in the scoping literature review by coding and interpreting these codes (Grbich, 2007; Hsieh & Shannon, 2005). These codes were then sorted into categories, guided by the two research questions. Themes were developed iteratively with the researcher's supervisors, and a data chart form was developed (Punch & Oancea, 2014). The qualitative data analysis software NVivo 11 (QSR International, 2015) was used to organize and manage the scoping review literature. The rationale, data collection, and data analysis of phase two will be described in the next section.

Assessing Quality

The articles' quality was assessed using the Critical Appraisal Skills Programme (CASP) (CASP, 2018). This systematic process contributed to the literature review's quality, given the limited number of articles included. The articles were each rated against the nine CASP items on a scale of 0-2, giving a maximum rating of 18 for each article. Two of the articles received a 'medium-quality' rating, and six of the articles received a rating of 'high-quality.'

3.5 Phase Two - Case Study Design

The second phase's research questions were 'What are healthcare professionals' experiences and perceptions in providing care for women who are survivors of sexual violence in

psychiatric inpatient units?’ and ‘How is Gender-Sensitive Care (GSC) enacted across acute psychiatric inpatient units for women survivors of sexual violence?’ A case study design was used to answer these research questions. A case study provides a useful method of answering these research questions by providing a detailed description of real-life examples of the case’s similarities and differences and phenomenon being studied (Lincoln & Guba, 1985).

Rationale

Case study research is a qualitative approach that explores a single or multiple bounded system(s)/case(s) over time (Thomas, 2011). While some researchers define case study research as a unit of analysis, this project will utilise its methodology as a means of inquiry that involves the investigation of a phenomenon within its real-life context (Stake, 2006). Researchers who use a case study approach are urged to seek out what is common and different about the case (Stake, 1995). It can also be used to explore complex and different views from multiple perspectives using a 'real-life' context (Simons, 2009). All case study designs involve careful and in-depth consideration of the nature of the 'case,' which consists of the 'subject' and the 'object', historical background, physical setting, and other institutional and political contextual factors (Denzin & Lincoln, 2008).

Stake (1995) proposed three types of case study design frameworks; the intrinsic, the instrumental, and the collective case. The intrinsic case is used to understand the details of a single case. An instrumental case study provides insight or advances the understanding of an issue or is used to refine theory. A collective case study refers to an instrumental case studied as multiple, nested cases, observed in unison, parallel, or sequential order. More than one case can be simultaneously studied; however, each case study is a comprehensive, single inquiry, studied holistically in its entirety (Denzin & Lincoln, 2008; Stake, 1995). Progressing on these three types of case study design frameworks is the multiple case study (Thomas, 2011). A multiple case study can be conducted by comparing different cases or comparing elements within one case. Furthermore, a multiple case study can be parallel or sequential, occurring concurrently or consecutively (Thomas, 2011). A cross-case analysis focuses on the difference between the cases and the significance of these differences in a collective or multiple case study design (Schwandt, 2001; Yin, 2009).

After some consideration, a collective instrumental design (Stake, 1995) with cross-case analysis (Schwandt, 2001) was chosen as the most suitable to illustrate the similarities and differences across the cases of this case study. This case study explored the practice of providing gender-sensitive care by health professionals working within four adult acute psychiatric inpatient units of a Mental Health Service (Thomas, 2015). This case study further explored the differences between occupational groups, gender, position level, and years of experience to answer the third research question. Normalisation process theory (NPT), a conceptual framework for understanding how new and complex interventions become normalised into clinical practice, was also used to answer research question four. NPT will be explained in more detail below (Table 6 and Figure 4). The key focus was on the nature of the similarities and differences between health professionals and their practices, and what these tell us about the dynamics and implementation experiences that were significant within and across the acute psychiatric inpatient units. This case study provided an in-depth description of the gender-sensitive care model understood by the health professionals within each psychiatric inpatient unit (Yin, 2009). It used these descriptions to illustrate how gender-sensitive care is implemented (Thomas, 2011). The case study is described below in detail.

The Case Study

The Mental Health Service

The Mental Health Service is one of the largest publicly funded providers of mental health services in Australia. This Mental Health Service set the geographical boundaries of this thesis. It provides treatment services in the community, acute inpatient, residential and specialist services, and consultation and education to a population of around one million people and a wide range of health and welfare organisations. The acute psychiatric inpatient units within this mental health service provide specialist treatment for people experiencing an acute mental illness episode who require treatment and care in a hospital inpatient setting. These acute psychiatric inpatient units are divided into aged persons, adult, and child and adolescent. Its acute services are integrated with mainstream health services and utilise a recovery framework. There are approximately 2,000 multidisciplinary staff employed across the Mental Health Service. These staff are comprised of primarily medical, nursing, occupational therapy, clinical psychology, and social work. Consumer and carer consultants are also employed to provide advice and input into improving the quality of care provided to people with a mental illness and their families. There is also an active consumer and carer advisory group.

Gender-sensitive care in acute psychiatric inpatient units

Within the case study design, it is crucial to place the 'case' (gender-sensitive care) in the analytical framework's centre. A case consists of the 'subject' (acute psychiatric inpatient units) and the 'object' (gender-sensitivity and safety guideline) (Thomas, 2011). The Mental Health Service was chosen as it is a local knowledge case due to one of the supervisor's familiarity with the service. However, it could also be described as a key case (Thomas, 2011) as it has a focus on the adoption and implementation of gender-sensitive care.

Acute Psychiatric Inpatient Units

This case study specifically looked at the four adult acute psychiatric inpatient units as the 'case' within the Mental Health Service and the health professionals who work within these units. These will be reported as Unit A, Unit B, Unit C, Unit D (Table 3). The four adult acute psychiatric inpatient units operate a total of 133 beds. Unit B is the largest of the four units, divided into two sub-units (2 x 25 beds) and therefore has two Nurse Unit Managers. Within Unit B, health professionals work across both sub-units, except the clinical nurse managers assigned to a sub-unit. Unit A and Unit C are the second largest, each comprising of one unit with 29 beds. Unit D is the smallest unit, with 25 beds. Units A, C, and D each have one Manager, one Clinical Director, and one Clinical Nurse Manager assigned.

Table 3. Overview of the case study.

Acute Psychiatric Inpatient Unit	Total Beds	Local Gender Sensitivity and Safety Committee
Unit A	29	Yes
Unit B	50 (25+25)	Yes
Unit C	25	No
Unit D	29	No

All units have an Intensive Care Area (ICA) and a Low Dependency Unit (LDU). The ICA is a mixed-gender area where the most acutely ill consumers are placed. This area has both en-suite and shared bathrooms. The LDU is divided into a women's only corridor, with a women's only lounge and mixed-gender corridors. In the LDU all bedrooms have en-suite bathrooms that are lockable. The women's only corridor also has a separate locking system with access via swipe bands provided to consumers allocated a room there. A total of 254 health professionals were working across the four units during the period of data collection. Two-thirds of these were women (n=173), and one-third were men (n=81). The majority of health professionals worked full time (n=153).

The Victorian Government published 'The Gender Sensitivity and Safety (GSS) Guideline, (Department of Health, 2011b), the 'object' of this case study, in 2011 and it continues to inform practice. Mental health service and acute psychiatric inpatient units began implementing the guideline in the same year. The Health Service established a Gender Sensitivity & Safety Steering Committee, this was composed of senior staff members from both clinical and management across the four inpatient units. Units A and B also established local level Gender Sensitivity and Safety Committees. The Gender Sensitivity & Safety Steering Committee of the Mental Health Service supported the implementation of the GSS guideline across all mental health service areas. The focus of the GSS steering committee was to review directions, documents, procedures. The Gender Sensitivity & Safety Steering Committee was disbanded in July 2017 and subsumed into a broader Social Inclusion and Safety Committee.

The boundary and shape

A defining period is a temporary boundary for a case (Thomas, 2011). Thomas (2011) suggests three possible timeframes; retrospective, snapshot, and diachronic. This research is a snapshot case study investigating a case(s) over a specific period (Thomas, 2011). Data were collected from February to December 2017, providing a snapshot of over ten months. A description of the data collection process during this timeframe is provided in the next section.

Case Study Data Collection

Case study methodology requires detailed, in-depth data collection involving multiple sources of information (e.g., accounts, diaries, group interviews, focus groups, questionnaires, observation, image-based methods, documents, etc.), to report a description of the 'case,' i.e., the Mental Health Service (Creswell & Poth, 2016; Thomas, 2015). These methods provide a multi-layered description of the case; however, it is the interpretation of this case rather than the detail itself that is important (Schwandt, 2001). This project collected data from multiple sources, including interviews, observation, and document analysis (Figure 3). These multiple sources provided a detailed understanding of health professionals' experiences of providing care for victim-survivors of sexual violence and how gender-sensitive care is enacted in acute psychiatric inpatient units.

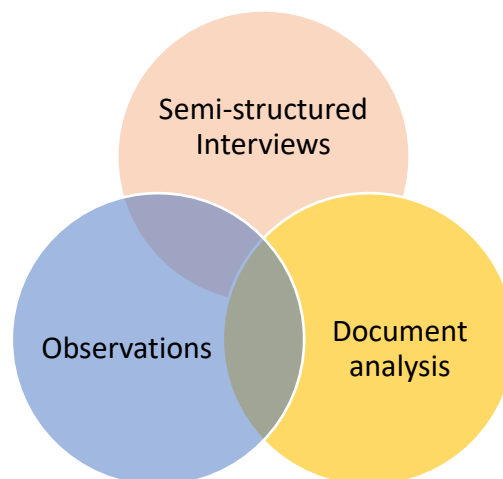


Figure 3. Overview of the data collection strategies.

Interviews were conducted with male and female health professionals from different occupational groups. Consent for this project was granted by the Director of Clinical Governance of the Mental Health Service, who was appointed as a sponsor of the project, and the Area Managers of each acute psychiatric inpatient unit. Observations included "setting, events, and social processes" to fully understand gender-sensitive care (Miles, 1994, p. 30). Documents such as policies, procedures, and guidelines that explain gender-sensitive care were also reviewed. The researcher then analysed the collected data and sought multiple confirmations from the various sources of evidence to triangulate findings and develop a rich

understanding of staff care in psychiatric inpatient settings (Yin, 2009). These data collection methods are described in detail below.

Interviews

Interviews are described as verbal interchanges, where the interviewer attempts to elicit information from the participant, which permits multiple viewpoints of the case (Kvale, 1996; Stake, 1995). Semi-structured interviews follow a set of predetermined questions but also allow for flexibility and discussion led by the participant. They rely on the interaction and exchange between the interviewer and the participant. The researcher and supervisors weighed up the benefits of semi-structured interviews over focus groups. Focus groups elicit multiple perspectives through the shared interactions of each participant's experiences and perspectives within a group (Kitzinger, 1994). However, semi-structured interviews were deemed more appropriate given the sensitive nature of the subject matter, possible personal experiences of gender-based violence, the hierarchy of professions within mental health settings, and a lower likelihood of breaching consumer confidentiality.

Forty semi-structured interviews were conducted with health professionals and management. Health professionals were able to be interviewed at their place of employment, on-campus at the University of Melbourne, or another place convenient to the participant. The option of a telephone interview was also offered. Thirty-six interviews were conducted face-to-face across the four acute psychiatric inpatient units. Four interviews were conducted via telephone. No interviews were conducted on-campus. Interviews ranged from 12 to 90 minutes (an average of 40 minutes). The semi-structured interview schedule covered questions on the type of care provided to women survivors of sexual violence, how care is implemented, and how it is supported (Table 4 below and Appendix 3). The demographic profile of each participant was also recorded (Appendix 4). The interviews were piloted with a convenience sample of five health professionals from the Department of General Practice at the University of Melbourne to ensure that questions were clear and comprehensive. Maximum variation sampling was used for all participant categories to balance gender and profession type ratios.

Table 4. Interview schedule.

Semi-Structured Interview Questions

1. Can you tell me about your profession and role within this AMHS/unit?
 2. Can you tell me about the care that you (is) provide(d) for women in the inpatient unit who have previously experienced unwanted sexual contact?
 - How is it implemented? E.g. policies, environmentally etc
 - How do you support this care? (Managers only)
 3. How supported do you feel to deliver this care?
 - by the system, organisation, your supervisor, your manager?
 4. What are the support systems that are provided for staff to provide this care? (committee/working group, supervision)
 5. What kind of supports do you draw on to deliver this care?
 - any differences in care for voluntary and involuntary female patients? Can you tell me what these are?
 - any training you have received that assists you to practice gender sensitive care e.g. type and length of training?
 6. Can you tell me your understanding of gender-sensitive care?
 - what do you think gender-sensitive care is? How would you describe gender-sensitive care?
 - How is it implemented on the unit? What does that look like on the ward? Can you give examples?
 - (if they have given examples, you could ask “what is the difference to not providing gender-sensitive care?”) if they tell you very little, you could drill down into it and get them to contemplate what the differences might be (?) is there any difference/ comparison to regular care?
 7. Could you describe barriers, challenges and enablers of (in supporting this) implementing gender-sensitive care?
 8. Is there anything you think you would need that would increase your ability to work with women who have experienced unwanted sexual contact?
 9. How do you think the women consumers experience/ feel about the care they receive?
-

Observations

Unstructured observations included absorbing information and taking notes on the environment's details, actions, and nuances (Gillham, 2005). These were completed throughout the data collection process, with the researcher operating as a 'partial observer'. A partial observer is predominately engaged in observation but can also interact with the people and engage in some aspects of the environment (Baker, 2006). The researcher did not approach, identify, or report on any consumer during observations. Observations were recorded in the researcher's detailed field notes using the four techniques described by (Berg, 2004) of jotting, detailed descriptions, analytic notes, and subjective reflections. These are explored in more detail in chapters 6 and 7.

Unstructured observations were conducted during staff meetings, handover meetings, in the nurses' station, on the ward, and office space. The interactions observed were between staff members, staff and management, and staff and the consumer. Observations were completed at the Mental Health Services Gender Sensitive and Safety Steering Committee meetings on three occasions and the local Gender Sensitive and Safety Committee meetings for Unit A and Unit B on two occasions. Unit C and Unit D did not have Gender Sensitive and Safety committees. These unstructured observations were conducted before and during the interview process enabling the researcher to experience the daily work patterns and interactions, inform the organisational context of gender-sensitive care, and set the scene for interviews.

Documents

Policies, procedures, guidelines, flow charts, referral pathways, frameworks, forms, and other documents that enact gender-sensitive care were reviewed to understand the implementation process across the Mental Health Service and each acute psychiatric inpatient unit. Documents are available across various levels. These include government and service level e.g., The Gender Sensitivity and Safety Guideline; mental health organisation e.g., organisational health policies, mental health guidelines and procedures; and unit-level e.g., allocation and decision making to allocate women to the women's corridors. New documents are frequently developed; therefore, it was important to consult with each unit's key informants throughout the fieldwork. Document analysis provided data on the context in which the research is being conducted, and verified other sources (Bowen, 2009). These are explored in more detail in chapter 5.

Field Notes

The field observation was continuous throughout the data collection period. The field notes were used to record details on both interviews and casual conversations and observations about the physical and social environment. Field notes were recorded in handwritten journals on-site to prevent loss of detail and then word processed as soon as possible after the event (Bazeley, 2013). For all entries, the location and date were recorded. Interviews were conducted at acute psychiatric inpatient units, at the mental health service's head office, and over the phone. These sites provided an understanding of the physical and geographical context. A description of the recruitment process and the study participants is detailed in the next section.

Recruitment

The researcher partnered with the Mental Health Service to undertake this case study. A Letter of Support was provided by the Director of Clinical Governance of the Health Service. Following this, a strong relationship was developed with some key informants across the Mental Health Service and within each acute psychiatric inpatient unit.

The first approach to management recruitment was presenting the project at the acute inpatient managers' meeting in September 2016. The second recruitment strategy was an invitation letter to the managers of the four acute psychiatric inpatient units (Appendix 5). This invitation letter requested the managers' participation and sought the managers' consent to approach health professionals to participate in this project. A project brief outlining the project, manager requirements, and benefits were also provided (Appendix 6). Upon receiving consent from the managers via email, the researcher approached the health professionals through unit meetings. The Unit Manager of each unit provided access to these meetings.

Health professionals were recruited following a PowerPoint presentation of the project at each unit staff meeting or handover meetings. These presentations were completed 2-3 times at each unit to inform as many health professionals on different shifts as possible. The presentation invited health professionals to participate in an interview at a time and date convenient for them. An expression of interest (EOI) (Appendix 7) was also distributed to all staff following

the project presentations. Completed EOIs were collected by the researcher at the end of the meetings. Advertisements with the researcher's contact details (Appendix 8) were also provided to Unit Manager's to be posted on each unit's staff noticeboards. The researcher was in situ at each unit for at least one day per week to promote the project to staff who were not present at meetings, answer questions, and conduct impromptu interviews as staff became available. Managers varied across each site in their approach and encouragement for health professionals to participate. Key informants, such as active members of the Gender Sensitive and Safety Steering Committees, were invited directly via email to participate in an interview.

The researcher followed up with all staff who expressed interest in organizing an interview time and location convenient for the individual. Not all of those who expressed an interest were able to be contacted. Many of the interviews were ad hoc; the participants were available on the day the researcher was present in the unit and were happy to be interviewed on-site. A Plain Language Statement (Appendix 9) was provided before the interview, and the participant had time to read and sign the Consent Form before commencing (Appendix 10).

Reflections on Recruitment Strategy

Gaining access at an organisational level can often be a challenge (Wolff, 2004). The researcher was permitted to observe the service level Gender Sensitivity and Safety Steering Committee, which enabled her to form relationships with key informants, including managers at each acute unit and key stakeholders. The importance of accommodating key informants (usually managers) in each unit became apparent throughout the data collection process. These key informants were gatekeepers to accessing potential participants. They had the responsibility of replying to the researcher's emails, arranging a time for her to present at a staff meeting, finding a space to remain in situ while data collecting, encouraging staff to participate in interviews, participating themselves, and connecting the researcher with other key informants e.g., local Gender Sensitivity and Safety committee member or a staff person who could send the required documents. Each gatekeeper's responsiveness varied, with some replying to the first email in a few days, while others required multiple emails and phone calls over months to glean a response.

Maximum variation sampling (Schreier, 2018) was used for all participant categories to balance gender and profession type ratios. However, nurses and allied health staff appeared to be more willing to participate in interviews than medical staff (consultants, registrars, and doctors). Doctors were reportedly reluctant to participate in interviews due to their short internships of approximately six weeks within the mental health setting. At a gender analysis, men mainly comprise the medical staff cohort, and women mainly comprise nursing and allied health staff. Recruitment was challenging due to the busy and unpredictable environment of an acute psychiatric inpatient unit. For example, a 'code grey' was called in response to a consumer displaying aggressive behaviour in Unit D, which resulted in recruitment being halted for the day. Health professionals' reasons for non-participation were varied. These included staff reporting to be too busy, registrars' recent rotation to the unit, perception that they did not have enough information on gender-sensitive care, or lacked experience working with women who are victim-survivors of sexual violence. One interview was ceased after 5 minutes as the male nurse was requested to return to the unit to assist a medical staff member with a consumer. Overall, the key informants' support and access to each unit for prolonged periods were fundamental to this case study's data collection.

Ethical Considerations

This research's ethical considerations were to balance the contribution this research would make towards the care provided in acute psychiatric units for women victim-survivors of sexual violence, while also protecting the participants. Given that the participants were employees of the Mental Health Service, there was potential for perceived pressure to participate. The researcher was cognisant of balancing the manager's support with the staff's vulnerability and considering the hierarchy in the mental health setting. At each recruitment stage, the staff was informed that all information provided would be confidential and de-identified, their participation was voluntary, consent could be withdrawn at any time, and non-participation would not lead to any adverse consequences to their work relationships. Managers were not informed about which staff members did or did not participate. However, some managers did encourage some staff to participate in the interviews. Information was not provided to managers at the end of data collection about who did and did not participate. Staff arranged their preferred location and time directly with the researcher, rather than through their manager.

Informed consent was sought from each participant before commencing the interviews. Participants were also reminded verbally that they could withdraw at any time.

There was the potential for psychological and social risks associated with participation in this research. Although the research focused on health professionals' experience of delivering gender-sensitive care, not about their personal experiences, it was essential to keep in mind that many health professionals are also survivors of violence (McLindon, Humphreys, & Hegarty, 2018). The researcher – who is a practising Clinical Psychologist - ensured that a sensitive and empathetic approach was utilised and that participants understood that the interview could be stopped at any time. A resource card (Appendix 11) was offered to each participant outlining relevant resources that could be accessed if they experienced distress. Participants were also encouraged to utilise their clinical supervision and reflective practice available through the Mental Health Service.

All interviews were audio-recorded and uploaded to a secure server using file numbers instead of the participant's name. All transcripts and audio recordings were de-identified, and pseudonyms were used in all reporting. The raw data were also safeguarded in secure online storage space. The transcripts were fully transcribed verbatim by a professional transcription service with appropriate privacy and confidentiality policies. Feedback on their transcripts was offered to all participants; two participants provided comments and corrections on their transcripts. Other than this, only the researcher and supervisors had access to the transcripts following transcription completion.

This project received ethical clearance from the Health Service first and then the University of Melbourne's Human Ethics Advisory Group (Ethics ID HREC/16/MH/429) and complied with their policy and procedures for ethical conduct in human research.

Data analysis, with specific detail on reflexive thematic analysis and Normalization Process Theory, is described in the next section. The credibility, dependability, and positionality used to support the rigour of the findings are also explained.

Case Study Data Analysis

In this section, the methods used to analyse the case study data are described. Summative content analysis (Hsieh & Shannon, 2005) was used to analyse the content of the policies, procedures, and guidelines of the health service and guidelines of the four acute psychiatric inpatient units. The qualitative data analysis software NVivo 11 (QSR International, 2015) was used to organize and manage the qualitative data, including demographic profiles, documents, observation and field notes, and the interview transcripts. Raw data files were initially created outside NVivo 11 and then imported into the software program. This storage preserved and backed up the original data files. A description of the process of using reflexive thematic analysis is provided in the next section. Table 5 provides a summary map of the analysis process of the case studies.

Table 5. Summary of steps taken for case analysis for phase two.

Steps of cross-case analysis	Research Question 3	Research Question 4
Step 1: Reiterate research questions	What are staff experiences of the care provided to women with a history of mental illness and sexual violence in psychiatric inpatient units?	How is gender-sensitive care enacted in psychiatric inpatient units?
Step 2: Create a synopsis for each case	Include case description, context information, key data sources. Highlight similarities and differences amongst other cases.	
Step 3: Determine the utility of case-specifics to answer the research questions	Within-case and cross-case analysis of professions, gender and levels of seniority.	Within-case and cross-case analysis of each inpatient unit.
Step 4: Choose the analytical process	Reflexive thematic analysis	NPT
Step 5: Generate themes and describe findings accordingly	Across cases: merge findings of each question.	

Reflexive Thematic Analysis

Reflexive thematic analysis was used for the interview transcripts and observation data (Braun & Clarke, 2019, 2020). Reflexive thematic analysis is suited to social constructivist feminist theory as it supports the critical exploration of how the participant's construct meaning of the care provided in acute psychiatric inpatient units for victim-survivors (Braun & Clarke, 2013). Immersion in the data was completed through repeated listening to the transcripts' audio recordings and readings to get a 'sense' of the tone and other idiosyncratic characteristics of the interview that may not be apparent in the transcript alone. Thematic analysis was used inductively to generate themes through identifying, coding, and categorising patterns in the data (Braun & Clarke, 2006). As part of the reflexive process, a coding framework was developed collaboratively by the researcher and supervisors. Co-coding was completed with one of the supervisors, and fresh insights were made through the supervisors' involvement, reflecting on the codes and possible categories (Braun & Clarke, 2019). Co-coding also helped distance the novice qualitative researcher on occasion from the data to avoid the 'coding trap': becoming too close to the data through the overuse of coding (Gilbert, 2002).

Descriptive coding was used to label sections of the data with codes that summarised the passage. These codes were refined by interpreting and grouping them into categories and finally into overarching themes (Braun & Clarke, 2019). The coding process utilised was cyclical, requiring the researcher to move between the data, description and analysis (Bazeley, 2013). Memos were also used to record ideas, reflections, key points, and links to other codes or concepts (Bazeley, 2013). Memos were useful to refine and clarify relationships between code categories and move from descriptive to conceptual analysis (Bazeley, 2013; Miles & Huberman, 1994). The researcher and supervisors worked collaboratively to discuss the themes, resolve any differences, and ensure consensus (Braun & Clarke, 2012).

Normalisation Process Theory

Normalisation Process Theory (NPT) (May & Finch, 2009; May et al., 2007) was also used as a framework to analyse the data of the final research question; how gender-sensitive care is enacted. NPT provides a theoretical lens and conceptual framework to understand how new and complex interventions become normalised into clinical practice (Murray et al., 2010). NPT can be used to design interventions or organise and evaluate interventions as part of the

implementation process (Pope et al., 2000). It accounts for the social aspects of implementation essential in a complex health system (Myall et al., 2020). NPT's proposes four primary constructs; Coherence-how participants make sense of the model of care, Cognitive Participation-commitment and engagement of the model of care by participants, Collective Action-organising and enacting the model of care, and Reflexive Monitoring- how participants appraise the model of care after it is in use (Murray et al., 2010). Each construct contains four components outlined below (Table 6) (Murray et al., 2010).

Table 6. NPT constructs and components.

NPT Construct	Construct Components
1. Coherence (sense-making work)	1.1 Differentiation 1.2 Communal specification 1.3 Individual specification 1.4 Internalization
2. Cognitive Participation (relational work)	2.1 Initiation 2.2 Enrolment 2.3 Legitimation 2.4 Activation
3. Collective Action (operational work)	1.1 Interactional Workability 1.2 Relational Integration 1.3 Skill set Workability 1.4 Contextual Integration
4. Reflexive Monitoring (appraisal work)	4.1 Systematization 4.2 Communal appraisal 4.3 Individual appraisal 4.4 Reconfiguration

NPT posits that implementation is operationalised in social contexts (including work settings) through these four primary constructs. That is, practices are routinely embedded as a result of

people working, individually and collectively, to implement them (May & Finch, 2009). These four constructs are affected by the organizing and immediate factors of these construct components (Table 6) that either promote or inhibit the normalizing of a practice in its social context (May & Finch, 2009). This normalizing of a practice requires continuous investment by those within the social context to sustain it (May & Finch, 2009). These dynamic and contingent processes are outlined below in Figure 4.

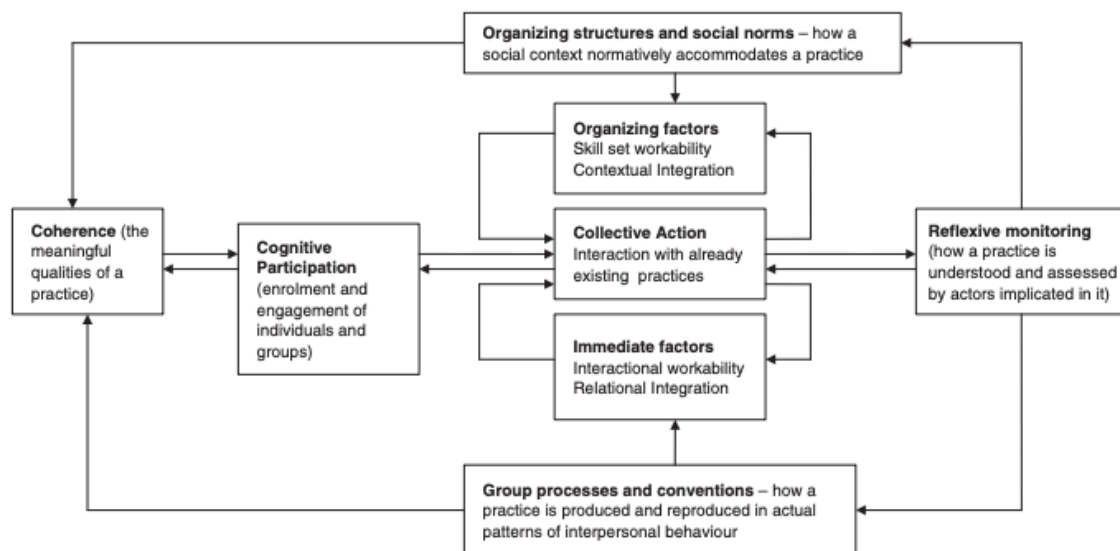


Figure 4. Model of the components of Normalization Process Theory.

(May & Finch, 2009)

The reflexive thematic and content analysis provided the method for an in-depth examination of the data for each acute psychiatric inpatient unit or 'case' (Braun & Clarke, 2006). The themes developed from this data then were mapped onto NPT's corresponding four primary constructs. Each case's themes were then analysed further to investigate any difference between the cases (Schwandt, 2001). The document review summative content analysis informed the results and key findings and implications of the thesis. The next section outlines the rigour applied to the research findings.

The Rigour of Research Findings

This section outlines how rigour was applied to the findings made in this case study. Within reflexive thematic analysis, meaning and knowledge are understood as situated and contextual, with the researchers subjectivity considered a resource for knowledge production rather than a bias (Braun & Clarke, 2020). However, given the inclusion of several methods of qualitative data collection and analysis, the application of methodological rigour was useful for the researcher. Several strategies were used based on the criteria proposed by (Lincoln & Guba, 1985), including credibility, dependability, positionality

Credibility was achieved through prolonged engagement and continuous observations at the four acute psychiatric inpatients units, providing sufficient time to gain a comprehensive understanding of the degree of gender-sensitive care as applied in each unit (Altheide & Johnson, 2011). Credibility was further supported by triangulating the multiple sources of evidence: interviews; observations; and documents. These multiple sources confirm findings and discount rival explanations and provide other ways of experiencing the case (Stake, 1995) that is gender-sensitive care in acute psychiatric inpatient units.

Dependability was ensured through an audit trail of comprehensive field notes relating to the data's contextual background and the methodological decisions made (Ryan-Nicholls & Will, 2009). Maintaining a reflexive journal throughout the research period also provided further understanding of how the research was carried out based on the researcher's self-awareness as part of the research (Van Maanen, 2010).

Positioning and assumptions are a part of qualitative research supported by reflexive practice (Braun & Clarke, 2019). To be reflexive is to have an awareness of personal, social, and cultural contexts in which we live and work and understand how these can impact the way we interpret our world (Etherington, 2004). Reflexivity integrates well with the researcher's professional background as a Registered Clinical Psychologist who has previous experience working with consumers with a history of mental illness, trauma, violence, and abuse. It was essential to identify and question assumptions held by the researcher and how they may have influenced the collection, selection, and interpretation of data (Braun & Clarke, 2019; Finlay

& Gough, 2008). Academic and clinical supervision was an essential aspect of self-reflection, understanding the positionality and developing reflexivity throughout this research.

3.6 Chapter Summary

In this chapter, the theory underpinning this research, and the methodology used to investigate this thesis's four research questions have been described. The rationale for social constructivist feminist theory and methodology supporting the research aims have been provided. The two phases of this qualitative design are described in detail. The primary ethical considerations of this research have also been outlined. The strategies used to add rigour and verify the findings, positionality, and bias and how this impacted the research findings were also defined. The next chapter is a peer-reviewed publication that answers research questions one and two. It discusses the current state of literature through a scoping literature review on health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient units.

CHAPTER 4: TRAUMA-INFORMED CARE IN ACUTE PSYCHIATRIC INPATIENT SETTINGS

4.1 Chapter Overview

This chapter presents the first of the three published articles of this thesis. This paper is a scoping literature review that answers research questions one and two: *What is the current state of knowledge on health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings?* and *What is health professionals' awareness of the gendered impacts of trauma, and how does this impact the care they provide?* Five themes were developed from the analysis of the studies that met inclusion criteria. The discussion explores the implications of the findings for acute mental health care and health professionals. The paper was peer-reviewed and published in *Trauma, Violence, and Abuse* in February 2020. The chapter concludes with a summary of the key findings related to this thesis's first two research questions.

4.2 Published Scoping Literature Review Manuscript (paper 1).

Health Professionals' Experiences of Providing Trauma-Informed Care in Acute Psychiatric Inpatient Settings: A Scoping Review

Carol O'Dwyer¹ , Laura Tarzia^{1,2} , Sabin Fernbacher³, and Kelsey Hegarty^{1,2}

Abstract

Background: Trauma-informed care is increasingly recognized as the ideal model of care for acute psychiatric inpatient units; however, it continues to be a challenge to implement. The aims of this review are (1) to synthesize the research exploring health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings and (2) to examine these experiences through a gender lens, particularly relating to gender-based violence. This research will provide additional insights to facilitate implementation of trauma-informed care in acute psychiatric inpatient care. **Method:** A comprehensive scoping review methodology was adopted. English-language, peer-reviewed articles published between January 1998 and March 2018 were identified from seven databases. Inclusion criteria included a qualitative or mixed-method study design. **Results:** Eight full-text articles were found. This review highlights the importance for health professionals to have a reflective environment and a multilayered level of collaboration to adopt trauma-informed care. However, negative attitudes toward female consumers and inconsistent implementation strategies continue to hold back implementation of trauma-informed care in acute psychiatric inpatient units. Overall, limited consideration for gendered issues and gender-based violence in the implementation of trauma-informed care in acute psychiatric inpatient settings was found. **Conclusion and Implications:** There is a lack of research on health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient units, with even less research considering gender-based violence. We argue that more research is needed to gain a better understanding of the experience of health professionals from acute psychiatric inpatient settings to inform future implementation of trauma-informed care.

Keywords

trauma-informed care, acute psychiatric inpatient unit, health professionals, mental health, gender, trauma

Trauma-informed care is a framework for human service systems. Over the past two decades, it has evolved and gained increasing traction in various fields and disciplines including drug and alcohol, psychology, psychiatry, education, public health, criminal justice, and social work (Champine et al., 2018; Donisch et al., 2016; Hanson & Lang, 2016). Trauma-informed care is based on an understanding of the impact of trauma on people's lives, their service needs, and vulnerabilities (Harris & Fallot, 2001). It includes the principles of safety, trustworthiness and transparency, peer support and mutual self-help, collaboration and mutuality, and empowerment, voice, and choice (Elliott et al., 2005; Fallot & Harris, 2009). It also takes cultural, historical, and gender issues into account (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014). Trauma-informed care framework acknowledges the pervasiveness, directionality, and impact of trauma experienced by people with mental health disorders (Barton et al., 2009; Bateman et al., 2013; Cusack et al.,

2003). It informs organizational and systems models of care globally and recognizes the responsibility of mental health services to be responsive to trauma at a systemic level (Heckman et al., 2005; Jennings, 2008; Markoff et al., 2005). Trauma-informed care offers the potential to improve both consumers and health professionals' experiences (Sweeney et al., 2018).

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Gender is an important consideration in responding to mental health issues and trauma. One in the 10 women with severe mental illness have recently experienced sexual violence (Khalifeh et al., 2016), and between 30% and 60% of women accessing acute psychiatric inpatient settings have experienced intimate partner, domestic/family, or sexual violence in their lifetime (Oram et al., 2013). Sexual violence (between 5% and 45%) is also prevalent during an admission to a psychiatric inpatient unit (Clarke, 2008; Frueh et al., 2005; Grubaugh et al., 2007). Research supports the value of trauma-informed approaches for women in psychiatric settings (Sweeney et al., 2016). It has been shown to improve mental health outcomes, provide safer environments for consumers, and decrease psychiatric and trauma symptoms and substance use (Bills & Bloom, 1998; Cocozza et al., 2005; Morrissey et al., 2005). Yet it is unclear from extant research to what extent gender is addressed in mental health settings, and what level of awareness is present about the gendered impacts of trauma.

Despite the increased recognition in the research context of the relationship between trauma, violence and mental illness, in practice, the biomedical model continues to be the dominant model of care in acute psychiatric inpatient settings (Wilson et al., 2017). The biomedical model treats mental illness as a medical problem, focusing on biological symptoms rather than acknowledging the role of psychosocial factors (Astbury, 2006). This has been identified as a hindrance to disclosures of violence and a promoter of ineffective responses to trauma (Trevillion, Hughes, et al., 2014). In severe cases, it can even further retraumatize consumers, particularly if health professionals are dismissive of their trauma experience (Ahrens, 2006). There is overwhelming research showing the benefits of trauma-informed care and the limitations of the biomedical model (Sweeney et al., 2018). It is important to gain further understanding of health professionals' attempts to implement trauma-informed care in psychiatric inpatient settings, and what barriers might prevent them from succeeding.

Trauma-informed care is a beneficial yet complex model of care for health professionals to implement (Sweeney et al., 2018). It improves the working environments, increases job satisfaction, and reduces work stress through improved relationships between consumers and health professional (Sweeney et al., 2018). However, where trauma-informed care has been encouraged, studies suggest that health professionals have struggled to translate the values and principles into their day-to-day practice (Muskett, 2014; Wilson et al., 2017). Traditionally, clinicians working in acute mental health settings have perceived embedding recovery, choice, and control as "too risky" (Harris & Fallot, 2001). This has been attributed to a lack of alternative interventions and low practitioner skill levels, as well as a limited understanding of the pervasive impact of trauma (Chandler, 2008). These limitations result in a preferencing of safety and containment of consumers over providing trauma-informed therapeutic interventions (Browne et al., 2014; Chandler, 2008; Cleary et al., 2014). Most research on trauma-informed care to date has focused on the challenges to

implementation with little focus on the perceptions of health professionals attempting to implement this model of care.

To date, the qualitative literature investigating how health professionals perceive and experience the delivery of trauma-informed care in acute psychiatric inpatient settings has not been synthesized or explored. Most research on trauma-informed care has focused on identifying trauma-informed practices and activities such as reducing restraint and seclusion. Other research in this area has focused on examining the challenges to implementing trauma-informed care in acute mental health settings and mapping these findings against the principles of trauma-informed care (Muskett, 2014; Wilson et al., 2017). This scoping review builds on previous literature reviews of trauma-informed care in mental health settings (Muskett, 2014; Wilson et al., 2017). The aim of this review is to identify and synthesize the existing research (either qualitative or mixed methods) that explores health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings. Its other main aim is to explore these experiences through a gender lens, relating to gender-based violence, and how this impacts on care delivery. This review will aid in bridging the translational gap to routine implementation of trauma-informed mental health care (Tansella & Thornicroft, 2009; Wensing et al., 2006).

Method

A five-stage scoping review methodology was used (Arksey & O'Malley, 2005; Levac et al., 2010). This involved identifying the research question, identifying relevant studies, study selection, charting the data and collating, and summarizing and reporting the results. This was an iterative process that involved flexibly moving between each stage and continuously gathering contemporary literature to ensure all appropriate articles were included.

Identifying the Research Questions

Our first research question was "What are health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings?" Our second research question was "What are health professionals' awareness of the gendered impacts of trauma in acute psychiatric inpatient settings and how does this impact on the care they provide?"

Identifying Relevant Studies

A three-step search strategy was utilized (The Joanna Briggs Institute [JBI], 2015). The searches were filtered by English language only and were conducted in March 2018. A time frame of 20 years (1998–2018) was applied to the search as preliminary reviews of the literature on trauma-informed care showed minimal activity prior to 2000. The initial search involved an analysis of the words contained in the title and abstract of retrieved papers and of the index terms used to describe the articles across MEDLINE and CINAHL. The

Table 1. Electronic Search Terms.

Key Word	Synonyms and Boolean Phrases
Trauma-informed care	"trauma-informed care" OR "sensitive care" OR "gender mental health care" OR "gender sensitive mental health care" OR "women centered mental healthcare" OR "women friendly environment" OR "trauma violence informed care" OR "gender sensitivity" OR "gender-sensitive" OR "gender sensitive care" or "feminist care"
Acute psychiatric inpatient unit	"acute psychiatric inpatient ward*" OR "acute psychiatric unit*" OR "mental health service*" OR "acute inpatient" OR "inpatient" OR "acute psychiatric inpatient ward" OR "acute psychiatric unit"
Experiences	Perception* OR experience* OR attitude

second search employed all key words and index terms across PsycINFO, Embase, PsychARTICLES, PubMed, and Cochrane library. Finally, the reference list of all identified reports and articles were searched for additional studies. Each key word search topic was searched independently and then combined with each other (see Table 1).

Titles and abstracts of the articles were reviewed manually to determine whether they met the inclusion criteria. Snowballing, contacting authors and review of reference lists of relevant articles, was then completed. The systematic and scoping literature reviews were then reviewed to identify 11 further relevant articles. Only empirical studies reporting primary data were included.

Inclusion and Exclusion Criteria

Any qualitative or mixed-method empirical studies published in peer-reviewed scientific journals where participants included staff working in acute psychiatric inpatient settings were included in this review. Only research published between January 1998 and March 2018 was included since there is little trauma-informed care literature prior to this time. Studies focusing exclusively on nonacute mental health settings (e.g., community, rehabilitation, and forensic) were excluded, as were studies where only consumers were involved. This review focused specifically on psychiatric inpatient units, due to their unique role, setting, and circumstances. Inpatient units in Victoria provide short-term admission (average length 12 days) for patients with high levels of acuity and distress. The context of high levels of acuity and care differs greatly in scope and opportunity to other settings such as community mental health. Equally, the type of setting with bedrooms, shared facilities, the gender-mix nature of inpatient units, and the associated prevalence of gender-based violence set them apart from other mental health settings. In studies where there were both staff and consumer participants, the study had to analyze and present the staff

experiences separately to be included. Articles were also excluded if not written in English.

All four authors were involved in reviewing the scoping review question, inclusion and exclusion criteria. Once agreed upon, two authors (CO'D & LT) concurrently and independently applied the inclusion and exclusion criteria to all citations and identified those meeting the research objective. In the case of uncertainty, the full article was obtained and reviewed until consensus was agreed. After the initial selection of applicable citations, full texts of all selected citations were obtained and then the full texts were independently reviewed to finalize the list of those included. In the case of disagreement, a third reviewer (KH) assessed the article in question.

Study Selection

Electronic database and hand searches yielded 1,046 studies after duplicates were removed (see Figure 1). One hundred eight articles were excluded as they did not meet inclusion criteria after titles and abstracts were reviewed. Thirty-eight full-text articles were reviewed; 32 of these were excluded as they did not meet inclusion criteria. Two articles were included after reviewing the references. Information from the identified studies were extracted into a custom-designed template and charted. The data charting form consisted of the following characteristics: author, year, country, aim of the study, study population and size, methods/study design, and main findings.

Data Analysis

Qualitative conventional content analysis (Hsieh & Shannon, 2005) was used to analyze the eight studies included in the review. This is a useful approach when there is limited research literature available on a phenomenon (Hsieh & Shannon, 2005). Underpinning this approach was a feminist theoretical framework that acknowledged the gendered issues associated with trauma experienced by consumers who access acute psychiatric inpatient units. Transcripts were coded initially by the first author using an inductive approach. Codes were identified and then sorted into categories. The coding was focused on two main areas of interest to answer the research question: health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient units and associated gender-based violence issues. All authors (CO'D, LT, SF & KH) contributed to the development of themes in an iterative fashion and codeveloped the data chart form. The software package, NVivo Version 11 (QSR International, 2015), was used to manage the data.

Assessing quality. Quality was assessed using the Critical Appraisal Skills Programme (CASP, 2018) Checklist for assessing qualitative research evidence. The CASP Checklist provided a systematic process of assessing the methodological quality of the studies included in the scoping review (JBI, 2015). This was particularly useful to strengthen the methodology given the limited studies included in this review. Nine of the 10 questions

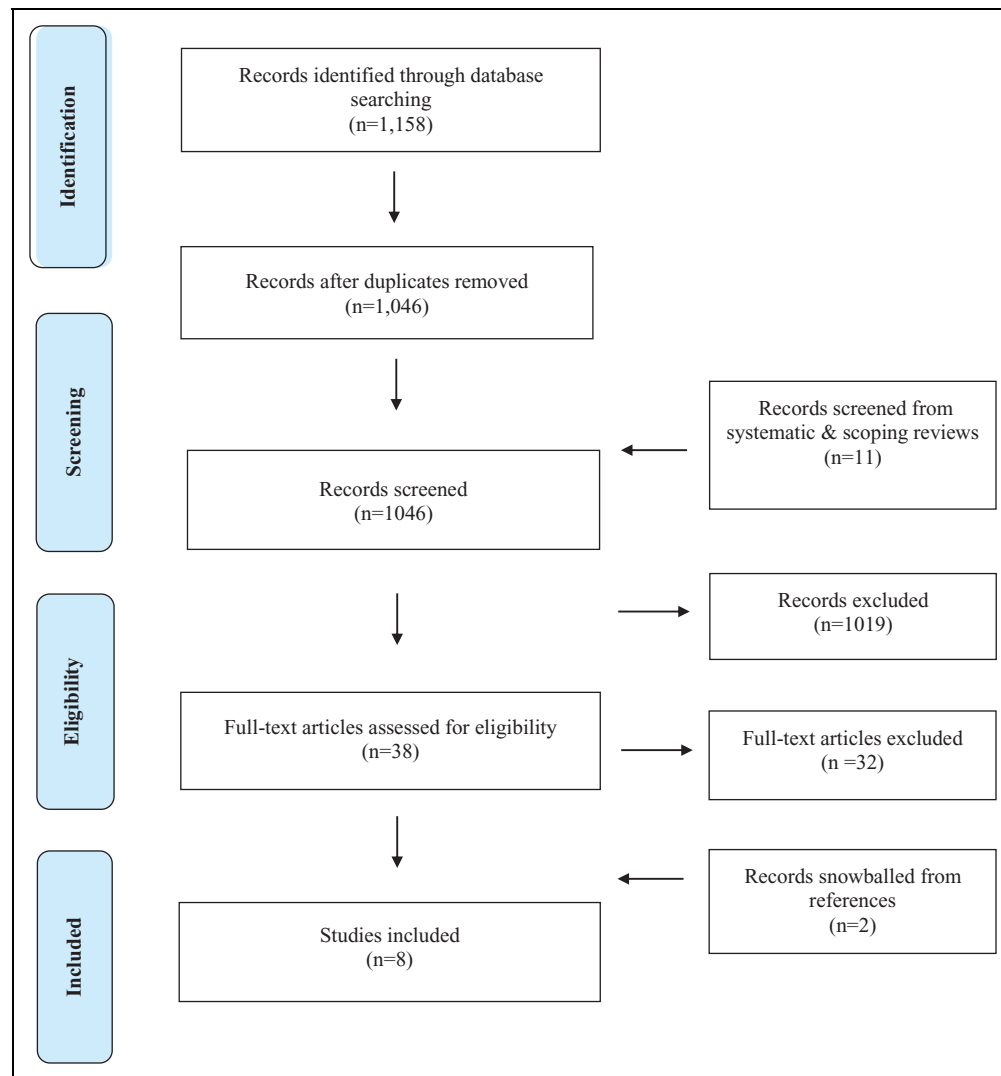


Figure 1. PRISMA flow diagram of completed search.

of the CASP Checklist are rated on a scale of *yes* (allocated 2 points), *can't tell* (allocated 1 point), or *no* (allocated 0 point), giving a maximum rating of 18. The 10th question requires a qualitative response. High quality was defined as a score of 13 or more, with medium-quality papers scoring 7–12 and low-quality papers scoring 6 or less (CASP, 2018).

Results

Descriptive Summary

There were eight studies included in this review. Three studies utilized a mixed-methods design (Isobel, 2015; Isobel & Edwards, 2017; Leavey et al., 2006), one used a case study design (Chandler, 2012), one used narrative design (Chandler, 2008), and one used focus groups (Krumm et al., 2006). Two studies used qualitative methods only (Copperman & Knowles, 2006; Kanerva et al., 2016). Information extracted from the studies is summarized in Table 2.

Two studies were conducted in Australia (Isobel, 2015; Isobel & Edwards, 2017), two in the United States of America (Chandler, 2008, 2012), two in the United Kingdom (Copperman & Knowles, 2006; Leavey et al., 2006), one in Finland (Kanerva et al., 2016), and one in Germany (Krumm et al., 2006). Three papers included both health professional and consumer perspectives (Copperman & Knowles, 2006; Isobel, 2015; Leavey et al., 2006), which were reported separately. Only health professionals' perspectives were included in this review. Nursing staff constituted the majority of health professionals in the studies included in this review. The studies also included service managers and directors, middle managers, and clinical supervisors who were principally from a nursing background. In addition, security staff, mental health counselors, occupational therapists, administration, social workers, and psychiatrists were also included in these studies. Only three studies identified the gender of participants, approximately 75% of whom were women (Chandler, 2012; Kanerva et al., 2016; Krumm et al., 2006).

Table 2. Summary of Articles Included in Review.

Author/Year/ Location	Research Aim	Study Participants and Methods	Main Findings	CASP Score
Chandler (2012), United States	Describe the structure that empowered staff of a locked community hospital unit to reduce the use of restraints and seclusion to create a culture of safety.	N = 11 health professionals (nurses, mental health counselors, occupational therapist, occupational therapist aide, and administrator) Single case study (interviews, document analysis, and observations)	Staff were provided opportunities to develop knowledge, skills, and key relationships with leadership. These staff then provided consumers with information, support, and resources to facilitate skill development and therapeutic relationships.	18
Chandler (2008) United States	Describe and compare the experiences of staff in reducing patient symptoms in a traditional inpatient model and a trauma-informed treatment model and describe how staff created a trauma-informed culture of safety.	N = 10 health professionals (nurses, counselors, and administrators) Narrative design (content analysis)	Overarching theme of transferring control from staff to consumer. This was achieved via consultation, education, and role modeling from a trauma expert, development of collaborative staff–consumer relationships, implementing flexible safety measures, and individualized evidence-based educational resources for staff and consumers.	18
Copperman and Knowles (2006), UK	Explore the progress of the women's mental health guideline into psychiatric services and strategic development of mental health care for women policy into practice.	N = 11 staff (service managers, clinical supervisor, security staff, practitioners, survivors/ users, and activists) Qualitative (interviews)	Increase in women-only wards in acute inpatient settings, women's crisis houses, and awareness of safety issues generally. However, only minimum requirements are being met in many settings: There is broad variability in terms of physical structures and facilities and staffing options offered; many women are admitted to mixed sex wards and organizations provide varied practice direction. Women's safety remains a concern and cultural change remains an ongoing challenge.	9
Isobel and Edwards (2017), Australia	Describe the process and effects on the nursing workforce of implementing a trauma-informed model of care in an acute mental health inpatient unit using a practice development process.	N = 5 nurses Mixed-methods case study design (interviews, survey evaluations)	Questioned whether trauma-informed care provided a significant change to their current practice for consumers. Hopeful but ambivalent about change to individualized and flexible care due to envisaged ongoing issues within the team. Change needs to be slow, positively framed with clarity, consistency, and clear role expectations. Defining the model of care, using a practice development approach and informing staff about trauma-informed care were important for implementation.	13
Isobel (2015), Australia	Review all nurse-initiated rules relevant to trauma-informed care on the unit.	N = 17 nursing staff Mixed methods (questionnaires with open-ended questions)	Frustrations with inconsistencies in rule use and criticized colleagues who used rules as excuses to avoid engagement, decision-making, or clinical judgment. Difficulties implementing rules that are rigid, restrictive or lacking common	10

(continued)

Table 2. (continued)

Author/Year/ Location	Research Aim	Study Participants and Methods	Main Findings	CASP Score
Kanerva (2016), Finland	Explore nursing staff's perceptions of patient safety in psychiatric inpatient care.	N = 26 nurses Qualitative (semistructured interviews)	sense, and expressed need for greater consumer input and flexibility. Restrictive policies heighten nurse and consumer frustration and suggested continuous process of review to improve awareness and consistency of rules. Importance of general experiences of safety for everyone on the ward such as ward atmosphere, absence of physical threats, or distressing behaviors; staffs' experiences of safety and security of alarm systems; and consumer safety in regard to themselves, other consumers, and staff. Factors affecting safety included seeing the consumer from a holistic perspective, staff maintaining their professional skills, promotion of a culture of care and reduction of restraint use, structure of the ward, and laws/guidelines directing practice.	15
Krumm (2006), Germany	Investigate staff attitudes toward patients and mixed versus segregated wards.	N = 25 health-care workers (nurses, social workers, and psychiatrists) Qualitative (focus groups pre- and postintervention)	Gender-specific behaviors described with female consumers discussed in more pejorative terms than male consumers. Vulnerable female consumers not adequately cared for on mixed gender wards, but this issue was minimized; however, staff expressed mixed views on the appropriateness of single gender wards. Male staff expressed fears of being harassed by female consumers.	15
Leavey (2006), UK	Examine preference for single-sex wards and patient and staff views on the changeover to single sex in relation to safety, dignity, and privacy.	N = 11 nurses Mixed methods (interviews only with nurses)	Single-gender wards improved aspects of staff and women consumers' safety due to less gender conflict. Male staff felt protected from sexual harassment claims by regulations, policies, and procedures; however, female staff expressed ambivalence about single-sex wards.	14

Note. CASP = Critical Appraisal Skills Programme.

Main Findings

Five themes were developed from analysis of the included studies: reflecting on past practices, recognizing personal experiences, moving from control to collaboration, overcoming disparities in the delivery of care, and negative attitudes toward women. The first two themes, "Reflecting on past practices" and "recognizing personal experiences," discuss health professionals' reflections on aspects that facilitated and hindered the

implementation of trauma-informed care. The themes "moving from control to collaboration" and "overcoming disparities in delivery of care" explore the shift from a controlling, risk averse, and patriarchal approach toward responsive; collaborative; and empowering practices. The final theme "negative attitudes toward women" highlights health professionals' negative attitudes toward female consumers and the overall limited consideration of gender-based violence in acute psychiatric

inpatient settings. The themes are described in detail below, highlighting the experiences of health professionals providing trauma-informed care in acute psychiatric inpatient settings and gendered issues relating to trauma.

Reflecting on Past Practices

Health professionals in the included studies reflected on previous practices, such as the use of control and diversion, older psychotropic medications, restraint and seclusion, “separating and silencing patients” (Chandler, 2008), rigid nursing rules, and restrictive policies (Isobel, 2015). Understanding the possible adverse effects of these practices, encouraged the adoption of evidence-based trauma-informed practices, including alternative ways of supporting consumers and therefore improved the working conditions for staff (Chandler, 2012). Reflecting on historical practices also encouraged staff to empathize with consumers, consider their historical trauma experiences in psychiatric inpatient units, and tailor their approach accordingly (Kanerva et al., 2016). Furthermore, understanding consumers’ behaviors and expressed emotions within the trauma-informed care framework encouraged staff to provide a more holistic care response (Chandler, 2012). Overall, reflecting on the past helped health professionals to recognize the benefits of adopting a trauma-informed model of care.

Recognizing Personal Experiences

Despite identifying the benefits of implementing trauma-informed care, health professionals expressed their fears and anxieties associated with these changes. They admitted feelings of confusion and anxiety due to misunderstandings between staff, lack of guidance from senior management, and their organization; an absence of policies or procedures; insufficient training or unclear therapeutic frameworks; and role expectations (Copperman & Knowles, 2006; Isobel, 2015; Isobel & Edwards, 2017; Leavey et al., 2006). Health professionals expressed worry about their own inadequacies in responding to trauma, described variously as, “Opening a can of worms” and a fear of being “overwhelmed by a flood of emotion” (Copperman & Knowles, 2006) or increased micromanagement through “control and reaction by way of policies and rules” (Isobel, 2015). Others were fearful of their approach being criticized or labeled as traumatizing (Isobel & Edwards, 2017), resulting in avoidance of supervision (Copperman & Knowles, 2006). These personal experiences significantly hindered their abilities to adopt a trauma-informed care approach.

Moving From Control to Collaboration

A multidisciplinary and collaborative approach between consumers and colleagues within the acute psychiatric inpatient unit was particularly important for relinquishing control of consumers. It allowed for the development of responsive and collaborative relationships with consumers, leading to increased choice and a more flexible and confident nursing

group (Chandler, 2012; Isobel & Edwards, 2017). However, this deepening of relationships and collaborative practice also raised many challenges as it required a paradigm shift from control to collaboration with consumers and all staff members (Chandler, 2008, 2012; Kanerva et al., 2016). Health professionals struggled to balance organizational pressures to follow safety and risk management procedures while integrating principles of trauma-informed care, promoting recovery, and reducing coercive practices (Isobel & Edwards, 2017; Kanerva et al., 2016). They struggled to relinquish control as they believed consumers were a risk to themselves and to each other (Isobel & Edwards, 2017; Kanerva et al., 2016).

These changes were managed effectively on a daily basis through proactive responses and attention to the needs and moods of the consumers and themselves rather than being reactive to consumer behaviors. This allowed space for the development of mutual respect and positive relationships between consumers and health professionals (Chandler, 2012). At an organizational level, these tensions were facilitated through consultation, education and role modeling by a trauma expert, and educational resources and bolstering evidence of a reduction of physical threats and distressing behaviors (Chandler, 2008; Kanerva et al., 2016). Furthermore, at an organizational level, scaffolding of trauma-informed care through strong leadership, structural, practical, and policy change were key to health professionals’ feelings of safety, enabling them to manage risk and bring about a cultural change (Chandler, 2008, 2012; Isobel & Edwards, 2017; Kanerva et al., 2016).

Overcoming Disparities in Delivery of Care

A significant challenge experienced by staff is the variability in how trauma-informed care is interpreted, adopted, and implemented. Disparities between each psychiatric unit depended on health professionals and management’s understanding of the impact of trauma and how they balanced the constant demands of bed management and physical space (Copperman & Knowles, 2006). These disparities regarding implementation of trauma-informed care and perspectives resulted in ongoing concerns for female consumers’ safety and cultural change issues (Copperman & Knowles, 2006). Developing systemic processes of shared understandings and accountability within acute psychiatric inpatient units alleviated some of these discrepancies and reduced the frustrations experienced by health professionals (Copperman & Knowles, 2006; Isobel, 2015). Furthermore, reflecting on the dominance and hierarchy of the biomedical model within acute psychiatric inpatient units was useful to address these issues. Promoting individual strengths, empowering nurses to make decisions, and speak up against the system were recognized as integral for fostering the implementation of trauma-informed care (Chandler, 2012).

Negative Attitudes Toward Women

The majority of studies failed to explore gender or gender-based violence. Only three articles made mention of consumers’

gender (Krumm et al., 2006; Leavey et al., 2006), and only one of these articles explored issues connected to women's mental health specifically (Copperman & Knowles, 2006). Those articles that did discuss gender, reported negative attitudes toward women, minimizing trauma and focusing on structural aspects of the psychiatric inpatient unit, such as single-sex wards. Most concerning was the open expression of negative attitudes and descriptions of female consumers as "demanding," "flirtatious," "sexually aggressive," and the belief consumers make false claims of sexual harassment against staff (Copperman & Knowles, 2006; Krumm et al., 2006; Leavey et al., 2006). These negative attitudes were predominately reported by male staff.

Discussion

The purpose of this scoping review was to understand health professionals' experiences of implementing trauma-informed care in acute psychiatric inpatient units. It also attempted to understand health professionals' awareness of gender-based violence given the prevalence of trauma experienced by female consumers.

This review highlights the various benefits and challenges experienced by health professionals when adopting trauma-informed care. It shows the importance for health professionals to have a supportive space to reflect on some historical practices as restrictive and move toward a trauma-informed model of care. Staffs' anxiety and fears due to lack of training, support, or direction negatively impacted their ability to adopt a new model of trauma-informed care. Conversely, staffs' reflections on their own personal behaviors and emotions positively built greater empathy toward consumers. These insights further strengthened health professionals' recognition of the benefits to implementing a trauma-informed approach. This is consistent with previous research that shows health professionals are more supportive of providing a safer environment for consumers when they are aware of the effects of trauma and violence (Farro et al., 2011; Hopper et al., 2010).

Furthermore, this review suggests that implementing trauma-informed care requires a meaningful collaboration between health professionals and consumers, supported by the organization to manage risk and relinquish control. It is evident that this multilayered level of collaboration in conjunction with systemic change facilitated a move toward a culture of empowerment and trust. This collaborative implementation strategy is not only in line with previous research (García-Moreno et al., 2015) but also likely to increase morale, job satisfaction, and collaboration among health professionals (Torchalla et al., 2014).

Most concerning, this review shows that gender, let alone gender-based violence, received limited consideration by health professionals working in acute psychiatric inpatient settings. This is a major omission given the prevalence of sexual and intimate partner violence amongst women experiencing mental health issues (Oram et al., 2013). Of those that did discuss gender, predominantly male staff reported negative

attitudes toward female consumers. Trauma was also minimized or responded to with structural responses, such as the use of single-sex wards only. These negative attitudes are not uncommon from male health professionals and can contribute to the retraumatization of female consumers (Henderson et al., 2014; Hockett et al., 2016; Ponice, 2016; Ranjbar & Speer, 2013).

Strengths and Limitations

This scoping review bridges the gap in trauma-informed care literature by providing insights into how health professionals experience the delivery of trauma-informed care in acute psychiatric inpatient settings. Uniquely, this gives an insight into their personal practices and experiences, in addition to organizational and attitudinal issues in relation to gender. Using a scoping review methodology (Arksey & O'Malley, 2005) and the CASP (2018) provided a comprehensive, rigorous, and critical evaluation of the articles reviewed. Despite the limited research studies available in this area, the CASP shows that six of the eight articles included in this review met the criteria for "high-quality" papers (Chandler, 2008, 2012; Isobel & Edwards, 2017; Kanerva et al., 2016; Krumm et al., 2006; Leavey et al., 2006), and two met the criteria for "medium-quality" papers (Copperman & Knowles, 2006; Isobel, 2015). Multiple reviewers, inclusion/exclusion criteria, and the assessment of interrater reliability further strengthened the methodology of this scoping review.

Limitations of this review include the practical restrictions of searching electronic databases, which may result in missing some important articles. Due to the paucity of research in this area, the themes synthesized are based on a small sample of research from only five countries which makes it difficult to generalize the findings. Furthermore, the health professionals from these studies were predominantly from a nursing profession thereby limiting the perspectives to one profession. Few studies reported the participants' gender, of those that did most of the participants were women. Given the reported negative attitudes toward women from this small sample of research, it would be useful to gather a broader sample of perspectives from men and women from various different health professional backgrounds.

Implications for Further Research, Practice, and Policy

Trauma-informed care has been around for almost two decades (Elliott et al., 2005; Fallot & Harris, 2009; Harris & Fallot, 2001) and continues to be a challenge to implement which is longer than expected (Proctor et al., 2009). There is limited research on trauma-informed care in acute psychiatric inpatient units, from either health professionals' or consumers' perspective despite the recognized challenges to implementation. There is also a major paucity of trauma-informed care research in acute psychiatric inpatient units that consider gender and gender-based violence. In-depth research is essential to understand health professionals' experiences in order to move

beyond fear and reluctance of change to a comprehensive implementation of trauma-informed care. Understanding the challenges impacting the implementation of trauma-informed care practices is important, particularly considering the lack of evaluation studies that have been completed thus far on this topic (Quadara, 2015). Future mental health research should focus on gender (Howard et al., 2017) including gender-based violence and health professionals attitudes. Normalization process theory (NPT; May & Finch, 2009) recognizes the challenges of implementing complex interventions in health-care systems with multiple professions and interactions (Murray et al., 2010). Future research could utilize NPT to aid in understanding the successful implementation of trauma-informed care in acute psychiatric inpatient units.

Pragmatically, the implementation of trauma-informed care into mental health services requires a multifaceted approach (Brooker et al., 2016). It needs to be integrated into all levels of an organization, including policy and practice to influence how services and staff respond to and provide care to female consumers (Williams & Paul, 2008). Moreover, policy and practice needs to acknowledge and address the tensions that exist between legislated compulsory treatment, the biomedical model with the juxtaposition of the principles of trauma-informed care, such as collaboration and choice. Health professionals need to be regularly and consistently supported through reflective practice, specific training, and skill development in sensitive inquiry and responsiveness to trauma (Elliott et al., 2005; Nyame et al., 2013; Trevillion, Byford, et al., 2014). In addition, specialist staff or advocates are needed to broaden the focus from a biomedical model to a trauma-informed model of care in acute psychiatric inpatient settings (Trevillion, Byford, et al., 2014). Perhaps, given the evidenced complexity, incorporating a trauma- and violence-informed care into practice and policy may be more appropriate than trauma-informed care alone (Wathen et al., 2011). A recent scoping review shows the benefits of integrating primary health-care providers, with women-specific services informed by a trauma- and violence-informed lens (Mantler et al., 2018). This approach increases access to health-care services and decreases future health-care burden (Mantler et al., 2018). This review highlights the need for acute psychiatric inpatient settings to adopt a collaborative and equitable multidisciplinary approach to responding to the individual needs of consumers to effectively implement trauma-informed care.

Conclusion

Trauma-informed care is becoming an increasingly recognized model of care across many settings, including acute psychiatric inpatient units. There is limited research to date of health professionals' and consumers' experiences of trauma-informed care in acute psychiatric inpatient units (Muskett, 2014; Wilson et al., 2017). There is also a significant lack of research on trauma-informed care in acute psychiatric inpatient units that consider gender-related issues and gender-based violence. It is

important to understand these experiences to aid in the translational gap of implementing trauma-informed care. Consistent with previous research, this review shows that implementation of trauma-informed care continues to be complex and challenging (Quadara, 2015). From our limited findings, it is clear that health professionals struggle to implement trauma-informed care despite acknowledging the perceived benefits. However, a multilayered response aids in the shift from a patriarchal approach to a collaborative, empowering, and trauma-informed approach. Most concerning is the negative attitudes toward female consumers and the overall limited consideration of gender-based violence in acute psychiatric inpatient settings. Further research will provide a greater understanding of the supports required to comprehensively implement trauma-informed care and consider gender-based violence in acute psychiatric inpatient units.

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Sabin Fernbacher has extensive experience in the intersecting areas of mental health/illness, family violence, sexual assault, trauma-informed care and practice, gender sensitivity and safety, and families where a parent has a mental illness and diversity/inclusion. I have developed organizational, regional, and statewide policy guidance and led a broad range of service improvement projects.

Kelsey Hegarty is an academic general practitioner who holds the joint Chair in Family Violence Prevention at the University of Melbourne and the Royal Women's Hospital. Her research includes the evidence base for interventions to prevent violence against women, educational and complex interventions around identification of domestic and family violence in primary care settings and early intervention with men, women, and children exposed to abuse. Interventions are delivered through health care and through the use of new technologies.

4.3 Updated Scoping Review Search

As outlined in Chapter 3 a search was carried out on the 4th of May 2020 to scan for any recent publications. One article met the inclusion criteria (Isobel, Gladstone, Goodyear, Furness, & Foster, 2020). This study used an interpretative qualitative design using semi-structured interviews. It was conducted in one state within Australia. The study participants were 13 psychiatrists (7 females and 6 males) who worked across inpatient and community settings in a metropolitan public mental health service. The findings from this study are similar to the themes included in the scoping literature review manuscript above. These are integrated into the overall scoping review findings below.

4.4 Chapter Summary

This chapter presented a scoping review of the literature exploring health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings. This scoping literature review answers research questions one and two of this thesis. Overall, nine articles (including the updated search) met inclusion criteria, highlighting the limited research conducted on this topic to date. Five themes were developed from the analysis of the included studies. These themes were reported as; *Reflecting on past practices*; *Recognising personal experiences*; *Moving from control to collaboration*; *Overcoming disparities in the delivery of care*, and *Negative attitudes towards women*.

Health professionals described various benefits and challenges that they experienced when adopting trauma-informed care, including a fear of their practice being criticised and the 'othering' of the implementation of trauma-informed care to other professions. Interestingly, this reluctance was explicitly linked by some psychiatrists to the tension between psychiatry and trauma-informed care. These tensions and misunderstandings need to be addressed to progress from a patriarchal and hierarchal approach to care. Trauma-informed care should take a multilayered response that is collaborative, empowering, and uses a trauma-informed approach. A notable finding was the overall limited consideration of violence against women in acute psychiatric inpatient settings. Of the limited number of health professionals that commented on gender differences, they expressed negative attitudes towards female consumers. Contrastingly to the scoping review article, the most recent investigation of

psychiatrists' perceptions (Isobel et al., 2020) did not report any negative attitudes toward women consumers.

The next chapter outlines the international and national policy context that relates to gender-based violence and mental health. It then takes a critical look at reports and guidelines that inform the federal government and, more specifically, the acute psychiatric inpatient units of the Mental Health Service included in this case study.

CHAPTER 5: VIOLENCE AGAINST WOMEN AND MENTAL HEALTH POLICY REVIEW

5.1 Chapter Overview

This chapter provides a brief overview of the international policy context of violence against women and mental health. The national context within the Commonwealth of Australia and more locally within Victoria is then critiqued. This is followed by a synthesis and analysis of the Mental Health Services' procedures, and the guidelines and resources of the four acute inpatient units. It is crucial to explore the global context to understand the more local policy landscape and the empirical research findings.

5.2 Policy Landscape

For the past three decades, gender equality and violence against women have featured on the international stage. This commenced with the development and continuous review of the *1979 United Nations Conventions to Eliminate All Discrimination Against Women* (CEDAW, 1992, 2017) and the publication of *The Vienna Declaration on the Elimination of Violence Against Women* (UN General Assembly, 1993). Following this, the *Beijing Declaration and Platform for Action* were released (Women, 1995), including identifying violence against women and girls as a key area of concern and action. More recently, the Council of Europe adopted the *Istanbul Convention* (Council of Europe, 2014) to prevent and combat violence against women and domestic violence. At a global practice level, the World Health Organisation and the United Nations have provided the global clinical practice guidelines (World Health Organization, 2013a, 2013b, 2015) and the *Sustainable Development Goals* (UN General Assembly, 2016) to target violence against women and girls, gender equality and women's mental health.

Although mental health policy has continued to develop since the 1960's, it is not as holistic and comprehensive as the global violence against women policy (Grob, 2008; Haque,

2005; Knapp, McDaid, & Mossialos, 2006; Lurie, 2005). It was not until the adoption of the *Comprehensive Mental Health Action Plan 2013–2020* by the 66th World Health Assembly did mental health policy gain international attention (Zhou, Yu, Yang, Chen, & Xiao, 2018). This plan's overarching goal is to prevent mental illness, promote well-being, support human rights, and individual needs, provide care, and enhance recovery (World Health Organization, 2013a). However, there is little consideration for gender, inequality, and violence against women. Gender and violence against women are social determinants of mental health and must be centred in all global policy (World Health Organization, 1993, 1997, 2000). The next section will explore how this plays out at the Commonwealth and Victorian State levels by looking at the current mental health and violence against women policies.

Commonwealth

There are two national plans and an interim inquiry report related to the national violence against women and the mental health landscape. *The National Plan to Reduce Violence against Women and their Children* (2010–2022) (Commonwealth of Australia, 2019) prioritises the prevention of sexual violence and sexual harassment through national and targeted initiatives. It promotes informed consent, bodily autonomy, and respectful relationships; delivery of client-centred; trauma-informed; specialised and consistent support to victim-survivors of sexual violence; and strengthening the capacity of all sectors to address sexual harassment to ensure women are safe at work, while studying, in public and online. This Plan is very comprehensive, but regrettably, there is minimal mention of the impact of violence on women's mental health. Similarly, the *Fifth National Mental Health and Suicide Prevention Plan* (2017–2022) (Commonwealth of Australia, 2017) and *the Productivity Commission Mental Health Inquiry Interim Report* (2020) (Australian Government, 2020) only focus on mental health and do not incorporate its complex relationship with gender and violence. This is a significant oversight, given that these plans and report are supposed to reform and improve the Australian mental health service system. There are four reports, two guidelines, and a framework related to the violence against women and the mental health landscape in Victoria, which will now be explored.

Victorian

The *Royal Commission into Family Violence*, commenced in 2015 and was a significant turning point for Victoria. It was the first of its kind of government investigation into family violence in Australia and elsewhere. Its mandate was to examine Victoria's response to family violence and make practical and innovative recommendations to prevent family violence, improve the system for victim-survivors, and hold perpetrators accountable. Of the Commission's 227 recommendations; four of the recommendations explicitly address sexual assault. Ten of the recommendations addressed the health and mental health system (State of Victoria, 2016). The Commission's report and recommendations included a strong focus on gender inequality and violence against women and their intersecting issues (Yates, 2020). *The Safe and Strong Report* (Department of Premier and Cabinet, 2016) evolved from the Royal Commission into Family Violence report's key finding that gender inequality is the key driver behind family violence. This strategy was another significant milestone as Victoria's first strategy for preventing violence against women through gender equality. However, it only briefly outlines the prevalence of mental illness experienced by women.

Since the Royal Commission into Family Violence, Victoria is continuing to lead the way in Australia with the first of its kind Royal Commission into Victoria's Mental Health System. The *Royal Commission into Victoria's Mental Health System Interim Report (2020)* recognises the practice of minimising of experiences of trauma survivors, lack of adequate trauma-informed understanding, and the potential for re-traumatisation within the mental health system. It identifies the significant need for consistent implementation of trauma-informed care and practice throughout mental health services in Victoria (State of Victoria, 2018–19). It recognises the occurrence of sexual violence in acute inpatient units against female consumers and the importance of appropriate physical infrastructure. However, disappointingly there is limited broader consideration of violence against women and gender issues. Equally concerning, *Victoria's 10-year Mental Health Plan* (Department of Health & Human Services, 2015) purports to embed trauma-informed practice. However, it only briefly acknowledges the gendered nature of mental illness and the impact of violence against women, central to trauma-informed care.

More encouragingly, *The Right to be Safe Report* was produced by the Mental Health Complaints Commissioner (MHCC) in 2018 (The Mental Health Complaints Commissioner, 2018). The MHCC is an independent, specialist body established under the Mental Health Act

2014 to safeguard rights, resolve complaints about Victorian public mental health services, and recommend improvements. The report identified key areas (primary, secondary and tertiary interventions) as part of a framework for preventing sexual violence and responding to sexual safety in mental health services. This report also makes recommendations to the government for clear policy directives, practice, and service improvements to ensure sexual safety, particularly for high-risk genders in mental health services. Furthermore, the *Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM)* (2018) (State of Victoria, 2018) cohesively incorporates gender, violence against women, and mental health. Promisingly, this progress should be seen more commonly going forward with the MARAM established under the Family Violence Victorian Protection Act. Therefore, authorised organisations and funded services, including mental health services must align their policies, procedures, and practice guidance and tools with the MARAM framework.

The earlier development of two service guidelines; *Service Guideline on Gender Sensitivity and Safety; Promoting a Holistic Approach to Wellbeing 2011* (2011) (Department of Health, 2011a) and *Promoting Sexual Safety, Responding to Sexual Activity, and Managing Allegations of Sexual Assault in Adult Acute Inpatient Units' Guideline* (2012) (Department of Health, 2009) highlight the importance of including sexual and women's safety in mental health settings. However, this policy review shows that gender, violence against women, and mental health must also be weaved throughout all policies to become an integral part of practice and culture, a must-do, rather than distinct aspects of care.

Table 7 below provides a summary of the value of all the Government (Commonwealth and Victorian) documents mentioned above in relation to gender, violence against women and mental health. It assesses whether gender, violence against women, and/or mental health are included on a scale of 0-2, where 0 is no mention, 1 is a brief mention, and 2 is comprehensive inclusion. This is incredibly insufficient at the Commonwealth level, with only one of the three documents including all three areas (Table 7). At the State level, the *Royal Commission into Family Violence Report (2015-2016)*, *The Right to be Safe Report (2018)*, and the *Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) (2018)* were the only three of the eight documents to address gender, violence against women and mental health comprehensively. The lack of integration is very concerning given the significance of policies to inform best practice (Ford-Gilboe et al., 2018; Lavis et al., 2005).

Table 7. Summary of Commonwealth and Victorian documents in relation to gender, violence against women and mental health.

	Title & Year	Gender	VAW	Mental Health
Commonwealth	The National Plan to Reduce Violence against Women and their Children 2010–2022.	2	2	1
	The Fifth National Mental Health and Suicide Prevention Plan 2017-2022.	0	0	2
	The National Productivity Commission Mental Health Interim Inquiry Report 2020.	1	0	2
Victorian	Royal Commission into Family Violence Victoria Report 2015-2016.	2	2	2
	The Safe and Strong: a Victorian Gender Equality Strategy Achievements Report 2017.	2	2	0
	Royal Commission in Mental Health Victoria Interim Report 2020.	1	1	2
	Victoria's 10-year Mental Health Plan 2015-2025.	1	1	2
	The Right to be Safe' Report, MHCC 2018.	2	2	2
	The Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) 2018.	2	2	2
	Service Guideline on Gender Sensitivity and Safety; Promoting a Holistic Approach to Wellbeing 2011.	2	1	2
	Promoting Sexual Safety, Responding to Sexual Activity, and Managing Allegations of Sexual Assault in Adult Acute Inpatient Units' Guideline 2012.	1	2	2

0 = no mention, 1 = brief mention, 2 = comprehensive inclusion

The next section provides an analysis of the procedures and guidelines of the Mental Health Service and the four acute psychiatric inpatient units where this research was conducted.

Mental Health Service

A document analysis was conducted to understand the policy context for the Mental Health Service and the adult acute psychiatric inpatient units. During data collection, the researcher collected organisational procedures and unit resources related to gender-based violence. These will be discussed in more detail below.

Organisational Level Procedures

The Mental Health Service provided three organisational, and procedural documents related to gender-based violence. These included;

- Managing allegations of sexual assault & sexual activity;
- Sexual assault & trauma-disclosures of past sexual assault;
- Responding to family violence.

These three documents provide consistency for responsibilities and procedures across the Mental Health Service (Table 8). All three procedures have expired in recent years and are currently under review. *The Managing allegations of sexual assault & sexual activity* procedure was under review by the Gender Sensitivity and Safety Steering Committee during the data collection phase. This review was halted until the Mental Health Complaints Commissioner investigation recommendations were published in 2018 and continues to be under review. This is a lengthy document that attempts to address all the possible sexual contact scenarios, which may confuse staff members further rather than facilitate reporting. Of the three documents, it is recommended by the researcher that future procedures at the health service organisation level are modelled on the *Responding to family violence procedure*. This document provides a succinct, clear, yet comprehensive direction that is functional for health professionals. Guidelines are more likely to be followed when written in an active voice, are clear and concise, but with sufficient information so that they can be understood without reference to other supporting material (NICE, 2020).

Table 8. Summary of the Mental Health Services organisational procedural documents.

Titles	Managing allegations of sexual assault & sexual trauma-disclosures of past sexual assault	Sexual assault & Responding to sexual assault & sexual trauma-disclosures of Family violence	Responding to Family violence
Responsibilities	All staff including medical, nursing, allied health & administration staff, volunteers, students & sessional workers	All staff including medical, nursing, allied health & administration staff	All staff including medical, nursing, allied health & administration staff
Procedure	Responses from staff depending on; - sexual activity, sexual assault or sexual harassment, - perpetrator was a staff member or consumer, - victim is a voluntary or involuntary patient & has capacity to make informed decisions about sexual assault. Reporting to Police, information sharing, discharge planning and follow-up.	Direction on; - inquiry, recording and documenting disclosures of past sexual assault, - consultation with senior staff, - reporting to the Chief Psychiatrist or appropriate statutory agency	Directions for sensitively supporting; - victim, - perpetrator, - capacity and consent. Supporting processes .

Unit Level Documents

There is a selection of documents and resources used by the four acute psychiatric inpatient units within this Mental health Service (Table 8). This shows the diversity and inconsistencies across all four units regarding gender-sensitive care and sexual safety, despite consistent procedures at the Mental Health Service level. Noticeably only one of the four units, Unit B, had developed a series of documents and practices that promoted sexual safety, gender-sensitivity, and trauma-informed care. These were developed by the Gender Sensitive Leadership Group within this unit. Unit B also developed additional practical resources such

as a staff checklist for managing allegations of sexual assault and sexual safety, in conjunction with an acronym of *SAFETY* (*Seriously, Affirmation, Facts, Explore Needs, Team and Your Responsibility*) to aid staff's ability to appropriately respond. Moreover, the Gender Sensitive Leadership Group of this unit also devised a sexual safety risk assessment tool and a Gender-Sensitivity and Safety Action Plan. This Action Plan included seventeen goals with specific areas of action, staff responsibility, and timeframes. Unit B was the only unit that showed evidence for long term implementation of gender-sensitive care.

As shown in Table 9, the only documents utilised across all four psychiatric inpatient units were the staff guidelines and flow chart for the women-only corridor and guidelines for consumers placed in the women-only corridors. The flow chart guided prioritising women at higher risk over women who reportedly had a lower comparative risk. This flow-chart also included guidance on allocating men to the women's only corridor if needed and how to mitigate risk in these instances.

Table 9. Summary of the unit level resources on gender-sensitive and sexual safety.

Gender-Sensitive Care Resources	Unit A	Unit B	Unit C	Unit D
Gender-Sensitive Leadership Group	✓	✓		
Creating Safety Nurse	✓	✓	✓	
Gender mix in shared accommodation procedure	✓			
Gender-Sensitivity and Safety Action Plan		✓		
Sexual safety risk assessment tool		✓		
Gender Safety & Sensitivity – Women's Corridor Procedure			✓	
Documents for staff on trauma-informed care and gender-sensitive practices		✓		
Staff resources for managing allegations of sexual assault and sexual safety		✓	✓	
Staff guidelines & flow chart for women only corridor	✓	✓	✓	✓
Guidelines for consumers who are placed in women-only corridors	✓	✓	✓	✓

It appears a key factor driving the development of resources was a strong Gender-Sensitive Leadership Group at the unit level with an allocated Creating Safety Nurse, as was the case in Unit B. Unit A shared the Creating Safety Nurse role amongst the nurse unit managers. Unit A also had a Gender-Sensitive Leadership Group; however, this group was undergoing committee member changes during the data collection period and may have impacted this unit's progress with gender-sensitive care. Unit C had neither a Gender-Sensitive Leadership Group nor a Creating Safety Nurse. Unit D had recently appointed a Creating Safety Nurse at the end of the data collection phase. Unit D did not have a Gender-Sensitive Leadership Group. Unfortunately, towards the end of the data collection phase, the service level Gender Sensitivity and Safety Steering Group Committee was subsumed into a broader committee. This analysis shows the importance of a specific gender-sensitive committee at the organisational and unit level to review policy and procedures and therefore adapt practice.

This document analysis provides a useful context of the main organisational procedures and differing unit practice resources across the four inpatient units. In part, this policy and document review informs health professionals' experiences of providing care to victim-survivors of sexual violence and how gender-sensitive care is enacted. This will be explored further in the empirical articles in the following two chapters.

5.3 Chapter Summary

This chapter provided an overview of the policy landscape from the International level to Commonwealth, State, and the Mental Health Service's local level including its four adult acute psychiatric inpatient units. This review highlights the lack of integration between violence against women and mental illness. The benefit of comprehensive reports and frameworks and key staff is evident from this review. The next chapter discusses the second publication of this thesis. This publication is based on qualitative research exploring health professionals' perceptions of providing care in acute psychiatric inpatient settings to women survivors of sexual violence.

CHAPTER 6: PROVIDING CARE FOR WOMEN SURVIVORS OF SEXUAL VIOLENCE IN ACUTE PSYCHIATRIC INPATIENT UNITS

6.1 Chapter Overview

This chapter presents the second of the three published articles of this thesis. This qualitative research paper answers research question three: *‘What are healthcare professionals’ experiences and perceptions in providing care for women who are survivors of sexual violence in psychiatric inpatient units?’* Three typologies were developed from the analysis of the 40 interviews conducted across the four acute psychiatric inpatient units. The discussion explores the implications of the findings for health professionals working in acute psychiatric settings. The paper was peer-reviewed and published in BMC Health Services Research in November 2019. The chapter concludes with a summary of the key findings and central observations from the fieldwork related to research question three of this thesis.

6.2 Published Results Manuscript (paper 2).

RESEARCH ARTICLE

Open Access



Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units

Carol O'Dwyer^{1*} , Laura Tarzia^{1,2,3}, Sabin Fernbacher⁴ and Kelsey Hegarty^{1,2}

Abstract

Background: Survivors of sexual violence, who are predominantly women, commonly access mental health services. Psychiatric inpatient units in Australia are predominately mixed gender and may further retraumatise these women. Sexual violence is under-recognised by mental health professionals and there is a lack of adequate policy or direction for mental health service services. To date, only a small amount of research has focused on health professionals' experiences of providing trauma-informed care to women in psychiatric settings, with most studies focused on specific practices or interventions. Qualitative data is particularly lacking on this topic. This is a critical gap in the knowledge given that health professionals are key to detecting and addressing victimisation. The aim of this study was to gain an in-depth understanding of healthcare professionals' experiences and perceptions in providing care to women who are survivors of sexual violence in psychiatric inpatient units.

Methods: This qualitative study utilised semi-structured interviews with 40 health professionals recruited from four psychiatric inpatient units within a large Australian public mental health organisation. Data were examined using thematic analysis.

Results: Three main typologies were developed to describe participants' experiences of the care provided to women; 1) *Dismissing and denying*; 2) *Acknowledging but unprepared*; 3) *Empathising but despairing*.

Discussion: Gender, professional training, adherence to the biomedical model, and level of experience influenced health professionals' experiences.

Conclusions: Health professionals in this study held varying attitudes towards female consumers and responses to sexual violence. Our findings suggest the need to address individual staff perception and promote trauma-informed and gender-sensitive care across all disciplines, genders, and levels of experience.

Keywords: Australia, Sexual violence, Mental health, Women, Health professionals, Psychiatric inpatient unit, Qualitative

Introduction

Sexual violence is prevalent in Australia and worldwide [1, 2] and it impacts negatively on mental health [2]. The World Health Organisation defines sexual violence as "any sexual act, attempt to obtain a sexual act,

unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" ([3] p. 149). In Australia one in five women experience sexual violence, usually perpetrated by someone known to them including an intimate partner [1]. Sexual violence is associated with morbidity and mortality; including substance misuse, mental illness and suicidal behavior [4]. The relationship between sexual violence and mental health is complex and bi-

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directional [5]. Research shows that sexual violence predisposes and maintains mental illness [2], conversely severe mental illness can increase women's risk of experiencing sexual violence [4].

Sexual violence is common in women who access mental health services. One in three women presenting at inpatient or outpatient mental health services has previously experienced domestic violence, including sexual violence [6]. The prevalence of sexual violence reported at time of admission to a psychiatric inpatient unit in Australia and USA varies across studies, with estimates between 5 and 45% [3]. A small study in Victoria ($n = 50$), Australia noted that almost half (45%) of women reported historic sexual assault and 67% reported sexual or other harassment while accessing a psychiatric inpatient unit [7].

Sexual violence is a highly gendered issue [3, 7]. In Australia, most psychiatric units have mixed wards [8] with two-thirds of women inpatients reportedly feeling unsafe in this environment and experiencing harassment, intimidation or abuse [9]. Similarly, in the UK over a third of psychiatric inpatients reported being attacked, threatened or made to feel unsafe [10]. Encouragingly, women with mental illness are more likely to disclose sexual violence to health professionals (including primary and secondary health care services) than to informal supports [11].

Studies indicate that mental health professionals are cognisant of the need to appropriately respond to women who have experienced sexual violence in a gender-sensitive and safe manner [11]. However, sexual violence is generally not identified by mental health services [12]. Staff frequently do not ask about a history of sexual violence due to lack of knowledge, confidence and skills to respond appropriately to such disclosures [13–15]. Furthermore, although mental health policies acknowledge the connection between sexual violence and mental illness, they lack direction or description of recommended action for mental health services and clinical care [16]. These practices are linked to the current dominant model of care in psychiatric settings that focuses on the biological symptoms of mental illness rather than the psychosocial [17]. Trauma-informed care is a model of care that recognizes the responsibility of mental health services to be responsive to trauma at a systemic level [18–20]. It aims to look through a 'trauma lens' to improve experiences, relationships and environments for consumers and health professionals [21].

There is limited research examining how healthcare professionals understand and experience providing care to women with a history of sexual violence and mental illness in psychiatric inpatient units. This knowledge is integral to the provision of high quality, gender-sensitive care and for ensuring the safety of consumers during their admission.

Study aim

The aim of this study is to gain an in-depth understanding of healthcare professionals' experiences and perceptions in providing care for women in psychiatric inpatient units who are survivors of sexual violence.

Methods

All participants have been provided with a pseudonym for de-identification purposes. This qualitative study involved semi-structured interviews within four different psychiatric inpatient units within one mental health organization in Victoria, Australia. The study specifically focused on health professionals' perceptions of care provided to women who are survivors of sexual violence. In Australia, the term 'consumer' is commonly used for people with a mental illness who access mental health services. The term 'female consumer' is used throughout this article to describe women accessing mental health services who are also survivors of sexual violence.

Recruitment

A purposive sampling strategy was utilised to include a range of health professionals from a variety of different professions, levels of seniority, and genders. Once approval was received from managers, the lead researcher attended staff meetings to promote the study and distribute Expression of Interest forms. A mutually convenient interview time was arranged with staff who expressed interest.

Data collection

Forty semi-structured interviews by phone (2) or face-to-face in a private office space (38) were conducted individually across the four psychiatric inpatient units between March and December 2016. All interviews were conducted by the female lead researcher, (COD) who is a registered Psychologist and PhD Candidate. The lead researcher also participated in a qualitative research methods course prior to conducting the analysis. Questions covered the following: type of care provided to women with a history of sexual violence; how care is implemented, and how it is supported. Questions were pilot tested with allied health professionals not employed by the Health Service. Interviews ranged from 12 to 90 min (average of 40 min). Field notes were made before, during and after the interviews. All interviews were audio recorded and fully transcribed verbatim by a professional transcription service. Feedback on transcripts was offered to all participants, two participants provided comments and corrections on their transcripts.

Data analysis

Thematic analysis was used in this study [24], underpinned by a feminist theoretical framework that foregrounds

gender as being central to the experience of sexual violence against women. Analysis focused on understanding health-care professionals' experiences and perceptions in providing care for women in psychiatric inpatient units who are survivors of sexual violence. It also focused on how this care was implemented (the basis of a forthcoming second publication). An inductive method was utilised to code the data by the lead researcher (COD) and co-coded by co-author (LT), moving from descriptive codes to interpretative codes and finally overarching themes. Relevant statements were coded with ample context to avoid data fragmentation and decontextualisation [23]. A final coding framework was agreed upon collaboratively with co-researchers and applied to the entire dataset. A selection of transcripts and quotes were reviewed collectively by all co-authors (COD, LT, SF, KH) under each theme to ensure consensus on the development [24]. In undertaking this process, it became evident that the overarching themes developed during analysis were in fact distinct typologies of participant experiences of care delivery. When the data were reviewed again with a focus on participant demographics, it revealed that responses from particular types of participants tended to fall within the different typologies; this additional layer of analysis is also described in our findings. The software program, NVivo 11 (QSR International, 2015) was used to manage the data and aid with analysis.

Ethical considerations

The study was approved by both the Human Research Ethics Committee (HREC) at [Participating health organisation] and the HREC at [Researchers' university]. Participation was confidential, and managers were not informed about who participated. Informed consent was obtained via a Plain Language Statement. Participants were asked to sign and return a consent form prior to commencing an interview. No incentive was offered.

Results

Forty health professionals participated, including 20 nursing staff, 10 allied health professionals, seven medical staff and three consumer/peer support staff. Twenty-seven participants identified as female and thirteen as male. Thirty-one staff worked full-time and nine part-time. Participants had varying levels of experience working in their current role within the acute mental health service, ranging from 3 months to 29 years. The age of participants varied from 21 to 64 years of age with a mean of 42.5 years. Staff predominantly identified as being of Australian nationality (77.5%). Other staff identified as New Zealander, Maori, Chilean, Ghanaian, British, Greek, Indian, Italian and Singaporean.

Three main typologies were developed based on dominant themes within the dataset: *Dismissing and denying*; *Acknowledging but unprepared*; *Empathising*

but despairing. Each of these typologies is described below with supporting quotes to illustrate them in more detail.

Dismissing and denying

Some staff expressed negative attitudes towards female consumers who were believed to be more difficult to care for than male consumers. There was some reluctance from these staff to consider working on women only wards. George (Manager) illustrated this by recounting recent discussions with his colleagues: *"You wouldn't get many who would want to work in a female only unit, because of the issues it causes, and women are, females generally are felt to be harder to look after ..."*. This negative bias toward female consumers extends further to those with a diagnosis of Borderline Personality Disorder. Camilla (Medical) described her Registrar telling her, *"People with borderline, everyone sort of just runs away because they're so difficult to manage"*. This perspective was frustrating for Maryann (Allied Health). She expressed her irritation with colleagues' negative attitudes, flippant comments and lack of understanding towards women with a diagnosis of Borderline Personality Disorder: *"I guess where I see lack of respect is the ward's attitude to women who have a diagnosis of personality disorder. A woman with a personality disorder comes from most likely 99.9 percent of child sexual abuse"*.

These negative attitudes towards female consumers resulted in staff not taking sexual assault disclosures seriously, minimising or blaming consumers. Elise (Allied Health) reported that female consumers were at times blamed for the perceived overexaggerated response to sexual violence. *"It's one of the other unwell people who's done this to [a young woman] consumer because he's so unwell, immediately afterward, the staff was describing he had kind of humped her, and she reacted with rage at that, but then staff were kind of blaming her a bit, saying her reaction was over the top"*. Health professionals justified their dismissive, minimising or blaming responses using reasons which included lack of information on the incident of sexual violence, fear of retraumatising and time limitations of the care provision within a psychiatric inpatient unit. Compartmentalising incidents of sexual violence as historic, 'confusing' or expected due to the woman working in the sex industry permitted staff to ignore and reassure themselves that *'it's not why she's here'* (Paul, Medical). Another reason for staff to justify their avoidance was expressed as a fear of *"opening old wounds"* by Jason (Allied Health) and a perception that it is better to *"leave what happened in the past, in the past"*, by Jane (Nurse). Kate (Allied Health) referred to the brevity of admission as a valid justification for this perception: *"We're an inpatient unit, the average*

time is maybe a week that someone's here. So, to reopen old wounds and to explore that, I don't think it benefits them and is better for an outsourced service".

Additionally, some staff shied away from asking about sexual violence as they didn't see it as part of their role. This view was particularly prominent for male staff and it was seen as a more appropriate role for female nurses. Jason (Allied Health) stated *"I guess my role isn't sort of specified towards that"*. Ryan (Nurse) reported that providing care to survivors of sexual violence can be difficult for male staff *"if someone has that sexual abuse history, they just see every male as being the perpetrator and being someone that's wanting to get them. That's always a challenge, it can always be confronting"*. A male doctor, Paul, described nurses as the preferred staff for this role as they have more time to spend with patients than doctors. Nurses were considered to be intermediaries for disclosures of sexual violence from consumers who could then liaise with medical staff: *"... the next best person would be the nurse, because nurses will spend way more time with them. I would say on average statistically the patients might like nurses better than doctors, so they might get a bit more history, and they'll flag it in their handover and it will be brought up to us as well"* (Paul, Medical). Patrick (Medical) reinforced this perception of providing care to women who are survivors of sexual violence as a nurses' role *"I think general nursing staff who are more established are reasonably good"*. Ruth, (Medical) pointed out the limitations of relying on nursing staff only to provide this care *"the need for one-on-one staff we have to have nurses available to do that. One on one is pretty resource intense."*

This division and avoidance was also reportedly evident at a leadership and an organisational level. Kaye (Allied Health) described, *"When we start talking about making definite decisions that affect everybody, the men are really engaged but when it's considered almost secret woman's business, they're nowhere to be found. They're not interested in the safety of their units, they're not really interested in family violence"*. Furthermore, Matthew (Manager) expressed the view that desensitising consumers who had survived trauma was more important than ensuring their sense of safety and security on the ward: *"There was discussions about making one ward female only. No, because the world's not like that, so it's a fake sense of security ... If you put them on a female ward then it's gonna be a fake environment, because the world is not segregated. It's about learning to manage. I know, trauma, and all that, but if we can learn to desensitise in the right way, that would help"*. These perceptions highlight the lack of understanding and reluctance of some health professionals to address women's experiences of sexual violence.

Acknowledging but unprepared

This theme describes the experience of many health professionals who recognised the prevalence and impact of sexual violence but felt unprepared to respond accordingly. Chris (Nurse) illustrates this understanding through his comment *"I think it [sexual violence] is a very common thing that's for sure. A lot of our consumers who have borderline personalities tend to have a history of sexual assault, physical assault, mental even, so there have been numerous cases in the past"*. These staff also had good insight into how consumers may be feeling during their inpatient stay, as illustrated by Josie's (Allied Health) comment: *"Essentially, it's about not feeling safe and not being able to predict what might happen next, and a vulnerability about not necessarily having the capacity to make oneself safe"*. Incidents of sexual violence were reported by several healthcare professionals to have occurred on the psychiatric inpatient wards. These incidents, understandably, re-traumatised and negatively impacted a consumer's recovery and ability to engage in treatment. This fear of harm while in the inpatient unit was real and a lived experience for female consumers as highlighted by Caroline's (Nurse) comment: *"A male exposed himself to her [consumer] and was offering sexual favours and was blowing her kisses from a bedroom and he was taken out of the unit. It was a trigger for her because she had had an experience in the past where she was sexually abused. She struggled with her progression of her treatment here because it had brought up so much for her and she was really afraid and frightened. It was really hard to nurse her after that exposure and that experience"*.

In particular, many junior doctors and new graduate nursing and allied health professionals recognised that they might not have the skills to ask about histories of sexual violence and respond to disclosures. This was clearly reported by Camilla (Medical) *"We were never taught it in Med [ical] School, even in orientation. Here it would be useful to have a rundown of how to approach it. I ask the question quickly and then kind of move on"*. Elise (Allied Health) was frequently approached by junior medical staff asking for help to discuss trauma and sexual violence: *"I think a lot of staff here try hard to do their best. A lot of staff openly say they don't quite know what to do. I've had doctors say to me they don't know how to ask"*. Amanda (Nurse) declared her lack of knowledge in this area and desire to know more: *"I would like to know if there's more that can be done. I guess for me, it's a case of 'I don't know what I don't know'. But I think there must be more things that we could do but I don't know what they are"*. Furthermore, Ray (Allied Health) described his feelings of fear and inadequacy due to his lack of experience and limited time in his role: *"There are days when we don't really feel prepared. There are*

days when I question whether or not I am ready or able, or capable of providing good service to [survivors of sexual violence]". Senior staff expressed concern as to how this affected appropriate follow-up, referrals, and care for female consumers within the inpatient unit: "Well, everything is quite new to [graduate staff] so they're not sure what to expect when I've asked them questions about their role and why things aren't done, you know, this way for example. 'We didn't know'. And that's understandable, but I'm just worried about how that then flows on and what they think about their roles and how that then influences our consumers" (Madeline, Allied Health).

A level of confidence was noted by some senior female nursing staff in listening to women's histories of sexual violence; however, this was often where their skills and confidence ended: "I guess I suppose just being very, very conscious and very aware of it. If women want to talk to me about it, I'm more than happy to listen" (Caroline, Nurse). Referrals to external agencies or to experienced allied health staff were perceived as the only avenues for care from this point for nursing staff. Olive (Nurse) describes: "Again, I don't know that we feel, or me particularly, or when people come to me to discuss it that we actually feel that we're [in] the best position to talk about what's happened in the past. We'll happily discuss it, but how do we work around it or with it? There's often referrals to other agencies or our social worker". However, senior male nurse Keith admits that seniority does not necessarily bring confidence or skills in caring for women who are survivors of sexual violence "I don't feel that I would be the best person to deal with difficult and very distressing issues for some people. I probably wouldn't feel equipped or all that comfortable to deal with quite serious issues".

Empathising but despairing

This theme encapsulates responses of several health professionals who understood the bidirectionality of sexual violence and mental illness and the individual responses from consumers. They expressed frustration towards colleagues and the mental health system for not responding sensitively or appropriately. Lucy (Nurse) described the individual experiences of sexual violence and the need for all staff to have an awareness of the possible impacts on victim-survivors. "It [the impact of sexual violence] is completely subjective to the client. Just because you don't feel that that is extreme, that's your opinion. It is not how you approach in a hospital, or in any other setting. Especially with sexual assault. I think some people still need to grasp that". In addition, staff who understood the aetiology of Borderline Personality Disorder recognised the high prevalence of trauma and sexual violence these women have likely experienced.

James (Manager) recognised that sexual violence is 'a complex topic' and that a staff member's personal bias may influence the consumer's decision to make a report: "Often guilt is associated with the assault or abuse, working through that with the consumer, trying to be supportive of whatever decision they make; whether they want to report it or not. Trying to have their best interests in mind, but also respecting their choices regardless of what they may be and setting your own opinions aside and trying to remain supportive but neutral".

Empathising and believing women's disclosures was more important to some staff members than others. These healthcare professionals were often frustrated with their colleagues who questioned the veracity of a disclosure of sexual violence due to psychosis or lack of evidence. Lucy (Nurse) empathetically discussed her understanding of psychotic symptoms as grounded in lived experience: "I suppose instead of just pushing that aside as, 'Oh, it's just the psychosis'. You're right, they are psychotic, but the memories of their experience from before is still real". Similarly, Angela (Allied Health) took the stance of believing the woman's disclosure: "Possibly [an allegation of sexual violence is] not true, but why did we believe it's not true until we find out. I find that common here". Lauren (Nurse) explained this is an issue they frequently face within the unit and try to address through training and challenging perspectives: "We'll often get people, and they will report 'I've been assaulted on the unit'. Sometimes it's difficult for staff, they'll think, 'Oh, is it just part of a delusion or something like that?' That's a pretty big challenge, and a big part of the training as well. Where I try to emphasise that it [truthfulness] doesn't matter". Madeline (Allied Health) described her strategy of acknowledging that their role is not to question but to create a safe and trusting environment for women to make disclosures: "Unfortunately, I still get responses like, 'We're not sure if it's true', or 'It's part of her illness'. So really just making sure that it's not our job to investigate whether something is true or not but more so to make sure that the person feels safe and has the option to disclose if they wanted to".

Staff were at times critical of the treatment recommended and provided to women. Some health professionals expressed their despair that certain retraumatising practices were still being carried out within the organisation. They had difficulty making decisions, asserting their opinions or having to 'follow certain rules' feeling it was incongruous with their personal beliefs and clinical judgement. Brooke (Nurse) illustrated this with a distressing example: "My old nurse in charge, when the female nurses were off, organised male staff and male security staff to hold down and give a female consumer IM [intra muscular] injections. And that's not on, so, that will be followed up by management because that's just appalling behaviour

and that shouldn't be happening here. And it happened again last month. I'm horrified by the whole scenario. We've just traumatised a patient". Encouragingly some staff felt confident enough to raise their concerns with management; however, this is not always the case. A barrier to assertively raising their concerns was a lack of confidence to speak up and disagree with more dominant colleagues as noted by Charlotte (Manager): "I think sometimes it's about confidence, that sometimes a colleague is a lot stronger in verbalizing what they think should go on, or even sometimes if I [the manager] go in, I notice that people withdraw. They'll wait for that authority, for people to decide for them. We're really trying to change this". In these instances, staff sought out and relied on management to assert their authority rather than feeling that they could be assertive or raise their concern themselves.

The main findings are summarised below in Table 1. The typology of *dismissing and denying* consisted predominantly of male staff who expressed fearfulness and ambivalence towards female consumers. The typology of *acknowledging but unprepared* consisted of male and female staff who expressed anxiety and a lack of confidence in response to providing care to survivors of sexual violence. The third typology, *empathising but despairing*, denotes health professionals' frustration with their colleagues and a sense of powerlessness with leadership and the health system.

Discussion

This study explored Australian health professionals' perceptions of care provided for women in psychiatric inpatient settings who are survivors of sexual violence.

Our findings suggest that health professionals working in the participating psychiatric inpatient units fell into three groups: those who expressed disparaging perceptions towards female consumers resulting in minimising, ignoring or blaming responses to disclosures of sexual assault; those who recognised the prevalence of sexual violence but felt unequipped to respond appropriately; and those who understood the complex bidirectionality

and the limitations of the care provided. Attitudes within these groups were mostly associated with particular types of participants, suggesting that training around gender-sensitive care may need to be targeted based on role, gender and years of experience.

The disparaging perceptions of female consumers in this study were predominantly held by male staff and less experienced health professionals. Health professionals who lack experience have been found more likely to be disrespectful or inconsiderate of survivors [25]. Unfortunately, negative responses, such as victim blaming, doubting the veracity of a story, minimising the seriousness of the violence or denying assistance, are not uncommon from health professionals, particularly men [26]. Specifically, consistent with the findings of this study, negative attitudes are often reported towards consumers with a diagnosis of Borderline Personality Disorder [27]. Such responses result in less empathy and retraumatisation of survivors [26].

Staff dismissed and ignored disclosures of sexual violence in a number of ways. Sexual violence is often overlooked as secondary to a diagnosed psychiatric disorder, dismissed as a symptom of psychosis or minimised as historical, therefore not relevant to the consumer's current presentation [28, 29]. These practices further contribute to the re-victimisation of consumers, in addition to the witnessed and experienced traumatic events that occur during admission to a psychiatric inpatient unit [29, 30]. Furthermore, the use of 'alleged' when recording disclosures on medical notes is another subtle form of dismissing a disclosure of sexual violence [31]. Health professionals relate these practices to the limited time they have with consumers on psychiatric inpatient units [13]. Ultimately, such attitudes and practices of health professionals continue to silence and re-victimise consumers [21].

Male health professionals in this study distanced themselves from providing care for women who are survivors of sexual violence, believing it to be a more appropriate role for a female nurse. This is consistent with

Table 1 Typology summary table

Theme	Emotional Experience	Occupation	Gender	Position level	Years of experience in current setting
Dismissing and Denying	Fear and ambivalence	Medical, Allied Health & Nurses	Mainly male staff & comments by female staff about colleagues	Graduate and junior staff but also senior management staff	Mainly less than 2 years' experience, some between 4 and 6 years' experience, one staff with more than 10 years' experience
Acknowledging but unprepared	Anxiety and lack confidence	Medical, Allied Health & Nurses	Male and female	Graduate and junior staff, some senior nursing staff	Half with less than 2 years' experience and half with more than 10 years' experience
Empathising but despairing	Frustration and powerlessness	Nurses & Allied Health	Mainly female staff	Senior to junior staff	Mainly less than 2 years' experience, some with 5 years' experience, some staff with more than 10 years' experience.

previous beliefs held by health professionals [32]. However, this is contrary to reports from victim/survivors, that gender of the clinician is irrelevant when they provide a supportive response to a disclosure of violence [33]. It is important to be cognisant of the sociocultural norms that reinforce attitudes of violence against women that might be shared by health professionals [34].

Staff acknowledged that sexual violence was a serious issue for many of the female inpatients. Nonetheless, nurses and allied health staff in this study reported feeling anxious, frustrated and powerless to respond appropriately to consumers with such experiences. This may also be a result of the dominant biomedical model that typically informs the mental health sector in Australia [35] despite the presence of gender-sensitive and trauma-informed policies in place across the participating psychiatric units. The biomedical model trains health professionals to focus on diagnosis, treatment, and prescription of medication [17], rather than how to respond to the impacts of trauma, with trauma symptoms seen as pathological rather than adaptive [31, 36]. This narrow focus results in a lack of adequate training on sensitive inquiry and response to disclosure of sexual violence. Thereby perpetuating a cycle of anxiety, avoidance and the use re-traumatising practices such as restrictive interventions, body searches and round the clock observations [21, 22, 37]. This approach is counterproductive for consumers and can result in vicarious trauma for health professionals [38, 39].

Consistent with previous research [40], our study suggests that female health professionals, who were predominately nurses and allied health staff, not only have greater empathy for female consumers, but also have greater understanding of sexual violence than their male or less experienced colleagues. They are also more likely to assess for trauma than their male colleagues [14]. Health professionals expressed frustration due to the disparaging perceptions held by their colleagues and the focus on symptomatology of the biomedical model. These challenges were further compounded by the hierarchy amongst health professionals working in this setting and the difficulty speaking up against the system [41]. To overcome this challenge, meaningful collaboration with other nurses and consumers provides an alternative but cohesive way of functioning [41]. Health professionals and management need to understand these power dynamics that are often enacted within acute psychiatric inpatient units.

Trauma-informed care is a model that offers a solution to these challenges in mental health settings. It provides an opportunity for improved experiences and relationships between consumers and health professionals through greater understanding, respect and trust [22]. This model of care sees the consumer within a holistic

context and it acknowledges the pervasiveness, directionality and impact of trauma [42–44]. Considering the above typologies within the trauma-informed care framework, the *dismissing and denying* group could be considered 'trauma-uninformed' [22] due to their negative attitudes towards female consumers and dismissiveness towards histories of sexual violence. The *acknowledging but unprepared* group, display emerging trauma-informed skills, as they demonstrate an understanding of the extent and impacts of sexual violence on a consumer's current wellbeing and feelings of safety but lack the skills and competencies to implement into their practice. The *empathising but despairing* group appear to have a fuller understanding of adopting a trauma-informed care approach, in addition to the skills and competencies to implement this in their practice. Understanding health professionals' level of knowledge of trauma-informed care, could help tailor training to meet their individual needs.

Limitations

Although participants were recruited from four different psychiatric inpatient units, these were all within the one mental health organisation. This sample is likely to have been informed by health professionals who had a greater knowledge of gender-sensitive issues than other mental health professionals. This sample comprising two-thirds females and half nurses, is representative of the female and nursing dominated mental health workforce [45]. Researcher bias was minimised through co-development of the coding framework and collaborative review of themes between four members of the research team (each drawing on different disciplinary backgrounds). However, it is still possible that the experiences of the research team influenced our interpretation of data.

Implications

Despite numerous training packages being implemented within mental health settings, disparaging perceptions or avoidance of providing care for survivors of sexual violence continues. There is some evidence to show that education and training on the effects of trauma and challenging paternalistic views has positive effects in changing attitudes of doctors and nurses [46]. Training programmes need to be tailored to health professionals' level of knowledge, their environment and provide clinical skills to sensitively identify, discuss and respond to trauma and sexual violence [14, 47]. Health professionals should also be encouraged to discuss and reflect on their personal gender stereotypes that perpetuate these pejorative perceptions and adversely impact on the care provided [35]. Further research is needed in this area. Policies need to clearly prioritise and address gender and sexual violence. Importantly, policy and practice need to align. Successful implementation of policy is

dependent on health professional attitudes, knowledge and preparedness to respond to trauma [14]. However, trauma-informed care is more than its sum of its parts; principles, understanding of trauma, reflective practice, individual practices or policy [48]. Comprehensive implementation is complex, multi-layered and requires whole of organisation approach over a sustained period of time [48, 49].

Conclusion

These findings highlight the presence of disparaging perceptions towards female consumers who are survivors of sexual violence and thereby the impact this has on the care they receive in psychiatric inpatient units. To date, there has been limited qualitative research into health professionals' perceptions of care provided in this setting. This is problematic as it has overlooked the tension between the collective attitudes held by health professionals depending on their training, gender and years of experience. Most research investigating mental health and trauma has centred around the reduction of restrictive interventions and seclusion, practical strategies of implementing trauma informed care, changes to leadership styles, modification to the historical authoritarian nurse-consumer relationships and changes to policies [35]. Further research is needed to understand origins of health professionals' perceptions and ways of changing perceptions, attitudes and culture.

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Authors' contributions

All authors (COD, LT, SF, KH) made substantial contribution to the conception and design of this research. COD conducted the interviews and completed the analysis and interpretation on all interview transcripts. Authors LT, SF and KH were involved in the coding, analysis and interpretation of the interview data. COD was a major contributor in writing the manuscript, with LT, SF and KH providing feedback on drafts throughout the writing process. All authors read and approved the final manuscript. All authors have agreed to be personally accountable for their own contributions and the contribution of co-authors. No editorial services, scientific writers or any other authors have been removed from authorship of this article.

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Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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The study was approved by both the Human Research Ethics Committee (HREC) at Melbourne Health and the HREC at the University of Melbourne. Participants were given a Plain Language Statement to read prior to interview and provided written consent prior to completing the interview.

Consent for publication

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Competing interests

The authors declare that they have no competing interests.

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6.3 Reflections from the field

Based on the typologies discussed in the above journal article, overall, the system was observed by the researcher to be mostly 'trauma-uninformed.' There was little discussion of trauma histories and gender-based violence during handover meetings and other observations during the data collection phase. Conversely, several possibly traumatising practices were recounted during handover meetings. These included the ongoing use of restrictive interventions that would be considered examples of gender-based violence and likely highly traumatising for the women who were restrained. During observations, much of the discussions during handover meetings centred around bed management and discharge planning. It is clear that the service system pressures of managing admissions are a high priority; however, this must be reformed to begin moving towards a system with 'emerging trauma-informed practices' (O'Dwyer, Tarzia, Fernbacher, & Hegarty, 2019a).

Despite attending the units weekly over many months, the researcher mainly felt unwelcome. This was experienced on many levels. Firstly, from the reception area at three units, staff frequently ignored the researcher and there were repeated issues gaining access to the units. Only one of the four units remembered the researcher, quickly facilitated contact with key staff members, and provided access to the unit. Once access was gained to the units, the researcher was often allocated a desk in the office space rather than in the ward's nurses' station. It was often difficult for the researcher to move freely around the unit due to swipe card access requirements. Only one unit provided the researcher with their swipe card to allow freedom of movement around the unit. Secondly, the researcher was locked out of the nurses' station on one occasion. When a staff member finally answered the researcher's knocks, they commented that there was a delay in answering as the researcher was unfamiliar and presumed a consumer's visitor or family member. This feeling of being ignored was observed as a parallel process with consumers whose knocks at the nurses' station windows were frequently unanswered or delayed for prolonged periods. This extended to the many and varied excuses staff members provided to avoid interview participation. Overall, this gave the researcher the impression that they were not welcome and did not prioritise the research despite the initial enthusiasm shown.

6.4 Chapter Summary

This chapter answered research question three of this thesis, exploring health professionals' perceptions of providing care in acute psychiatric inpatient settings to women survivors of sexual violence. Three themes were developed: *Dismissing and Denying*; *Acknowledging but Unprepared*; and *Empathising but Despairing*. Three typologies were developed from these themes, which showed the differing attitudes and responses towards victim-survivors by health professionals. These include gender, professional training, and the level of experience of health professionals. These typologies were further linked to health professionals' level of understanding of trauma-informed care. In conjunction with the fieldwork observations, the findings show that much work needs to be done before a genuinely trauma-informed care approach is embedded. These findings suggest a need to address health professionals' attitudes, sociocultural norms, and care models dominating acute psychiatric inpatient units. These changes must co-occur with policy and practice guideline reforms that are direct, inclusive, and implemented consistently across all units throughout the mental health service regardless of staff professional background or gender and supported by leadership. The next chapter discusses the third publication of this thesis. This publication explores health professionals' experiences of enacting gender-sensitive care using Normalisation Process Theory.

CHAPTER 7: GENDER SENSITIVE CARE IN ACUTE PSYCHIATRIC INPATIENT UNITS

7.1 Chapter Overview

This chapter presents the third and final published article of this thesis. This qualitative research paper answers research question four: *How is Gender-Sensitive Care (GSC) enacted across acute psychiatric inpatient units for women survivors of sexual violence?* Normalisation Process Theory (NPT), a conceptual framework for understanding how complex interventions can become normalised in practice, was used to evaluate the implementation of gender-sensitive care. Using the four NPT constructs, this paper explores how gender-sensitive care is implemented in acute psychiatric inpatient units. The paper was peer-reviewed and published in BMC Health Services Research in December 2019. The chapter concludes with a summary of the key findings and central observations from the fieldwork related to research question four of this thesis.

7.2 Published Results Manuscript (paper 3).

RESEARCH ARTICLE

Open Access



Health professionals' perceptions of how gender sensitive care is enacted across acute psychiatric inpatient units for women who are survivors of sexual violence

Carol O'Dwyer^{1*} , Laura Tarzia^{1,2}, Sabin Fernbacher³ and Kelsey Hegarty^{1,2}

Abstract

Background: Sexual violence is a global public health issue. It is a form of gender-based violence commonly experienced by women accessing mental health services. The biomedical model has been the dominant model of care in acute psychiatric units, however, there has been a global movement towards more gender-sensitive and trauma-informed models. To date, only a small amount of research has focused on evaluating these models of care and health professionals' experiences of providing this care. The aim of this study is to gain an in-depth understanding of healthcare professionals' perceptions of how Gender Sensitive Care (GSC) is enacted across acute psychiatric inpatient units for women who are survivors of sexual violence.

Methods: This study used case study methodology and the Normalisation Process Theory (NPT) conceptual framework. NPT is a practical framework that can be used to evaluate the implementation of complex models of care in health settings. It included semi-structured interviews with 40 health professionals, document and policy reviews, and observations from four psychiatric inpatient units within a large Australian public mental health organisation. Data were examined using thematic and content analysis.

Results: Themes were developed under the four NPT core constructs; 1) Understanding GSC in acute psychiatric units: "Without the corridors there's not a lot we can do", 2) Engagement and Commitment to GSC in acute psychiatric units: "There are a few of us who have that gender sensitive lens", 3) Organising, relating and involvement in GSC: "It's band aid stuff", 4) Monitoring and Evaluation of GSC in acute psychiatric units: "We are not perfect, we have to receive that feedback".

Discussion: Many health professionals held a simplistic understanding of GSC and avoided the responsibility of implementing it. Additionally, the competing demands of the biomedical model and a lack of appraisal has resulted in an inconsistent enactment of GSC.

Conclusions: Health professionals in this study enacted GSC to varying levels. Our findings suggest the need to address each NPT construct comprehensively to adequately implement GSC.

Keywords: Health professionals, Mental health care, Acute psychiatric inpatient setting, Trauma, Normalization process theory

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Contributions to the literature

- Previous research has shown that the shift towards trauma-informed principles in mental health settings is encouraging, however, there is limited research to date evaluating the implementation and effectiveness of models of care in acute psychiatric inpatient units.
- This research provides qualitative insights using a case study methodology and NPT to further understand that challenges of implementing a complex model of care. NPT is a practical framework that can be used to evaluate the implementation of complex mental health models of care.
- These findings contribute to improving the provision of high quality, gender-sensitive care of female consumers during their admission to acute psychiatric inpatient units.

Introduction

Sexual violence is a global public health problem and the health system has a key part to play in a multisectoral response [1]. Primarily perpetrated by men against women, sexual violence has strong associations with poor mental health [2], including serious mental illness [3, 4]. It is estimated that one in three women accessing inpatient or outpatient mental health services have previously experienced domestic violence, including sexual violence [5]. Despite this, historical sexual violence is generally not identified by mental health services [3]. Furthermore, international research suggests that mental health services have tended to overlook the privacy and safety needs of female patients in psychiatric settings [6]. Women consumers in inpatient units frequently report experiencing harassment, intimidation, abuse, feeling threatened or unsafe [7]. Currently in Australia, most psychiatric units continue to have mixed gender wards [8, 9]. Staff report a lack of confidence and skills to respond appropriately to disclosures and therefore frequently do not ask about sexual violence [10, 11], whether historical or experienced on the ward. This avoidance of sexual violence is further compounded by the dominant biomedical model that informs mental health services [9]. The biomedical model views trauma symptoms as pathological rather than adaptive [12], and focuses on diagnosis, treatment, and prescription of medication [13, 14].

Encouragingly, there is a global shift across mental health settings from the biomedical model [15] to more trauma and gender inclusive models of care to support consumers with various presentations and comorbidities [16–21]. Trauma-informed care (TIC) recognizes the responsibility of mental health services to be responsive to the pervasiveness, bidirectionality and impact of trauma experienced by people with mental

health disorder at a systemic level [22]. GSC is a multi-elemental model of care, within TIC, that specifically considers gender and individual factors in the context of service provision [16]. However, implementing these models of care in acute psychiatric inpatient units is complex, resource-intensive and requires a whole of systems response [1]. Despite training and education, health professionals continue to struggle to translate the values and principles into their day to day practice [23]. Previous work in this area suggests that in order for a model of care to be effective, it must be integrated into all levels of policy and practice to influence how services and staff care for female consumers [24] and be in line with the values of staff implementing it [25, 26]. Moreover, it needs to acknowledge and address the tensions that exist between the biomedical model, including compulsory treatment, control, risk and safety with the principles of gender sensitive and trauma-informed care, such as collaboration and choice [27]. Yet, existing research would suggest that this has not yet occurred within the acute psychiatric inpatient setting in Australia.

There is a paucity of literature that evaluates the implementation and effectiveness of trauma-informed models of care at an organisational or systems level [28]. There is also an underdeveloped systems approach to implementing GSC [16], specifically in clinical psychiatric settings [29]. Most research on trauma-informed care to date has focused on reducing restraint and seclusion and utilized quantitative approaches [30]. It has also focused on examining the challenges to implementing trauma-informed care in acute mental health settings and mapping these findings against the principles of trauma-informed care [30]. The aim of this study is to gain an in-depth understanding of health professionals' perceptions of how GSC is enacted across psychiatric inpatient units for women who are survivors of sexual violence. We draw on rich qualitative data, document and policy reviews and observations, and use Normalisation Process Theory (NPT) [31] to assist with interpreting our findings. NPT is a social implementation theory [31] that recognises the challenges of implementing complex interventions in healthcare systems with multiple professions and interactions [32]. NPT provides a conceptual framework for understanding how new and complex interventions become *normalised* into clinical practice [33] through implementation, embedding and integration [31]. NPT can be used to design interventions or organise and evaluate interventions as part of the implementation process [32]. The knowledge generated by this study is integral to understanding and improving the provision of high quality, gender-sensitive care of female consumers during their admission to acute psychiatric inpatient units.

Method

Context

The Victorian Government began to focus on GSC as a model of care following reports by women in psychiatric inpatient units of feeling unsafe and experiencing sexual violence [10]. This resulted in the publication of 'The gender sensitivity and safety in adult acute inpatient units' project report and the 'Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units' guideline [34]. Furthermore, the 'Service Guideline on Gender Sensitivity and Safety: Literature Review' [35] and 'Service guideline on gender sensitivity and safety; Promoting a holistic approach to wellbeing' were published in 2011 [36]. The latter was implemented by the mental health organisation included in this study following its publication. This guideline specifically provides practical directions on gender-sensitive care, trauma-informed care, bed-based services and responding to incidents [36]. It also provides directions for supporting those who have experienced various forms of violence and diverse populations and communities, including women with mental illness and trauma histories [36]. The gender sensitive model of care operates at an organisational and systems level, including the environment, management and leadership, direct contact staff, practitioner support, referral pathways, information sharing, protocols and policies, and community linkages [36].

Study design

This study used a qualitative case study design as its methodology of inquiry. Case study methodology involves the investigation of a phenomenon within its real-life context [37]. A collective instrumental design with cross-case analysis [38] was chosen as the most suitable to illustrate the similarities and differences of this case study. This case study specifically explores health professionals' perceptions of providing GSC for women who are survivors of sexual violence within four different acute psychiatric inpatient units within one mental health organization in Victoria, Australia. It involved semi-structured interviews, document and policy analysis, and observations over a 12-month period.

Recruitment

Health professionals were recruited from a variety of different professions, levels of seniority, and genders using a purposive sampling strategy. Approval was sought initially from managers, the lead researcher then attended staff meetings to promote the study and distribute Expression of Interest forms. Interview times and dates were arranged at a mutually convenient with staff who expressed interest. For de-identification purposes all participants have been provided with a pseudonym.

Participants

Forty mental health professionals participated, including 20 psychiatric/nursing staff, 10 allied health professionals (psychologists, social workers and occupational therapists), seven medical staff (psychiatric registrars, medical officers and consultant psychiatrists) and three consumer/peer support staff. Staff in psychiatric inpatient units undergo specialization in mental health/illness prior to working in these settings. Twenty-seven participants identified as female and thirteen as male. Thirty-one staff worked full-time and nine part-time. Participants had varying levels of experience, ranging from three months to 29 years. Their age varied from 21 to 64 years with a mean of 42.5 years. Staff predominantly identified as being of Australian nationality (77.5%). Staff had access to training on gender sensitivity and safety as part of the implementation process of the gender sensitivity and safety guideline [36]. Participants names have been changed to pseudonyms'.

Data collection

Forty semi-structured interviews by phone [2] or face-to-face [38] were conducted between March and December 2016. The female lead researcher (COD), who is a registered psychologist and PhD Candidate, conducted all interviews individually in a private office space across the four psychiatric inpatient units. Confidentiality, anonymity, the research aims and rationale were reiterated prior to commencing the interview to reduce social desirability bias [39]. The semi-structured interview involved predetermined open-ended questions but also allowed for discussion with the participants. Interviews ranged from 12 to 90 min (average of 40 min), covering questions on the type of care provided to women with a history of sexual violence, how care is implemented, and how it is supported (see Additional file 1 for further information). Questions were pilot tested with allied health professionals not employed by the Health Service. Field notes were made before, during and after the interviews. Observations were also conducted at the four psychiatric inpatient units over the 12-month period. All interviews were audio recorded and fully transcribed verbatim by a professional transcription service. Participants names have been changed to pseudonyms by the researcher. These are used, along with professional background, to support quotations and give context. Feedback on transcripts was offered to all participants, two participants provided comments and corrections on their transcripts. Documents were also collected from the mental health organization and specifically from all four acute psychiatric units.

Data analysis

The documents and transcripts were coded by the lead researcher using NVivo 11 (QSR International, 2015)

software to manage the data. The lead researcher (COD) used content analysis to analyse the documents [40]. Analysis focused on understanding health professionals' experiences of how gender-sensitive care is enacted across acute psychiatric inpatient units for women survivors of sexual violence. It also focused on understanding the experiences and perceptions of providing this care [41]. The lead author engaged in regular reflective practice and supervision with co-authors throughout the analysis and coding process. The lead researcher used an inductive method to code all the interview transcripts and conduct a thematic analysis [42]. Relevant statements were coded with ample context to avoid data fragmentation and decontextualisation [43]. The authors (KH, LT, SF) worked collaboratively to discuss the emerging themes, resolve any differences and to ensure consensus on the development of these themes [44]. These themes were mapped to the corresponding NPT core constructs. NPT is operationalised through four main constructs; Coherence-how participants make sense of the intervention, Cognitive Participation- commitment and engagement of the intervention by participants, Collective Action- organising and enacting the intervention and Reflexive Monitoring- how participants appraise the intervention after it is in use [31].

Ethical considerations

The study was approved by both the Human Research Ethics Committee (HREC) at Melbourne Health and the HREC at the University of Melbourne. Participation was confidential, and managers were not informed about who participated. Informed consent was obtained via a Plain Language Statement. Participants were asked to sign and return a consent form prior to commencing an interview. No incentive was offered.

Results

The findings from the health professionals' interviews, documents and policy reviews, and observations are outlined below within the four NPT core constructs, relating them to the main findings in each construct. No major differences were found across the four different psychiatric inpatient units following data analysis, thus the similarities between the four units is discussed below.

Understanding GSC in acute psychiatric units: "Without the corridors there's not a lot we can do"

This construct refers to an individual and communal understanding of the intervention or process required and how it differs to previous work. For an intervention such as GSC to be normalised, all stakeholders need to understand and value the model of care and to demonstrate some investment in the *meaning* of it. Most of the health professionals in this study make sense of GSC

predominately through the physical characteristics of the units and the biopsychosocial treatment modalities provided.

Health professionals across all four inpatient units appeared to have a similar understanding about what GSC is, with consistent use of documents across all four units. Many of the staff described the physical aspects of the units such as the segregation of genders through women only corridors and women only groups, and the provision of swipe wrist bands to access the women only corridors. As Chris (nurse) described "*The female corridor can be locked off, the consumer gets a swipe [band] to swipe in and out of that locked area. I think if anything we've made advances in that area, being a bit more protective of our vulnerable females. We've also got women's only lounges for the girls if they don't feel comfortable sitting in the lounge area with multiple people. It's definitely the biggest difference in recent years*". Several staff also identified the ability to monitor and observe women who were deemed more vulnerable as part of GSC. They described doing this by placing them in closer proximity to the nurses' station if a bed wasn't available in the women's corridor. Alternatively, women were moved to another area of the ward following an incident or allegation, however, this was not always possible as described by Jason (Allied Health) "*The perpetrator and victim had to stay in the locked ward together, so we had to get extra nursing staff to observe the perpetrator. Once the victim became better, she was transferred to her own space*".

Treatment was described as providing individualised treatment plans, including sensitive physical examinations if needed. It includes attempts to manage risk through frequent risk assessments and minimise retraumatisation through a reduction in restrictive intervention. Bernadette (Nurse) reported "*throughout your shift you do a constant risk assessment*", furthermore Lucy (Nurse) described the care as "*coordinating restraints, injections and bedroom allocations, avoiding placing a female consumer beside a male who is disorganised*". Treatment modalities reportedly ranged from "*medication that we use through to sensory modulation. The occupational therapy team has the best expertise in that. Psychology if it's appropriate. We will sometime make safety plans. In terms of day to day care and making sure the staff are aware of any anxiety that they may have, and they are attentive to that*" (Jack, Medical). Some staff also reported that this treatment planning extended to internal referrals, and external referrals as part of discharge planning. Internal linkages between different disciplines (OT, psychologist, social worker, peer support staff) and external referrals (Police, sexual assault services, community services) were made to ensure appropriate support regarding sexual assault or safety

issues. Gillian (Nurse) described the care provided to a woman who was admitted who had recently been sexually assaulted *"she was admitted to our intensive care area, started on medication for her mental state, became better and was supported to get in touch with (sexual assault service) contacting the police and the (sexual assault police unit) interviewed her on the ward, she got better and went ahead with the charges"*.

Engagement and commitment to GSC in acute psychiatric units: "There are a few of us who have that gender sensitive lens"

This construct states that normalisation of a new practice or model occurs if all stakeholders engage with the model and use it and that there is a demonstration of commitment to GSC required to implement the intervention. Participation in the implementation of GSC was dependent on health professionals' understanding of how they make sense of GSC as described above and their commitment to it. Female staff and middle management recognise the importance of GSC as part of their role. However, many staff described it as "others" role.

Many of the health professionals described female staff as key participants in providing GSC *"We do try to accommodate the patient by trying to get female clinicians or doctors"* (Frank, Medical). These also included staff with specialist knowledge in GSC, such as the "creating safety" nurse on each ward, staff who were part of the gender sensitivity and safety committee at a unit or organisational level, allied health staff and peer support staff. *"Allied Health's really good. Their understanding of issues and their awareness is greater. Our creating safety nurse on the unit's an enabler. I recently lobbied to have a women's group reinvigorated for consumers around their safety on the units and having consumer peer workers involved and that was really warmly received by the coordinator, the peer workers themselves and the nurse unit manager"* (Kaye, Allied Health). Middle management, such as clinical managers, nurse unit managers, shift leaders, nurse in-charge were also identified by staff as being key participants in implementing GSC on the units. It was described as the responsibility of specialist staff and middle management to collaborate and consult with external services, such as sexual assault services. This collective response to an incident or allegation was described by Bernadette (Nurse) *"The social worker would be involved, the treating team on both clients, and the team meaning there's a psychiatrist and a doctor, whether it's a hospital medical officer, whether it's a registrar, or an intern. The nurse in charge gets involved somewhat, the contact nurse definitely gets involved"*. However, only one unit reported identifying Executive Management as driving implementation and having strong linkages with external services. This deficit was

recognised by James (Nurse) *"It flows down from management and senior clinicians, whether it's doctors, nurses... it trickles down into culture to support and take these incidences seriously"*.

Key staff, described above, recognised GSC as part of their role, however, most staff dismissed it as the role of others. Male staff avoided responsibility for participating in GSC due to it being "secret women's business". Many of these health professionals from various professional backgrounds blamed their inability to participate in GSC on others and external factors rather than reflecting on their own personal reasons or deficits. Examples of this include not having a psychologist on staff, a lack of staff with specialist knowledge or having to follow directions by leadership or management as getting in the way to them being able to implement GSC. Some staff also blamed process issues, such as lack of multidisciplinary involvement and collaboration during handover, ward rounds etc. *"The doctors are working so intensely with someone I think they forget the scope of what other disciplines can offer"* (Alison, Allied Health). Many staff recognised a major reason for this othering was due to a high percentage of new staff, students and interns who lack the training and skills to implement GSC.

Organising, relating and involvement in GSC: "It's band-aid stuff"

This construct refers to doing the work needed to enact a set of practices. This includes how new roles are organised, how people relate and are involved, and the knowledge and skills needed to complete the work. Normalisation of a model involving GSC occurs if all stakeholders work to operationalise it and demonstrate investment in effort. Staff reported many challenges to operationalising GSC, such as the physical barriers, consumer presentations, bed pressure, quick discharge of consumer, prioritising administrative tasks with time spent with consumers etc. These challenges highlight the dominance of the biomedical model in mental health which thereby impacts who is involved in the work and how the work gets done. Staff expressed the importance of collaboration, drawing on specialist knowledge direction and training as highly important to encouraging staff to enact and maintain involvement in GSC. These issues were further reinforced by an organisational emphasis on reactivity to incidents, a lack of consistency and commitment to enacting GSC.

Many staff expressed physical challenges to enacting GSC that were in contrast to the physical aspects they described as how GSC is enacted e.g. women's only corridor. These included physical barriers of the wards, such as mixed gender wards, small environments with limited space to move around, shared rooms and bathrooms, and the layout with the nurses'

station overlooking the unit and therefore not engaging with consumers. Kelly (Health professional) comments on the overall issue *"The environment is crucial to improving mental health, so I think there really needs to be a lot of changes around the way mental health units are designed. And because I used to work at [another hospital] there was a lot of work done on the design of the hospital, and just integrating the natural environment into the hospital environment. I think there is a lot of improvement needed in that area"*. Nursing staff frequently identified an uncertainty of prioritising daily unit tasks and duties, such as administration, with apportioning time to building relationships with consumers, which is key to GSC. This was reflected by Elise (Allied Health) *"The nurses try really hard to be on top of it which is impossible because they are so busy and the demands of day to day tasks of observing and medication and nursing care and a zillion other thing"*. This time pressure and burden of tasks resulted in responding to consumers at a reactive level as per *'squeaky wheel'* rather than providing individualised proactive care to all consumers.

Health professionals reported an increase in acuity and aggressive behaviours from consumers due to substance use, namely ICE. This resulted in a retraumatising and countertherapeutic environment. Keith (Nurse) provided an example *"At 2am in the morning and people are screaming, carrying on. Fires are being lit in the ward, people are being assaulted. The police are here, the fire brigade are here. I know the management are quite supportive, but I think it's a different thing. Being supportive against being there in the moment and experiencing those sorts of things"*. Another pressure reported by most staff was to stabilise the consumers mental health symptoms and to discharge. Camilla (Nurse) stated *"It's very much a band aid here, you just stabilise them and send them out and hope for the best. I don't think it would be that great, especially in ED, I did a couple of emergency shifts over the weekend and apparently if anyone comes in with issues related to sexual violence issues, no-one in ED here deals with it, they have to go to the [another hospital]"*. A lack of collaboration with other hospitals, community or external services also impedes enactment of GSC or long term follow up. Furthermore, staff reported pressure to prioritise bed availability and filling beds over safety of women or ensuring women were allocated to women only corridor. Due to the limited number of women only corridor beds, staff were required to assess women's vulnerability using a checklist and allocate accordingly. Observations at meetings and on the units supported this pressure to prioritise discharge of consumers and allocate beds to admissions. Lauren (Nurse) described *"I think there's some challenges, we've got the guidelines, the*

flowchart that prioritises, which women will go into the female corridor, sometimes we will just have women say, "No, I don't want to be moved, I want to stay here." In the end we have to respect someone's choice. There's always challenges I think, just in terms of staff awareness, and being more attuned to those risks". This struggle was evidenced in documents that aided in decision making and prioritising of women to women's only corridors based on assessment needs.

Staff recognised the importance of a supportive team environment and collegiate support to overcome some of these daily challenges and concerns. This was evident at various levels and across all professional backgrounds. This was maintained through good communication on daily issues, regular unit meetings and good linkages with specialist services and staff, regular training, information sharing and clear resources. This maintained individuals' motivation and engagement in participating and practicing GSC. For junior staff having regular access to supervisors was important. Nursing and allied health staff reported being able to approach colleagues with specialist knowledge and those on the gender sensitivity and safety committee for advice and feedback. Allied Health staff appreciated being collaborated with at a multidisciplinary level. Kate (Allied Health) commented *"I have good supervisors. They provide really good support. We have a good multidisciplinary team. We're quite good at bouncing ideas off each other, just coming up with ways in which we can further support the person. If we're hitting dead ends, I know a lot of the nurses are the main contacts for people. They get quite a lot of information"*. Medical staff and those at middle management level reported supportive leadership and being able to seek out clinical governance advice was extremely beneficial. *"Just get some advice from my seniors to see if there's something more to be done"* Frank (Medical) commented. Overall most of the health professionals in this study reported working collaboratively was highly motivating and provided job satisfaction.

Many health professionals recognised that having clear procedures, protocols, guidelines and evidence-based practice, regular training as useful in enacting GSC. This was supported by the consistent use of policies and procedures promoting gender sensitive practice and sexual safety across the mental health organisation. Furthermore, clear reporting avenues and documentation enabled staff to share information from one shift to the next. However, this was also seen as a downfall if staff did not clearly document then it was often overlooked as described by Brooke (Nurse). *"If there's an incident on the ward where sexual activity has taken place, we have protocols in place. We have a clear outline of what needs to happen and what has to happen. It just depends on which nurse is on, as to whether it happens or not."*

Management will follow it up. All incidences. Make sure everything gets [reported on the internal database]. Make sure that the proper channels are gone through". The gender sensitivity and safety committee provided a regular opportunity for key drivers from each unit to collaborate to work together on GSC topics *"Having champions that will hold that information and that's where the Gender Sensitivity Committee's become really important. We've always got that lens in our work, but how do we have other people have that lens in their work as well? That's the challenge"* commented Maryann (Allied Health). Developing all health professionals knowledge and skills in GSC through forums, training, education and staff meetings where gender sensitive topics were raised was highly valued by staff. This was particularly important for new graduates and junior staff who lacked the skills and experience to confidently respond to gender sensitive issues.

It was evident across all four units that engagement with GSC and therefore implementation varied depending on key drivers. Some documents across the four units were consistent however this was not always the case, which contributed to the varied staff involvement. At an organisational level, staff reported that senior staff were not involved in the practical implementation of gender sensitive care model. *"That's one of the things I've thought the [gender sensitivity and safety] committee fell down a bit because these came out of that committee but they weren't really endorsed by the Executive, the whole organisation, I think we need the Exec to push this stuff"* (Kaye, Allied Health). Furthermore, individual units and key drivers were required to build relationships with other services (Police and sexual assault services) to effectively work together. This was resource intensive and again dependent on the priorities of each unit.

Monitoring and evaluation of GSC in acute psychiatric units: "We are not perfect; we have to receive that feedback"

This construct is the individual or group assessment of the way new practice affects participants and other stakeholders. Normalisation occurs if continual monitoring and evaluation of GSC occurs. It refers to an investment in *comprehension* (May et al., 2011). At an individual unit and organisational level, evaluation and appraisal of GSC was reactive and in response to incidents that occurred. This reactive appraisal highlights the prioritising of safety and risk management that inadvertently reduces the priority of the principles of choice and control, women's or gender specific needs.

Monitoring and evaluating GSC was dependent on the priorities and the key drivers of each unit. This was predominately at a reactive level, with middle management health professionals reporting implementing

recommendations and changes based on review of incident reports, presenting and receiving feedback at a forum level. The review of a key sexual safety policy was delayed due to the involvement of an external organisation. Furthermore, staff identified opportunities for reflective practice to be minimal or reactionary to an incident i.e. diffusion/ debriefs post incidents of sexual violence. Staff reportedly appreciated and benefitted from these opportunities when offered. Jason (Allied health) described *"We do have regular diffusion sessions and reflective practice sessions on this ward. The diffusion is after an incident has occurred but reflective is where we are encouraged to open up about our feelings. There are so many things that happen on a ward on a regular basis that we need the opportunity to get it off our chests"*.

Appraisal of the effectiveness and usefulness of GSC was reported to be minimal. The feedback sought was often reactive with each unit reportedly contacting consumers post discharge however limited feedback was sought regarding safety, choice, control etc. Charlotte (Management) described how this was carried out on her unit *"taking the feedback and/ or complaint and talking to the consumers and staff, figuring out what went wrong and how we can improve that process"*. One unit did report to have held a focus group of female consumers some years ago to seek input into the development of a document. However, this appeared to be the only proactive appraisal reported.

At an organisational level, data was collected via a risk reporting database that categorised incidents of sexual violence. Those reported to be of a serious level were reviewed by senior management. These incidents reviews lead to discussion at a middle management, an individual staff or staff meeting level depending on what was needed. This lengthy process was describe by Steven (Management) *"Once an incident has been reported at level two, we review it internally and look at the rating of the event and the incident and determine the level of review that's required, for a more serious incident we would do an in-depth clinical review, for a medium rating it might be a team based review and then for a more straight forward one it might be just to ask the manager to review internally, the review findings and recommendations have to be reported to the board committee, which oversees safety"*. Attempts to refine procedures and modify practices again reportedly occurred on a reactive basis, depending on outcomes of incident reviews and via external sources.

Discussion

The aim of this study was to understand health professionals' perceptions of how GSC is enacted in acute psychiatric inpatient units. This was undertaken using a case

study methodology [37] and the NPT framework [31] to guide analysis. Overall, we found that staff understand GSC in simplistic terms. A significant challenge to implementing GSC is health professionals' lack of understanding of the complexity of this model of care. GSC is a multi-element model of care that considers gender, and individual factors in the context of service provision [16]. It is based on the principles of safety, knowledgeable staff, respect, acceptance and the avoidance of re-traumatization [16]. These challenges are perpetuated by the biomedical model's focus on symptoms and the constant pressures to manage compulsory treatment, control, risk and safety in psychiatric inpatient units [13]. The development of women's only corridors was initially used to highlight the need for safety [45], but has now become the main intervention that accompanies the biopsychosocial interventions routinely utilised in acute psychiatric units.

This study found that key drivers and working as a team were essential in participating and enacting GSC in all four units. However, a significant number of health professionals', predominantly male staff, justified their discretionary involvement in GSC. As a result, the role of enacting GSC was designated to key health professionals with specialist knowledge and/or female staff to implement a systems level model of care. This diffusion of responsibility has been linked to role, gender and health professionals' years of experience [41]. Furthermore, this perspective results in a lack of systems or organisational approach to implementation and thereby individual units implementing GSC inconsistently depending on the motivation of the key drivers. The appointment of 'champions' would be a proactive way of supporting all staff within the organisation to implement GSC and improve cultural change to address violence against women [46]. Furthermore, health professionals across the organisation need a shared understanding of roles and language, strong relationships between teams, regular training with feedback mechanisms and mandatory or motivated training attendance [46]. Importantly, this training needs to be targeted at the appropriate level depending on individual health professionals' knowledge, attitudes and skills of GSC [41]. Another challenge for staff was enacting GSC whilst balancing the competing demands of an acute psychiatric inpatient unit. Successful implementation of healthcare-based interventions needs to be tackled at an organisational level. Commitment needs to come from executive leadership and involvement from the bottom up to promote GSC, trauma-informed principles and gender-equitable attitudes [1]. The organisation also needs to establish clear referral pathways between health care services and special sexual violence services [1].

Monitoring, evaluation and appraisal was shown to be reactive at an individual unit and organisational level in

this study. This is a major deficit to adequately implementing GSC and within mental health organisations more broadly [47]. Monitoring and appraisal is essential to strengthen a health systems response to address violence against women [1]. It aids progress at an organisational level by feeding back referral data, monitoring progress of consumers, quality of care provided, funding requirements but also at a systems level to provide feedback on whether the model of care is effective or not [1]. Services must collect information to inform policies, monitor services and improve the care they are providing. In order for GSC to be normalised, all stakeholders need to have a comprehensive understanding, engage with the model of care and use it, work to operationalise it and demonstrate investment in effort, and continual monitoring and evaluation [31]. This study has shown that many of these important features are lacking and therefore will continue to be a barrier to providing quality GSC.

Limitations

Although participants were recruited from four different psychiatric inpatient units, these were all within the one mental health organisation. This sample is likely to have been informed by health professionals who had a greater knowledge of gender-sensitive issues than other mental health organisations. Researcher bias was minimised through co-development of the coding framework and collaborative review of themes between four members of the research team (each drawing on different disciplinary backgrounds). However, it is still possible that the experiences of the research team influenced our interpretation of data.

Implications

Further research is needed to identify and evaluate effective models of care to target the intersectionality of mental health and sexual violence within the healthcare sector. Additionally, there is a need for a functional health system response, with a multi-element response that addresses violence against women [1] and incorporates comprehensive monitoring and evaluation of the care provided [48]. This is an ongoing challenge in Australia and internationally due to frequently changing political landscapes and priorities [1].

Conclusion

These findings highlight the challenges of implementing a new model of care within the biomedical model of mental health organisations in Australia. To date, there has been limited qualitative research into health professionals' perceptions of care provided in this setting or evaluation of the model of care being implemented. This is problematic as it has expected health professionals to

understand, participate, enact and appraise a new model of care that is incongruent to the overarching biomedical model that governs their practice. Most research investigating mental health and trauma has centred around the reduction of restrictive interventions and seclusion, practical strategies of implementing trauma informed care, changes to leadership-styles, modification to the historical authoritarian nurse-consumer relationships and changes to policies [30]. As we can see a multi-element healthcare systems response is needed to adequately address violence against women with associated mental health difficulties and monitor its effectiveness [1]. Further research could include understanding consumers' perceptions of attending acute mental health and the models of care they expect.

Supplementary information

Supplementary information accompanies this paper at <https://doi.org/10.1186/s12913-019-4812-8>.

Additional file 1: The GSC Project Semi-Structured Interview Guide.

Abbreviations

GSC: Gender Sensitive Care; NPT: Normalisation Process Theory; TIC: Trauma Informed Care

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Authors' contributions

All authors (COD, LT, SF, KH) made substantial contribution to the conception and design of this research. COD conducted the interviews and completed the analysis and interpretation on all interview transcripts. Authors LT, SF and KH were involved in the coding, analysis and interpretation of the interview data. COD was a major contributor in writing the manuscript, with LT, SF and KH providing feedback on drafts throughout the writing process. All authors read and approved the final manuscript.

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Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Ethics approval and consent to participate

The study was approved by both the Human Research Ethics Committee (HREC) at Melbourne Health and the HREC at the University of Melbourne. Participation was confidential, and managers were not informed about who participated. Informed consent was obtained via a Plain Language Statement. Participants were asked to sign and return a consent form prior to commencing an interview.

Consent for publication

Participants' provided consent for the publication of quotes and information provided during interview.

Competing interests

The authors declare that they have no competing interests.

Competing interests

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7.3 Reflections from the field

This paper's key finding was the health professionals' simplified understanding of gender-sensitive care being women-only corridors and women-only groups. Furthermore, during unit-level gender-sensitive committee meetings, health professionals reported improved allocation to the women-only corridors. However, this was incongruent with observations on several occasions across all units. During handover meetings, the researcher observed reports of admissions of women who appeared to be at risk or vulnerable to harm who were not allocated to the women-only corridor e.g., an older woman with memory impairment. Similarly, during the data collection phase, the researcher observed staff discussing the allocation of men to women-only corridors or the continued placement of a perpetrator and victim in the same area, intensive care unit, due to acuity of illness and lack of availability on the women-only corridor. Furthermore, linkages with specialist services were reported as a key part of gender-sensitive care (Sweeney et al., 2019). However, Unit B was the only unit observed to collaborate with a sexual violence service during the data collection phase.

This paper reported that female staff, such as nurses, creating safety nurses, nurse unit managers, and middle management, are key staff members to report enacting gender-sensitive care. In contrast, medical staff, who are predominately male, were observed to lead most handover meetings across all four units, reflecting a hierarchy. This was observed in many ways. Firstly, through seating arrangements, with medical staff sitting around the table in the middle of the room, nursing and allied health staff either sat or stood around the room's outer walls. Secondly, the medical staff were observed to do most of the case presentations, involved in the clinical decision-making process and discharge planning. Only on one occasion during the data collection phase did the researcher observe a challenge to this process. This discussion involved a discharge coordinator from a nursing background, challenging a medical consultant's decision to discharge a consumer. This hierarchy of the biomedical model, which has previously been discussed, reinforces a lack of multi-disciplinary collaboration and dismisses the expertise of the key drivers of gender-sensitive care. Trauma-informed and gender-sensitive care are built upon the principles of collaboration, choice, and empowerment (Department of Health, 2011a; SAMHSA, 2014); however, this was rarely evident during handover meetings. Furthermore, it is suggested that handover meetings would be an opportune forum to collaborate on how gender-sensitive care is enacted and appraised within each unit.

These two NPT constructs, Collective action and Reflexive monitoring, were observed to be lacking.

7.4 Chapter Summary

This chapter answered question four of this thesis, investigating how gender-sensitive care is enacted by health professionals in acute psychiatric inpatient units for women consumers who are survivors of sexual violence. Health professionals held simplistic understandings of gender-sensitive care, with key staff holding responsibility for implementing gender-sensitive care. However, there was some incongruity between staff perceptions and observations during the data collection phase. Gender-sensitive care was inconsistently enacted across all four acute psychiatric inpatient units. These inconsistencies were related to multiple and varying factors, including the inconsistency of resources across the four units (Table 8, Chapter 5), the tensions between the biomedical model with gender-sensitive care, and a lack of appraisal and monitoring. These findings suggest the need to address each construct individually and comprehensively to implement gender-sensitive care adequately. The next chapter provides an overall discussion and a synthesis of the key findings. It will also discuss the strengths and limitations of this thesis and provide concluding comments.

CHAPTER 8: DISCUSSION AND IMPLICATIONS

8.1 Chapter Overview

This chapter begins with a review of the research aim and questions, and is followed by a discussion of the research findings that addressed these research questions. The second half of this chapter includes a synthesis of the overall key findings in the context of other literature and the strengths and limitations of the research. A description of the proposed implications for practice, implementation, and policy based on the synthesised key findings is then outlined. Following this, suggestions for future research opportunities are identified and discussed, and finally concluding comments are presented.

This research aimed to gain an in-depth understanding of health professionals' experiences of providing and enacting trauma-informed or gender-sensitive care in acute psychiatry for women victim-survivors of sexual violence within one mental health organisation. This overarching aim was addressed through the following research questions:

1. What is the current state of knowledge on health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings?
2. What is health professionals' awareness of the gendered impacts of trauma, and how does this impact the care they provide?
3. What are healthcare professionals' experiences and perceptions in providing care for women who are survivors of sexual violence in psychiatric inpatient units?
4. How is Gender-Sensitive Care (GSC) enacted across acute psychiatric inpatient units for women survivors of sexual violence?

A scoping literature review was conducted to answer the first two research questions (Chapter 4). This review builds on the limited extant literature on health professionals' experiences of providing trauma-informed care in acute inpatient units (Muskett, 2014; A. Quadara, 2015; Wilson et al., 2017). It provided an understanding of the need for a comprehensive, multi-faceted approach to implementing trauma-informed care. The most concerning finding was the gender-blindness and lack of consideration for violence against women within the studies

examined. In the few studies discussing gender, predominantly male staff reported negative attitudes towards women, trauma experiences were minimised, and perceptions focused on single-sex wards as sufficient support to address their trauma. Understanding gender, negative attitudes, and the impact these have on the care provided within mental health are essential (Howard et al., 2017). To date, the majority of research into trauma-informed care has been conducted with nurses (O'Dwyer, Tarzia, Fernbacher, & Hegarty, 2020; Wilson et al., 2017) with some recent research including psychiatrist perspectives (Isobel et al., 2020). The scoping review provided an understanding of the need and rationale for the third and fourth research questions.

A collective instrumental case study design (Stake, 1995) with cross-case analysis (Schwandt, 2001) was conducted to answer research questions three (Chapter 6) and four (Chapter 7). This case study design provided a method to explore the similarities and differences of health professionals' practices working within four adult acute psychiatric inpatient units of a Mental Health Service. An overview of the violence against women and mental health policy context was provided to further understand the context of the health professionals' experiences and practices (Chapter 5). This review showed that policy on mental health and violence against women were considered separate at all levels. This lack of integration is particularly concerning given the influence of the global and national policy at state and local level (Savage & O'Connor, 2015). At the State level, The Royal Commission into Family Violence in Victoria Report (2015-16), the 'Right to be Safe' Report (2018), and the MARAM framework (2018) were exemplary, with each incorporating gender, violence against women, and mental health. There were three organisational procedures within the Mental Health Service; however, these were lengthy and unclear, making them difficult for staff to use. There were significant inconsistencies at the Unit level, with Unit B standing out as having the most comprehensive resources to implement gender-sensitive care. This policy and document review informed research questions three and four; these will be explored below.

The third research question explored health professionals' experiences of providing care in acute psychiatric inpatient units for women survivors of sexual violence through a case study methodology (Chapter 6). This study's findings are the first to develop novel typologies to understand the idiosyncrasies of health professionals' adoption of care for victim-survivors of sexual violence. The first theme *Dismissing and Denying*, consisted of predominately male health professionals who were fearful and ambivalent towards female consumers, particularly

those diagnosed with Borderline Personality Disorder. This misguided perception of complex trauma is not uncommon in mental health (Salter et al., 2020). The second theme *Acknowledging but Unprepared*, consisted of male and female staff who were anxious and lacked confidence in responding to women victim-survivors. Implementing a new care model or providing care that extends beyond treating symptomatology is often a challenge for health professionals (García-Moreno et al., 2015). The third theme, *Empathising but despairing*, described male and female health professionals who were frustrated with their colleagues and felt powerless within the health systems and the organisational leadership to respond. A sense of powerlessness is commonly reported due to the hierarchy of professions within the biomedical model (Laker, Cella, Callard, & Wykes, 2019). This research and its developed typologies, helps understand health professionals' knowledge and the level of training required to target their readiness to implement trauma-informed and gender-sensitive care appropriately. The field work observations in conjunction with these findings, suggest a substantial amount of work is needed to progress from a mainly 'trauma-uninformed' approach to a trauma-informed and gender-sensitive approach to care. It is essential that strong health systems are in place to enable health professionals' to appropriately respond to gender-based violence (Hegarty et al., 2020).

The fourth research question aimed to understand how gender-sensitive care is enacted in acute psychiatric inpatient units for women survivors of sexual violence (Chapter 7). Normalisation process theory (NPT) was used to interpret the findings of how gender-sensitive care is enacted as it recognises the complexity of implementing interventions within healthcare systems (May et al., 2007). For gender-sensitive care to be normalised, all stakeholders need to be guided by governmental and organisational policies to aid a comprehensive understanding and engagement with the care model. All stakeholders need to work together to operationalise gender-sensitive care, demonstrate investment in effort, and continual monitoring and evaluation (May & Finch, 2009). This study showed that many of these essential features were lacking at this health service and will continue to be a barrier to providing quality gender-sensitive care. Engagement, implementation, and evaluation varied across all four units depending on the key drivers of female staff and specialist knowledge in gender-sensitive care and middle management. Monitoring and appraisal at an individual and organisational level were reactive and in response to incidents. Furthermore, the tensions between the biomedical model with gender sensitive care were observed. Contrastingly, a top-down approach of board members and senior leadership is also insufficient to influence complex systems change

(Leggat & Balding, 2017). The conclusive need is for a functional whole of health system approach (García-Moreno et al., 2015), with a multi-element response that addresses the intersection of mental health and sexual violence (Hegarty, Tarzia, Rees, Fooks, Forsdike, Woodlock, Simpson, McCormack, & Amanatidis, 2017). The next section draws together the key findings of the three journal articles, policy review, observations, and overall research results.

8.2 Synthesis of key findings

To address the overall aim of this research, the key findings have been synthesised below into four areas: *Ignoring Gender and Violence Against Women*; *Attitudes and Gender Inequity*; *(Dis)Empowerment in a Restricted Environment*; and *Diminished Interpretation of the Care*. These findings explain why health professionals, organisations, and systems may feel ill-equipped to respond to sexual violence and to enact gender-sensitive care.

Ignoring Gender & Violence Against Women

A significant hindrance to adequately implementing gender-sensitive care is the gender-blindness of issues affecting women by many health professionals (O'Dwyer et al., 2020). This is concerning, given that approximately 30,000 women access Victoria's mental health services per year (Department of Health & Human Services, 2019). Many of the current healthcare models set out to address gender, trauma, and violence (Department of Health, 2011b; Harris & Fallot, 2001; Ponc, 2016). However, these principles are not always practically implemented at ground level, in fact services are often 'trauma-uninformed' (O'Dwyer et al., 2019a; O'Dwyer, Tarzia, Fernbacher, & Hegarty, 2019b). A significant challenge for implementing these principles is not understanding gendered mental health needs, and pathologizing of the responses to trauma and violence displayed by victim-survivors (Hayward, 2019; Sweeney et al., 2019). This gender-blindness simplifies the models and ignores the complexities between mental illness and violence against women and the need for gendered care (M. Afifi, 2007; Afifi et al., 2009; Howard et al., 2017).

International and Commonwealth mental health policy is often gender-blind, and integration of the impact of violence against women is lacking. The Gender Sensitivity and Safety guideline perpetuates this segmented response to gender-sensitive care (Department of Health, 2011a). It is divided into seven topics, including gender-sensitive care, and trauma-informed care. Although it outlines in the initial section of the document that the topics are all related to gender-sensitive care, the guideline's layout implies that they are separate topics from each other. Furthermore, there is no current federal or state policy for trauma-informed care, and therefore no trauma-informed care policy at the organisational health service level exists. These policy and guideline shortfalls contribute to staff confusion and a diminished understanding of the care model. Mental health services, specifically acute psychiatric inpatient settings, need a model of care that has a gendered, trauma- and violence-informed lens (see Figure 6 below) to reduce stigma, prevent re-traumatisation and maintain a victim-survivors sense of safety, trust, and self-esteem (Friehe, 2019).

Attitudes and Gender Inequity

Inequitable attitudes towards women was a recurring theme across the research findings (O'Dwyer et al., 2019a, 2020). Most Australians hold accurate knowledge of what constitutes violence against women and do not endorse violence (Webster et al., 2019). However, there is evidence that some Australians continue to have a lower level of understanding of violence against women and hold violence-supportive attitudes (Webster et al., 2019). The broader socio-cultural norms and attitudes are present in the microcosm of any health system. However, these gender inequitable attitudes are particularly harmful in acute psychiatry due to the bidirectionality and complexity between mental illness and sexual violence (Jonas et al., 2014; Khalifeh, Moran, et al., 2015). This research found that a lower level of understanding of violence against women and violence-supportive attitudes were held predominantly by male mental health professionals towards female consumers (O'Dwyer et al., 2019a). This finding that men are more likely to hold violence supportive attitudes is consistent with previous gendered research (Anderson, Cooper, & Okamura, 1997; Markowitz, 2001) and is an important consideration for service and professional development in mental health settings.

This inequitable view has many adverse effects on the mental health system. This results in minimising, mistrust, dismissing and/or blaming victim-survivors: a trauma-

uninformed approach which presents a barrier to implementation of gender-sensitive or trauma-informed care (Fulu et al., 2013; Hardesty & Ogolsky, 2020; O'Dwyer et al., 2019a). These differing attitudes also divide staff, burdening female staff with additional responsibilities and permitting avoidance of implementation of appropriate care by male staff (Currier & Briere, 2000; Sampson & Read, 2017). This avoidance is disadvantageous for male staff as it perpetuates fear, worry, and anxiety when caring for women survivors (O'Dwyer et al., 2019a). Furthermore, this continued avoidance could lead to the trap of blaming male staff who do not implement the strategies, procedures, and guidelines of the new model of care (Muir-Cochrane, O'Kane, & Oster, 2018). This has a flow-on effect at a systems-level (Colombini et al., 2019); contributing to further division rather than collaboration between staff. Furthermore, inequitable attitudes could continue to hinder the progress of the Mental Health Service incorporating gender, trauma-or violence-informed approaches (Colombini et al., 2019). Transforming socio-cultural norms and inequity within acute mental health settings, coupled with the high attrition of staff in acute mental health, is a significant challenge. However, these challenges are worth addressing to improve the mental healthcare system's response to the many women who have experienced gender-based violence in inpatient units (Sohal et al., 2020).

(Dis)Empowerment in a Restricted Environment

The dominance of the 'bio-bio-bio model' (Sharfstein, 2008) within Victoria's current mental health system is strongly evident from this research study in many ways (O'Dwyer et al., 2019a, 2019b, 2020). In particular, the avoidance of risk which is perpetuated in the Mental Health Act (2014) by the provision for compulsory treatment and restrictive interventions. Compulsory treatment and restrictive interventions are incongruent with implementing the principles of collaboration, choice, and control, of gender-sensitive and trauma-informed care (O'Dwyer et al., 2020; Pauly, 2008; Varcoe et al., 2019). The provisions for compulsory treatment and restrictive interventions can be disempowering for consumers and a source of despair for many health professionals (O'Dwyer et al., 2019a). Restrictive interventions are countertherapeutic to gender-sensitive or trauma-informed care given the high potential for causing traumatic or re-traumatising experiences for consumers (Ghassemi, 2020; Sethi, Parkes, Baskind, Paterson, & O'Brien, 2018). Restrictive intervention use may also distress or

re-traumatise health professionals who may also be victim-survivors of abuse (McLindon et al., 2018).

The hierarchy of professions further compounds these competing organisational principles within the biomedical model (O'Dwyer et al., 2019a, 2019b, 2020). A lack of interdisciplinary collaboration also contributes to health professionals' frustration and difficulty in speaking up against the current restrictive system in acute inpatient settings (Isobel, 2015). Reducing restrictive intervention use and taking a more gender-sensitive and trauma-informed approach requires collaboration between all health professionals, not just women and key staff. Furthermore, each profession needs a supportive care team environment to troubleshoot these dilemmas, depending on individual consumers' circumstances (Hegarty et al., 2020). Reflective practice and supervision would be appropriate forums for these discussions. This would progress health professional's knowledge but also challenge inequitable and violence supportive attitudes in an indirect manner, aiding in staff readiness to adopt the new model of care (Kelly, Hegarty, Barry, Dyer, & Horgan, 2017). Empowerment is essential to support health professionals in adopting a new care model (O'Dwyer et al., 2020), and consumer self-determination and recovery (Department of Health and Ageing, 2013).

Diminished Interpretation of the Care

All units showed an equal lack of understanding of the care required for victim-survivors and, therefore, inadequate implementation of gender-sensitive care (O'Dwyer et al., 2019a, 2019b). Unit B provided an excellent example of their commitment to implementing gender-sensitive care through their motivated Gender-Sensitive Leadership Group, permanent employment of a Creating Safety Nurse, action plan, and collaboration with sexual assault services. However, despite Unit B's outstanding efforts, they encountered similar staff perceptions and implementation challenges as the other three units. Cognitive participation or 'who does do the work' is one of the four NPT constructs (see Figure 5 below). Thus, it is unsurprising that these key staff members were unable to implement gender-sensitive care within a unit given their lack of capacity to create and effect change at their middle management level (Myall et al., 2020). However, it is interesting that there were no differences in comprehension and practices across the units despite the standout efforts of key staff.

To explore the reasons for this ineffectual change, it may be useful to reflect on the other three NPT constructs (Figure 5). The first NPT construct, Coherence or 'what is the work', showed all health professionals had a simplified understanding of gender-sensitive care across all four units. This incoherence was evident at the mental health professional level and the policy advisor and senior government executive level. For guidelines to be effectual at the ground level, they must be supported by robust procedures and policy at the organisational and state level (Frueh et al., 2000; Henggeler, 1999). A collaborative approach is required to address this multi-layered failure. Consultation with mental health professionals and people with lived experience/victim-survivors is essential to develop ideas, design, and enact the care model (Varcoe et al., 2019; Zimmerman et al., 2013). Building on previous findings, a transformative approach to address gender inequitable and violence supportive attitudes and norms are needed at the systems level, including by executives, leadership and policy advisors (Colombini et al., 2019). At an organisational level, there are a diverse range of factors, from the short admission times to the placement of male consumers in the women-only corridors, that impede staff ability to provide a therapeutic environment for women victim-survivors. The lack of reflexive monitoring also substantially limits the ability to identify and address the array of discrepancies highlighted in this research (May & Finch, 2009; May et al., 2007).

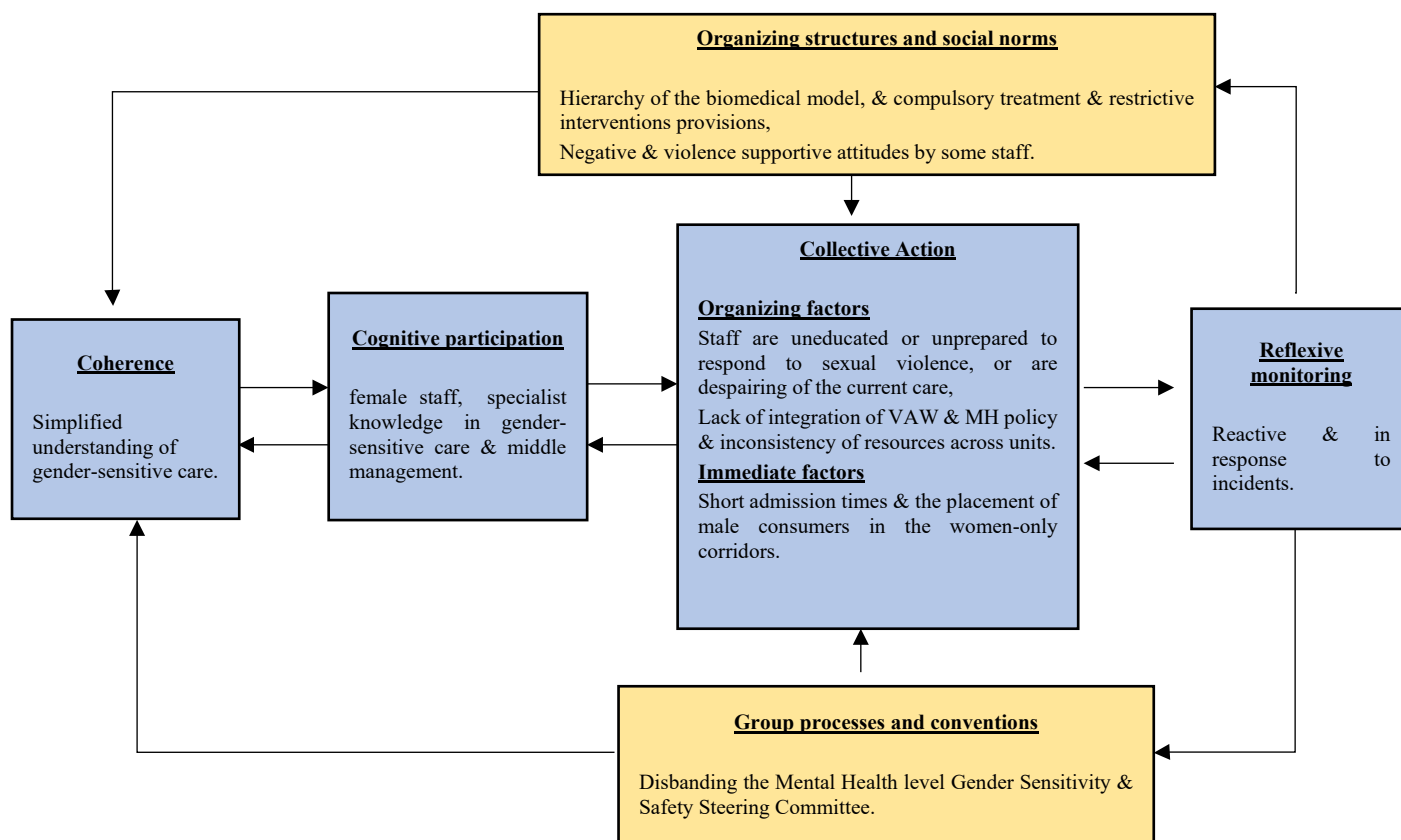


Figure 5. Summary of case study research findings mapped onto the Normalization Process Theory components model.

(May & Finch, 2009)

In summary, this research shows that the mental health system frequently ignores violence against women. This ignoring occurs from international policy to the local Mental Health Service and the health professionals working within this case study's four adult acute psychiatric inpatient units. Concerningly, some health professionals hold violence- supportive attitudes similar to the broader Australian population. Furthermore, the biomedical model's dominance with its hierarchy of professions, and provisions for compulsory treatment and restrictive interventions, obstruct the implementation of trauma-informed and gender-sensitive care. Therefore, it is unsurprising that most health professionals hold a simplified understanding of gender-sensitive care, and many staff do not see it as their role or responsibility to implement this model of care. NPT provides a useful framework for

understanding the relational and dynamic work that is continuously needed to normalize and sustain gender-sensitive care in acute psychiatric inpatient settings. These findings inform several practice, policy, and research implications outlined below.

8.3 Implications for Practice and Implementation

The previous chapter outlines the many challenges impeding the implementation of care that adequately addresses gender, violence against women, and mental illness. There is a need to adopt Trauma-Gender and Violence-informed Care (TGVIC) to address this intersection, as described below.

Trauma, Gender and Violence Informed Care

The findings show gender-blindness or gender inequitable attitudes are held by many mental health professionals and middle management. This results in a siloed approach, diminished understanding and fragmented implementation of trauma-informed or gender-sensitive care. Addressing gender inequality, disrespectful and poor attitudes towards women, and violence supportive attitudes through education and early intervention programs can prevent family, domestic and sexual violence (Our Watch, 2015; Secretary-General of the United Nations, 2006). Furthermore, there is a need to take a broader view that encompasses experiences and environments to understand the complexity between gender-based violence and mental illness, rather than pathologizing or stigmatising (Campbell, 2020). As outlined in table 1 of chapter 2, some models of care implemented globally in health settings share principles of gender, trauma, safety, collaboration, and choice (gender-sensitive care, trauma-informed care, trauma-and-violence-informed care). Addressing and minimising the impact of violence experienced by consumers and health professionals are important principles (trauma-informed care, trauma-and-violence-informed care, Safewards). A new model of care that is trauma-gender and violence-informed (TGVIC) is proposed (Figure 6) based on these fundamental shared principles and the findings of this research. This TGVIC model addresses the needs of victim-survivors who are both consumers and mental health professionals. This research only focused on women consumers; however, TGVIC could also possibly meet the needs of other genders. Similarly, although this research was conducted in an adult acute inpatient setting, a TGVIC

model could be used more broadly across mental health services. It is suggested that by having one comprehensive model, the organisation and health service can focus on implementation rather than introducing new and multiple care models.

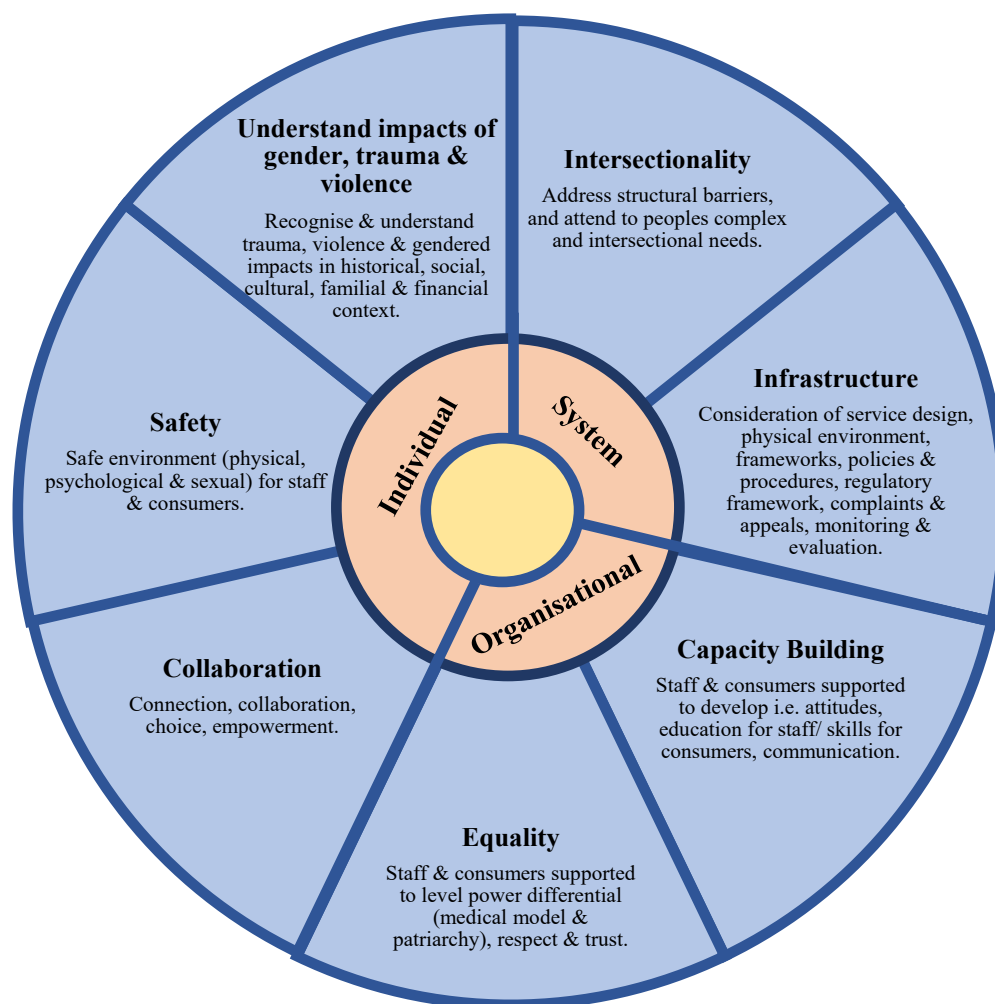


Figure 6. Proposed pillars of Trauma-Gender and Violence-Informed Care.

The TGVIC model (Figure 6) includes seven pillars within a three-tiered response; individual, organisational, and system. The first three pillars of the TGVIC model addresses the individual level within the mental health system. The first pillar, *Understand impacts of gender, trauma and violence*, recognises the complexities of trauma, violence, and gender within the historical,

social, cultural, familial, and financial context. The second pillar, *Safety*, commits to a safe environment for consumers admitted to acute inpatient units and staff working within these units, with a particular focus on sexual safety (McGarry, 2019). The third pillar, *Collaboration*, focuses on connection, collaboration, choice and empowerment between consumers and staff. Multi-disciplinary and consumer collaboration should be encouraged. This collaborative approach could encourage reflections on their understandings of all types of gender inequities and violence against women and how these influence their practice (Short, Cram, Roguski, Smith, & Koziol-McLain, 2019; Tolmie, Smith, Short, Wilson, & Sach, 2018). Challenging these sociocultural norms would potentially mitigate further structural inequities and promote equity across genders within the mental health service (Short et al., 2019).

The fourth and fifth pillars of the TGVIC model address the mental health services organisational level. The fourth pillar, *Equality*, includes a thorough integration of the peer support model to balance the hierarchical-patriarchal power differential between health professionals and consumers (State of Victoria, 2018–19). There is evidence to support the benefit of peer-lead group support approaches for victim-survivors of sexual violence (Konya et al., 2020). Integrating advocates and therapists to support victim-survivors of recent and past sexual violence into acute psychiatric inpatient units would help peer support and assist the health professional workforce consistently and sensitively respond to abuse (Oram, Khalifeh, & Howard, 2017). The fifth pillar, *Capacity Building*, includes mandatory, continual, and tiered workforce development depending on health professionals' experience, training, knowledge, and attitudes (Carter & Blanch, 2019; O'Dwyer et al., 2019a; World Health Organization, 2013a). A tiered approach to learning would progress the knowledge of staff who remain, while also catering for the high attrition rate of staff within acute psychiatry. It must include multicomponent aspects (identification, clinical skills, attitudes and norms, documentation, and provision of referral) of trauma, gender, and violence to improve identification and change health professionals' attitudes and behaviours (World Health Organization, 2013a). Graduate programs, continual support, follow-up, supervision, reflective practice, and initial training reinforcement should also be included to maintain these skills (World Health Organization, 2013a).

The sixth and seventh pillars of the TGVIC model address the mental health service system level. The sixth pillar, *Infrastructure*, addresses the complex and interrelated issues of service design, physical environment, governance, and appraisal. It is recommended that women-only

wards are established instead of women-only corridors within mixed-gender wards. Informed by this research, Mental Health Reform Victoria (MHRV) recently released a request for Expressions of Interest from public/private hospital partnerships to establish a 35 bed Women's Mental Health service through a private/public partnership. Women-only wards would provide an immediate minimisation of re-traumatisation risk. It would also mitigate the simplifying of the model of care to purely women-only areas, thereby opening up staff capacity to understand and implement the broader aspects of TGVIC. Workforce development should occur in conjunction with systemic supports such as collaborative and effective leadership, routine facility-level quality assessments; quality improvement processes at every level; referral pathways, and accessible violence against women staff (Lichtveld & Cioffi, 2003; Wayman, Midgley, & Stringfield, 2005). A balanced gender mix of staff should be considered, including more women in leadership roles (State of Victoria, 2018–19). These systemic changes must also be supported by policy and added as a core curriculum component of tertiary education for those professionals most likely to provide care for women (Ashmore, Spangaro, & McNamara, 2015; State of Victoria, 2016; World Health Organization, 2013). Supported partnerships and referral pathways with multiple key agencies and systems, national and state-wide policy guidance, and universal strategies are also essential (Carter & Blanch, 2019; Hughes et al., 2019). An example of this is the across-service alignment with the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) currently being rolled-out across organisations in Victoria (State of Victoria, 2018). The seventh pillar, *Intersectionality*, addresses the structural barriers, and attends to women consumers complex and intersectional needs. Violence against women is culturally produced out of intersecting hierarchies of power alongside defined categories such as race, class, gender and sexuality (Sokoloff, Dupont, Sokoloff, & Pratt, 2005). Gender inequality is further impacted by intersections with power and oppression and how women are judged depending on variables such as race, wealth and disability (Bograd, 1999). TGVIC provides a holistic contextual framework that is required to prevent further marginalization of women who have experienced violence (Lockhart & Danis, 2010) and consider the multilayer and intersecting variables that affect their lived experiences (Baird, Mitchell, & Baird, 2014; Lockhart & Danis, 2010).

Implementation Strategy

The tendency to focus on a single intervention, simplify, and take a linear approach to implement healthcare models is a common mistake (Robert, Greenhalgh, MacFarlane, & Peacock, 2010; Thygeson, Morrissey, & Ulstad, 2010). This research supports the need for a comprehensive mental health system response (García-Moreno et al., 2015). This should include a multisectoral and multi-element response that addresses violence against women and mental health. For TGVIC to be normalised, an adaptive, and non-linear implementation strategy that considers the complexity (clinical protocols, resources and infrastructure, provider, client and community attitudes, and willingness to address) of the health system is required (Colombini et al., 2019; Sheikh, George, & Gilson, 2014). The Missouri Model, a developmental, flexible, process-based approach to implementing trauma-informed care, could be adapted to implement TGVIC (Carter & Blanch, 2019). This model identifies key tasks, organisational processes, and key indicators for the organisation to reach informed by links to resources. These strategies could easily be implemented by the Mental Health Service to monitor and appraise the implementation of trauma-gender and violence-informed care.

Another complexity within mental health services to consider at the system level is the tensions between legislated compulsory treatment and restrictive interventions and the biomedical model with the juxtaposition of the principles of TGVIC, such as collaboration, choice, and empowerment. The Mental Health Act (2014) provisions for compulsory treatment are a barrier to genuinely implementing a TGVIC model in acute psychiatric patient settings. A significant revision and transformation of current practice, legislation, and policy are needed to advance mental health services. The Royal Commission into Victoria's Mental Health System Interim Report (State of Victoria, 2018–19) proposes a service designed and delivered by people with lived experience. This would provide an ideal environment to pilot TGVIC as it would be exempt under current legislation of the Mental Health Act (2014). The next section explores the implications for policy and procedures of these proposed practices.

8.4 Implications for Policy and Procedures

This section will outline the suggested policy and procedures needed to implement TGVIC, including a comprehensive gendered mental health strategy, TGVIC clinical practice guideline,

and directions for implementing and evaluating policy. These are described in further detail below.

A Comprehensive Gendered Mental Health Strategy

Based on the researcher's review and critique of the current policies, procedures, and guidelines in Victoria, it is recommended that a comprehensive gendered mental health strategy should be developed. This gendered mental health strategy must address the social determinants, inequalities, attitudes, and violence experiences that contribute to poor mental health for women and girls. It should take a life course approach, including prevalence, risk factors, proactive preventative, and treatment measures. It should include health professionals' requirements to address these needs and incorporate a system-wide and coordinated cross-government approach, including applying a gender lens on policy formulation across all portfolios relevant to women's mental health (Department of Health and Human Services, 2020). This comprehensive gendered mental health strategy must also include an outcomes framework to measure change throughout the strategy's implementation.

TGVIC Clinical Practice Guideline

The Victorian Department of Health and Human Services is currently reviewing the sexual safety procedure and the gender sensitivity and safety guideline and is developing a trauma-informed care guideline. Informed by the research presented in this thesis, the researcher has consulted with the Department of Health and Human Services on these guidelines. It is recommended that a gender-trauma-and-violence informed policy and practice guideline would be more advantageous rather than adding to the separation of these bidirectional issues. A TGVIC clinical practice guideline should carefully synthesise the available evidence whilst also integrating the health system's values into clear useable recommendations and directions (Barreto, 2018). Specific directions for health professionals such as responding to different types of sexual violence disclosures in acute psychiatric inpatient settings, should also be included (Ashmore et al., 2015). It could also include examples of common dilemmas of balancing risk and safety with choice and collaboration.

Implementing and Evaluating Policy

Policy is the instrument of governance; it is how government make authoritative decisions that direct public resources in one direction or another (Althaus, Bridgman, & Davis, 2017). Unfortunately, in Australia, National and State government policy are non-binding, therefore mental health organisations are not required to implement such policies (Althaus et al., 2017). It is suggested that TGVIC is prioritised at the Commonwealth and State level through the Australian National Mental Health Plan and the recommendations of the Royal Commission into Victoria's Mental Health System. They must also be included in the agreements between State Government and Health Service (for mental health services) to ensure performance monitoring and measurements can be applied. Furthermore, the WHO (2010) provides a framework for the development and implementation of comprehensive national health policies, strategies and plans (World Health Organization, 2010). Once developed, the TGVIC policy content and formulation should be evaluated using internationally recognised tools (Juengsiragulwit, 2015; Zhou, Yu, Yang, Chen, & Xiao, 2018).

Monitoring and Appraisal Strategy

A significant failure in the operationalising and implementation of gender-sensitive care was the distinct lack of proactive appraisal, monitoring, and feedback (O'Dwyer et al, 2019b). Monitoring and appraisal should be included in the policy cycle and implementation plan occurring continuously, adapting, and revising the implementation of TGVIC (Fischer & Morgenstern, 2010). Frameworks and guidelines are most effective when paired with measurable indicators (The Lancet Global Health Commission on High Quality Health Systems in the SDG Era, 2020). However, this is often overlooked due to services or governments' main goal to roll-out a new intervention or model of care (Hurley, Baum, Johns, & Labonte, 2010). Resources to monitor and evaluate health services with key indicators for health programmes addressing violence against women and girls could be used to appraise the implementation of TGVIC (World Health Organization, 2008, 2013a). Another method of appraising TGVIC would be effectively utilising and expanding the data that health services already collect to proactively assess implementation (Brooker, Edmondson, & Hughes, 2019). The next section will explore the implications for future research.

8.5 Implications for Future Research

This section will outline the suggested implications for future research. These focus on Gender and Gender-Based Violence in Mental Health Research and Continued Evaluation of Care.

Gender and Gender-Based Violence in Mental Health Research

Gender and violence against women cannot continue to be overlooked in mental health research. Future mental health research should focus on gender, specifically women's mental health (Howard et al., 2017). Mental health data should be gender-disaggregated and analysed using a gender lens. It also needs to explore how gender impacts the care victim-survivors of sexual violence receive in acute inpatient units. This impact on care should also be explored in conjunction with health professionals' attitudes. The developed typologies could be utilised to research health professionals' understanding of TGVIC. A gender-lens should be further extended to look at the policies that impact women's mental health, including family violence, sexual violence, homelessness, and employment. A paucity of research has examined the effects of professional development and training provided to health professionals in sexual violence against women. Of the extant research conducted to date, it suggests that professional development may lead to improved knowledge and attitudes about sexual assault, and practices to support survivors (Donohoe, 2010; McLaughlin, Monahan, Doezema, & Crandall, 2007; Milone, Burg, Duerson, Hagen, & Pauly, 2010; Parekh, Currie, & Brown, 2005; Sampson & Read, 2017). However, this research did not examine whether this training translated into improved outcomes for victim-survivors of sexual violence. Future research should explore the knowledge translation of ongoing professional development to health professionals' practices and how this affects consumers.

Continued Evaluation of Care

This research provides insights into understanding how care has been provided in acute psychiatric inpatient units for women victim-survivors of sexual violence, according to the health professionals who participated in this research. This research could serve as a baseline

for the mental health organisation involved in this study to assess the implementation process and monitor future policy, guidelines, and practices (Brooker et al., 2019). It is suggested that future research includes consumers, health professionals, leaders, and policymakers. This research should be extended to other genders and more broadly across mental health services, including regional and rural services. Integrated knowledge translation (IKT) offers a possible means, as it encourages co-production between researchers, health professionals, people with lived experience, and decision-makers to engage in a mutually beneficial programme of research (Kothari & Wathen, 2013). It encourages relevance, buy-in, longevity, cyclical review, and has specified implications for policy and practice while also creating consistency (Kothari & Wathen, 2013). Importantly, IKT also considers evaluation and context, integrated with health professionals' beliefs, values, and attitudes to encourage gender equality. The next section describes the strengths and limitations of this research.

8.6 Strengths and Limitations of the research

Strengths

Overall this research had several strengths. To the best of the researcher's knowledge, this is the first study investigating health professionals' experiences of providing care for women survivors of sexual violence and how this care is enacted in acute psychiatric inpatient units. A strength of this research was that it used purposive sampling to include a range of health professionals from different professional backgrounds; nursing, allied health, medical, and management. Previous research in this area has predominantly been with female health professionals from a nursing background (Muskett, 2014; Wilson et al., 2017; O'Dwyer et al, 2020). This diverse population provided a range of experiences due to their training, the different settings they have worked in, and the length of experience they had gained. As a result, it illustrated the contrasting views and attitudes that different types of health professionals have, and how this may impact upon the care of women victim-survivors in acute psychiatric care settings.

The strong theoretical underpinnings of the research was also a strength. The social constructivist feminist approach facilitated in-depth understanding of the diverse perspectives

of health professionals, their understanding of gender, and gender care (Schwandt, 2000). A collective instrumental case study design, with cross-case analysis of four acute psychiatric inpatient units within one mental health organisation was utilised. This allowed for in-depth investigation across all units to compare and contrast the health professionals' experiences across all four sites (Stake, 1995). The qualitative data was triangulated using interviews, documents, observations, and field notes. As well as case study methodology, Normalisation Process Theory (NPT) was used to guide the data analysis of the fourth research question. As previously argued in chapter 3, NPT is a useful framework when looking at how changes to complex health systems are implemented (May & Finch, 2009; May et al., 2007; Myall et al., 2020). Using the four constructs of NPT provided a clear understanding of the barriers and facilitators of how gender-sensitive care was implemented.

The researcher's background as a health professional and researcher was also a strength. As a clinical psychologist, the researcher shared a professional experience working with acutely mentally unwell people and women who are victim-survivors of sexual violence. The researcher's training provided interpersonal and relational skills required to build rapport quickly with interview participants. This was particularly important given the sensitive nature of the research topic and the prevalence of trauma experienced by health professionals themselves (McLindon et al., 2018). This rapport enabled participants to feel at ease, open up, and explore their experiences without judgment or bias. The researcher was onsite at each unit at least one day per week over ten months and attempted to work flexibly with preferred days and time of interview participants. This facilitated each of the units' competing demands and the highly unpredictable nature of the environments.

Limitations

In addition to the strengths, this research also had several limitations, particularly related to the findings' transferability. This research's scope was limited to four acute psychiatric inpatient units within a public mental health organisation in a metropolitan setting in Australia. Therefore, the findings may not be transferable to private mental health organisations, rural or regional areas. Another limitation is that the Mental Health Service had a prior commitment to implementing gender-sensitive care and were, therefore, invested in this topic before participation. Likely, this population was particularly engaged and motivated to participate, so they are not representative of acute care or mental health organisations. Another limitation of this research was the larger sampling of female health professionals and nurses comparatively

to male health professionals and staff from other professional backgrounds. A larger representation of male health professionals, medical staff and consumer/ peer support staff would have expanded the understanding of how sexual violence and gender-sensitive care is influenced by gender and professional background; however, the participant demographics are reflective of the female and nursing-dominated mental health workforce in Australia (Australian Institute of Health and Welfare, 2016). Furthermore, this research was confined to mental health professionals' experiences only, thereby excluding consumer voices. Furthermore, this research was confined to mental health professionals' experiences only, thereby excluding consumer experiences. Future research should include a diverse range of victim-survivor consumer experiences of treatment, care, and subsequent service delivery and advocacy agendas (Daya, Hamilton, & Roper, 2020). It will be critical to examine the differences between how consumers and staff understand gender-sensitive care.

8.7 Conclusion

This thesis with publication provides new knowledge about health professionals' perceptions and experiences of providing care in acute psychiatric inpatient settings that is trauma-informed and gender-sensitive for victim-survivors of sexual violence. The findings highlight the importance of qualitative case study research in this area to gain in-depth knowledge of health professionals' diverse perspectives. This research provides a framework of themes and typologies to understand health professionals' perceptions of providing care for victim-survivors of sexual violence. These typologies can also be used to recognise the degree to which health professionals are trauma-informed. Gender-blindness, negative attitudes and inequity towards women are significant personal barriers to health professionals enacting trauma-informed and gender-sensitive care. The dominance of the biomedical model, coupled with the segregation of mental health and violence against women in policy and practice, is a significant organisational and systems barrier to enacting trauma-informed and gender-sensitive care.

This research supports the need for a multi-element health system response to care for victim-survivors. Based on the findings of this thesis, a total reform and transformation of system-wide policy and practice are required. Drawing on the literature available on the current models and frameworks of care, a new care model that considers the key elements is proposed. Trauma-

gender and violence-informed care (TGVIC) would comprehensively address the diverse and intersecting needs of consumers, health professionals and the mental health system, if adequately implemented. This TGVIC model must be supported by policy and practice guidelines that are comprehensive, adaptable, and specific to inform health professionals across the mental health system. Finally, a continuous process of collaboration, appraisal, and adjustment is needed to meet the changing needs of consumers, health professionals, society, and the mental health system.

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APPENDICES

Appendix 1: Electronic Search Terms

Key Word	Synonyms and Boolean Phrases
Trauma-informed care	“trauma-informed care ” OR “sensitive care” OR “gender mental health care” OR “gender sensitive mental health care” OR “women centred mental healthcare” OR “women centered mental healthcare” OR “women friendly environment” OR “trauma violence informed care” OR “gender sensitivity” OR “gender-sensitive” OR “gender sensitive care” or “feminist care”
Acute psychiatric inpatient unit	“acute psychiatric inpatient ward*” OR “acute psychiatric unit*” OR “mental health service*” OR “acute inpatient” OR “inpatient” OR “acute psychiatric inpatient ward” OR “acute psychiatric unit”
Experiences	Perception* OR experience* OR attitude

* used to capture both plural and singular terms.

Appendix 2: Summary of Articles Included in Scoping literature review

Author/ year/ location	Research aim	Study participants and methods	Main Findings	CASP Score
Chandler 2012 USA	Describe the structure that empowered staff of a locked community hospital unit to reduce the use of restraints and seclusion to create a culture of safety.	N=11 health professionals (nurses, mental health counsellors, occupational therapist, occupational therapist aide, administrator). Single case study (interviews, document analysis, observations).	Staff were provided opportunities to develop knowledge, skills and key relationships with leadership. These staff then provided consumers with information, support and resources to facilitate skill development and therapeutic relationships.	18

Chandler 2008 USA	Describe and compare the experiences of staff in reducing patient symptoms in a traditional inpatient model and a trauma-informed treatment model and describe how staff created a trauma-informed culture of safety.	N=10 health professionals (nurses, counsellors, administrators). Narrative design (content analysis)	Overarching theme of transferring control from staff to consumer. This was achieved via consultation, education and role modelling from a trauma expert, development of collaborative staff-consumer relationships, implementing flexible safety measures, and individualised evidence-based educational resources for staff and consumers.	18
Copperman & Knowles 2006 UK	Explore the progress of the women's mental health guideline into psychiatric services and strategic development of mental health care for women policy into practice.	N=11 staff (service managers, clinical supervisor, security staff, practitioners, survivors/ users and activists). Qualitative (Interviews)	Increase in women only wards in acute inpatient settings, women's crisis houses and awareness of safety issues generally. Only minimum requirements are being met in many settings: there is broad variability in terms of physical structures and facilities and staffing options offered; many women are admitted to mixed sex	9

wards and organisations provide varied practice direction. Women's safety remains a concern and cultural change remains an ongoing challenge.

Isobel Edwards 2017 Australia	& Describe the process and effects on the nursing workforce of implementing a Trauma-Informed Model of Care in an acute mental health inpatient unit using a practice development process. N=5 nurses. Mixed methods case study design (interviews, survey evaluations)	Questioned whether trauma-informed-care provided a significant change to their current practice for consumers. Hopeful but ambivalent about change to individualised and flexible care due to envisaged ongoing issues within the team. Change needs to be slow, positively framed with clarity, consistency and clear role expectations. Defining the model of care, using a practice	13
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development approach and informing staff about trauma-informed-care were important for implementation.

Isobel 2015 Australia	Review all nurse-initiated rules relevant to trauma-informed-care on the unit.	N=17 nursing staff. Mixed-methods (questionnaires with open-ended questions)	Frustrations with inconsistencies in rule use and criticised colleagues who used rules as excuses to avoid engagement, decision-making or clinical judgement. Difficulties implementing rules that are rigid, restrictive or lacking common sense and expressed need for greater consumer input and flexibility. Restrictive policies heighten nurse and consumer frustration and suggested continuous process of review to improve awareness and consistency of rules.	10
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Kanerva 2016 Finland	Explore nursing staff's perceptions of patient safety in psychiatric inpatient care.	N=26 nurses. Qualitative (semi-structured interviews)	Importance of general experiences of safety for everyone on the ward such as ward atmosphere, absence of physical threats or distressing behaviours; staff experiences of safety and security of alarm systems; consumer safety in regard to themselves, other consumers and staff. Factors affecting safety included seeing the consumer from a holistic perspective, staff maintaining their professional skills, promotion of a culture of care and reduction of restraint use, structure of the ward and laws/ guidelines directing practice.	15
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Krumm 2006 Germany	Investigate staff attitudes towards patients and mixed versus segregated wards. Qualitative (focus groups pre and post intervention)	N=25 healthcare workers (nurses, social workers, psychiatrists).	Gender-specific behaviours described with female consumers discussed in more pejorative terms than male consumers. Vulnerable female consumers not adequately cared for on mixed gender wards, but this issue was minimised. Staff expressed mixed views on the appropriateness of single gender wards. Male staff expressed fears of being harassed by female consumers.	15
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Leavey 2006 UK	Examine preference for single sex wards and patient and staff views on the change-over to single sex in relation to safety, dignity and privacy.	N=11 nurses. Mixed-methods (Interviews only with nurses).	Single gender wards improved aspects of staff and women consumers safety due to less gender-conflict. Male staff felt protected from sexual harassment claims by regulations, policies and procedures; however, female staff expressed ambivalence about single sex wards.	14
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Appendix 3: Interview Schedule

GSC Project

Interview Schedule

Introduction

- Introduce interviewer and project;
- Ask for responses to consent form questions (e.g. regarding confidentiality, attribution, and recording);
- Retain signed copy of Consent Form.

Interview Questions

1. Can you tell me about your profession and role within this mental health service/unit?
2. Can you tell me about the care that you (is) provide(d) for women in the inpatient unit who have previously experienced unwanted sexual contact?
 - a. How is it implemented? E.g. policies, environmentally etc
 - b. How do you support this care? (Managers only)
3. How supported do you feel to deliver this care?
 - by the system, organisation, your supervisor, your manager?
4. What are the support systems that are provided for staff to provide this care? (committee/working group, supervision)
5. What kind of supports do you draw on to deliver this care?
 - any differences in care for voluntary and involuntary female patients? Can you tell me what these are?

- any training you have received that assists you to practice gender sensitive care e.g. type and length of training?
6. Can you tell me your understanding of GSC?
 - what do you think GSC is? How would you describe GSC?
 5. How is it implemented on the unit? What does that look like on the ward? Can you give examples?
 6. (if they have given examples, you could ask “what is the difference to not providing GSC?” if they tell you very little, you could drill down into it and get them to contemplate what the differences might be (?) is there any difference/ comparison to regular care?
 7. Could you describe barriers, challenges and enablers of (in supporting the) implementing GSC?
 8. Is there anything you think you would need that would increase your ability to work with women who have experienced unwanted sexual contact?
 9. How do you think the women consumers experience/ feel about the care they receive?
 10. Is there anything else you would like to add?

General prompts/Tips;

- Be silent
- Probing questions e.g. can you expand on that/previous point? How so?, how not?, tell me more about that...?, could you elaborate on that?
- Hypothetically what you do? Similarities?
- Examples (specific, different etc)?

Should you become distressed or affected by our interview please remember that there is a list of numbers you can contact for professional advice on the resource card. Thank you again for participating.

Appendix 4: Demographic Questionnaire

12. Demographic questions

- Age and gender:
- Highest level of education:
- Ethnicity/Nationality:
- Employment (Full/part-time/casual etc.):
- Profession:
- Role:
- Years/months working on the unit:

Appendix 5: Letter Requesting Manager Support

Gender Sensitive Care Study

Dear [insert managers name],

We are writing to seek your support for a research study between the Department of General Practice at the University of Melbourne and [The Mental Health Service]. The project will explore staff engagement with gender sensitive care for women who have experienced unwanted sexual contact and mental illness. This study is undertaken by PhD student Carol O'Dwyer under the supervision of Prof Kelsey Hegarty, Dr Laura Tarzia (University of Melbourne) and Dr Sabin Fernbacher (Northern Area Mental Health Service).

We plan to hold interviews with staff from psychiatric inpatient units of [The Mental Health Service]. They will be conducted by the student researcher, take no longer than 60 minutes and will be audio recorded with participants' permission. This research will have received ethical clearance from [The Mental Health Service] and The University of Melbourne prior to commencement.

The Director of Clinical Governance [name removed for confidentiality] of the Mental Health Service has provided in principle support for this study. A presentation on this project was held



on the 14/09/2016 at the [Mental Health Service] Acute Managers Meeting and was fully supported by Manager of Operations [name removed for confidentiality]. Expressions of Interest to participate in this project were completed and signed by the Unit Managers.

We are writing to request your approval for [The Mental Health Service] to participate in this project.

If you require any further information, or have any concerns, please do not hesitate to contact Carol O'Dwyer on (03) 9035 5183 or carol.odwyer@unimelb.edu.au.

Yours sincerely,

Carol O'Dwyer (Student Researcher)

Prof Kelsey Hegarty

Dr Laura Tarzia

Dr Sabin Fernbacher

Appendix 6: Project Brief

The Gender Sensitivity and Safety (GSS) Project

Women with chronic mental illness are particularly vulnerable to sexual violence prior to and during admission. Sexual violence and mental health is a public health priority due to the significant bidirectional effect and association with morbidity and mortality. These include injuries, chronic physical illness, poor sexual health, adverse perinatal outcomes, substance misuse, mental illness and suicidal behaviour. Health professionals play a key role as women who have experienced sexual violence are more likely to disclose to them. The Gender Sensitivity and Safety (GSS) guideline implemented across [The Mental Health Service] discusses trauma informed care and the need to accommodate the vulnerabilities of women who have experienced sexual violence and mental illness. The model of care includes all levels of an organization in order to work, including environment, management and leadership, direct contact, practitioner support, referral pathways, information sharing, protocols and policies, and community linkages. The GSS guideline has the potential to improve women's experiences within an inpatient setting by recognising and responding to the complexity of their trauma and wellbeing.

The GSS project aims to:

- Understand how care for women who have experienced sexual violence is perceived by staff in a mental health inpatient setting?
- Explore how Gender Sensitivity and Safety (GSS) is enacted across four inpatient settings.
- Drawing on existing literature and policy; guideline and procedure review; interviews with stakeholders and women; and consultation with services.

PROGRESS TO DATE

A literature review is being completed on stakeholders and consumers' account on the care provided in an inpatient mental health setting to women who have experienced sexual violence. A partnership has been developed with [The Mental Health Service] to participate in this project.

NEXT STEPS

We will be submitting ethics application in September 2016. We aim to conduct interviews with stakeholders and staff exploring the model of care for women who have experienced both sexual violence and mental health issues. We will also look at how the GSS guideline is operationalized within an inpatient mental health setting.

The Hospital's involvement

We would like Executive Management to be involved as follows:

- Support this project across the adult inpatient units.
- Provide access to review policies, procedures, guidelines, assessment forms, templates and files.
- Enable key stakeholders and health practitioners to participate in interviews of ~1 hour.
- Enable and support female consumers to participate in interviews of ~1 hour.

Study Collaborators

PhD Student

- Carol O'Dwyer, The University of Melbourne

Supervisors & Project Team

- Professor Kelsey Hegarty, The University of Melbourne
- Dr. Laura Tarzia, Research Fellow, The University of Melbourne
- Dr. Sabin Fernbacher, Consultant

Appendix 7: Expression of Interest

☐ **No, I am not interested in participating in the GSS study**

☐ **Yes, I am interested in participating in the GSS study**

☐ **Yes, I would like more information about participating in the GSS study**

Name: _____

Phone No. : _____ **Hospital:** _____

Email : _____

The best time(s) to contact me: *(Please tick all that apply)*

Monday	Tuesday	Wednesday	Thursday	Friday
☐	☐	☐	☐	☐

Morning	Lunchtime	After lunch	Late afternoon	Evening
☐	☐	☐	☐	☐

Scan and email back this form to
carol.odwyer@unimelb.edu.au

OR phone Carol O'Dwyer on 9035 5183

Appendix 8: Recruitment Flyer

Gender Sensitive Care Project

**Are you a staff member working in the inpatient unit?
Have you worked with female patients who have experienced
unwanted sexual contact?**

What will I have to do?

You are invited to participate in an interview (30-60 mins), either over the phone or in person at a place convenient to you to express your experiences of gender sensitive care.

For further information, contact Carol O'Dwyer

(03) 9035 5183 or

carol.odwyer@unimelb.edu.au

Project Team

Carol O'Dwyer (PhD student), Professor Kelsey Hegarty, Dr Laura Tarzia, The
University of Melbourne, Dr Sabin Fernbacher, Consultant

Appendix 9: Plain Language Statement

Plain Language Statement

[The Mental health Service] & The University of Melbourne

Title	<i>The Gender Sensitive Care Project.</i>
Short Title	<i>The GSC Project</i>
Protocol Number	XXXX
Coordinating Principal Investigator/ Principal Investigator	<i>Professor Kelsey Hegarty</i>
Associate Investigator(s)	<i>Dr Laura Tarzia, Dr Sabin Fernbacher, Ms Carol O'Dwyer</i>
Locations	<i>[The Mental Health Service] including the psychiatric inpatient units of [names removed for confidentiality]</i>

Introduction

You are invited to take part in the Gender Sensitive Care (GSC) Project, which is being conducted by Professor Kelsey Hegarty, Dr Laura Tarzia and Dr Sabin Fernbacher (supervisors) and Carol O'Dwyer (PhD student) of the Department of General Practice at the University of Melbourne in conjunction with [The Mental Health Service] including the psychiatric inpatient units of [names removed for confidentiality].



You are invited to participate in this research project because you have indicated that you have worked in an inpatient unit with women who have experienced unwanted sexual contact. This project will inform part of Ms O'Dwyer's PhD thesis and has been approved by the [Health Service] Ethics Committee and the University of Melbourne.

Purpose

The aim of this project is to find out about staffs' experiences of gender sensitive care for women who have experienced both mental illness and unwanted sexual contact. We would like to find out about your approach to working with female patients who have experienced unwanted sexual contact.

Women who have a mental illness have often experienced unwanted sexual contact. This unwanted sexual contact has many negative effects on the women, including injuries, chronic physical illness, poor sexual health, adverse perinatal outcomes, substance misuse, and suicidal behaviour. Mental Health staff play a key role in caring for these women.

Procedures

Participation in this project will involve taking part in a 30-60-minute interview with a member of the project team about your experience of care provided to women who have experienced mental illness and unwanted sexual contact.

After you have completed the Expression of Interest form, Carol will contact you to arrange an interview time that is convenient for you. The interview can be done over the phone, or in person, at a location of your choosing. We will need to receive and sign your consent form before we can commence the interview (you can post or email it back to us or bring it along to your interview if you are meeting in person).

The interview will have some prompts to guide the discussion, but we are interested in hearing your views and your experiences, so you can say as much or as little as you wish. With your



permission, the interview will be audio-recorded for transcription at a later date, however, no personal information about you will be used.

The information you provide in your interview will be combined with information from other staff and used to inform the model of care provided within an inpatient setting to women who have experienced both mental illness and unwanted sexual contact.

Participation and Withdrawal

Participation is voluntary and you may decline if you wish. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Please read this information and ask questions if you need more information. You may also discuss the project with a colleague or manager. Your manager will not be informed of your participation and it will not affect your employment at [The Mental Health Service]. Once you understand what the project is about and if you agree to take part in it, you will be asked to give your consent to participate by signing the Consent Form.

Possible Risks

There are no perceived risks associated with completing this interview. However, if you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately.

Privacy, Confidentiality and Disclosure of Information

The project team will collect your name, age, contact details (telephone and email) and other demographic information including your education, ethnicity, profession, and current employment status. This information is only used to describe staff members who participate in this study as a group. It will be stored separately to your interview transcript and audio recording, which will be de-identified and kept in a locked filing cabinet at the Department of General Practice, The University of Melbourne, and in electronic format on the University's secure server. Only members of the project team will have access to your personal details or



interview data. Your personal information and interview data will be stored for a period of 5 years in accordance with The University of Melbourne's guidelines.

By signing the consent form, you consent to the project team collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential as stated above. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

It is anticipated that the results of this project will be published and/or presented in scientific forums such as journals or conferences. In any publication and/or presentation, information will be provided in such a way that you cannot be identified (for example, using a pseudonym to describe participants).

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the project team. You also have the right to request that any information with which you disagree be corrected. Please inform the project team member named at the end of this document if you would like to access your information.

Results of Project

You will also be provided with a copy of your interview transcript and a briefing document by the project team if you wish. You will be able to contact the project team after your interview if you wish to discuss anything further.

Funding

The project is funded by the Australian National Research Organisation for Women's Safety (ANROWS) and the Melbourne Social Equity Institute (MSEI).



Further Information or Issues

If you require and further information, or have any concerns, please do not hesitate to contact Carol O'Dwyer on (03) 9035 5183. Should you have any concerns about the conduct of the project or any questions about your rights as a research participant, then you may contact the Manager Human Research Ethics Committees, [The Mental Health Service ethics details removed for confidentiality]. You will need to provide the number or name of the project (refer to page 1).

Appendix 10: Consent Form

Consent Form

[The Mental health Service] & The University of Melbourne

Title *The Gender Sensitive Care Project.*

Short Title *The GSC Project.*

Protocol Number

Coordinating Principal Investigator/ *Professor Kelsey Hegarty*
Principal Investigator

Associate Investigator(s) *Dr Laura Tarzia, Dr Sabin Fernbacher, Ms Carol O'Dwyer*

Locations *[The Mental Health Service] including the psychiatric inpatient units of [names removed for confidentiality]*

1. I consent to participate in the GSC project, the details of which have been explained to me. I have received a copy of the information sheet relating to this project and I fully understand its content.
2. I understand that I will be interviewed, and that this will be recorded and transcribed.
3. I acknowledge that:
 - I understand that I am free to withdraw at any time during the project without affecting my future employment.
 - The project is for the purpose of research;
 - I have been informed that the confidentiality of the information I provide will be safeguarded. Subject to any legal requirements; but that absolute confidentiality cannot be guaranteed.

4. I understand that I will be given a signed copy of this document to keep.

Participant's Name (printed)

Signature

Date

Investigators Name (printed)

Signature

Date

Appendix 11: Resource Card

Resource Card	National Sexual Assault and Domestic Violence Helpline 1800 737 737 Sexual Assault Crisis Line 1800 806 292 CASA House (03) 9635 3600
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