



Women's Trauma Recovery Centre

# A NEW MODEL OF CARE

for women experiencing trauma from  
domestic, family and sexual violence

Co-design  
report  
July 2021

in partnership with



## Report prepared by

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This research is a partnership between  
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### Cover picture

Melissa Edwards, Voices for Change Advocate.  
Photograph by Silvia Liber 2020.

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# Summary

In Australia, one in four women has experienced violence by an intimate partner since the age of 15 and one in five experience sexual violence across their lifetime<sup>1</sup>. Beyond physical injury, women who have experienced violence have increased rates of health service access, poorer physical and mental health including anxiety, depression, post-traumatic stress and substance use, and are over-represented in prison<sup>2-6</sup>.

The Fourth Action Plan of the National Plan to Reduce Violence against Women and their Children 2010-2022 acknowledges that progress toward ending violence against women and children is complex and will take sustained long-term action.<sup>7</sup> At the state and national level, there is increasing recognition of the need to address the fragmented services system and go beyond the crisis intervention model to address the long-term impact of trauma, particularly in terms of the complex psychosocial needs of women and their families.<sup>7,8</sup>

In response, the Illawarra Women's Health Centre is proposing to establish a Women's Trauma Recovery Centre that provides comprehensive and long-term support to women who have experienced domestic, family and sexual violence. Strongly aligned with local, state and national priorities, the Centre will address the trauma arising from domestic, family and sexual violence to improve long-term health and psychosocial outcomes for women and families.

The Centre will be an Australian-first community-led initiative, co-designed with women with lived expertise, professional experts, and service providers. In this report we present the process and outcomes from co-designing the core components of the model of care, the principles, and goals of the centre.

# Background

In Australia, one in four women has experienced violence by an intimate partner since the age of 15 and one in five have reported emotional abuse by a previous partner or experienced sexual violence across their lifetime.<sup>9</sup> Compared to one in thirteen, one in eight and one in twenty men respectively, women are disproportionately burdened by domestic, family and sexual violence (DFSV).

For some women, the rate of violence and abuse is higher, including Aboriginal and Torres Strait Islander women, women with disability, young women aged 18-34, women from culturally and linguistically diverse backgrounds, LGBTIQ people, women living in rural or remote areas, and women from socioeconomically disadvantaged areas.<sup>10</sup> This unequal burden of DFSV cannot be understood without appreciating how the intersecting aspects of women's identities can increase the risk, severity and inadequacy of service responses.<sup>11</sup>

The long-term impacts of experiencing DFSV are well established.<sup>12-15</sup> They encompass health, economic and social consequences that often affect women long after the violence and abuse has stopped.<sup>2-6</sup>

Amongst women aged 25-44 years in Australia, domestic and family violence is the leading risk factor contributing to disease burden.<sup>16,17</sup> Poor mental health outcomes are the most reported health consequence<sup>12,13,16,18</sup> and are often associated with chronic health conditions, such as chronic pain,<sup>19</sup>

and higher chronic disease risk factors.<sup>16,20-23</sup>

In multiple ways, DFSV can indirectly or directly impact access, or ability, to sustain employment or housing.<sup>24</sup> Experiencing economic abuse restricts some women's ability to leave a violent relationship, while for others experiencing violence is a high economic burden.<sup>25-27</sup> For example, some women face challenges engaging in employment due to coercive control or the impacts of trauma, while others may have poor tenancy records because of their partner's violence.

Experiences of DFSV can also have intergenerational impacts on children and perpetuate intergenerational cycles of violence and abuse.<sup>28</sup> Children who experience and witness DFSV in their homes are more likely to develop health, social and developmental issues in childhood and adulthood as a result of lasting trauma.<sup>16,29,30</sup> Additionally, living with DFSV as a child is associated with the intergenerational transmission of violence, with increased risk of experiencing or perpetrating violence as an adult.<sup>9,28,31</sup> Within Aboriginal and Torres Strait Islander communities, experiences of DFSV are compounded by historical and intergenerational trauma, and the ongoing impacts of colonisation and racism.<sup>32,33</sup>

Current DFSV workforce and service system responses are siloed and focused mostly on crisis intervention, restricting women's access to holistic support, limiting their ability to recover



Melissa Edwards, Voices for Change Advocate. Photograph by Silvia Liber 2020.

from trauma.<sup>34,35</sup> Siloed service delivery also results in limited knowledge translation and coordination between sectors, as well as lack of cohesive or consistent service responses within sectors.<sup>34</sup>

Often trauma is perpetuated, or re-traumatisation is experienced when women engage with DFSV support services, which frequently require women to repeat their story multiple times.<sup>35</sup> Additionally, some services do not have the tools or resources to recognise the wide-reaching impacts of DFSV, leaving women to separately and independently manage the intersecting health, economic and social consequences.<sup>36</sup> Across sectors there are also well recognised short-comings in service provision that is criteria driven (and often restrictive or exclusionary) and time-limited, which does not adequately support women with multiple, complex or long-term needs.

In response, the Illawarra Women's Health Centre is proposing to establish a Women's Trauma Recovery Centre that provides comprehensive and long-term support to women recovering from the trauma of DFSV. Strongly aligned with priorities in the *Fourth Action Plan of the National Plan to Reduce Violence against Women and their Children 2010-2022*, the *National Women's Health Strategy 2020-2030*, the *New South Wales (NSW) Health Integrated Prevention and Response to Violence, Abuse and Neglect Framework* and the *NSW Blueprint for Reform*, the Centre will address the trauma arising from

DFSV to improve long-term health and psychosocial outcomes for women and families.

To ensure the Centre reflects community priorities and supports the long-term needs of women and their families, community-led co-design was embedded in the design. This design process aimed to generate new knowledge of an Australian-first model of DFSV response and recovery that can be replicated in other settings to improve the health, well-being and lives of women and their families. In this report we outline the findings from the co-design process including the core components of the model of care, the principles, and goals of the centre.

# Designing together

## Why co-design?

High quality health and social services must be designed for and with the people who use the services (clients, carers) and other end-users (practitioners, managers, policy actors).<sup>37-39</sup> Essential to co-design is involving people from the outset of service design and centring the experiences of those who are experts by experience to ensure that services are accessible, effective and equitable.

Co-design can look very different depending on the aims, actors, setting and context. Likewise, there are various methods and processes that can be used. Co-design is situated within the broader field of design, and the processes derive from design thinking, which is depicted by the UK Design Council's Double Diamond model.<sup>40</sup> This model is a visual representation of the four key stages of the design process (Figure 1), which shows points across the four stages where ideas and knowledge expand (discover and develop) and when they converge (define and deliver). Importantly, in this model, the design process is not linear, as shown by the arrows, which emphasises that as we discover more, define the problem more clearly and test possible solutions, there are continual refinements and developments.

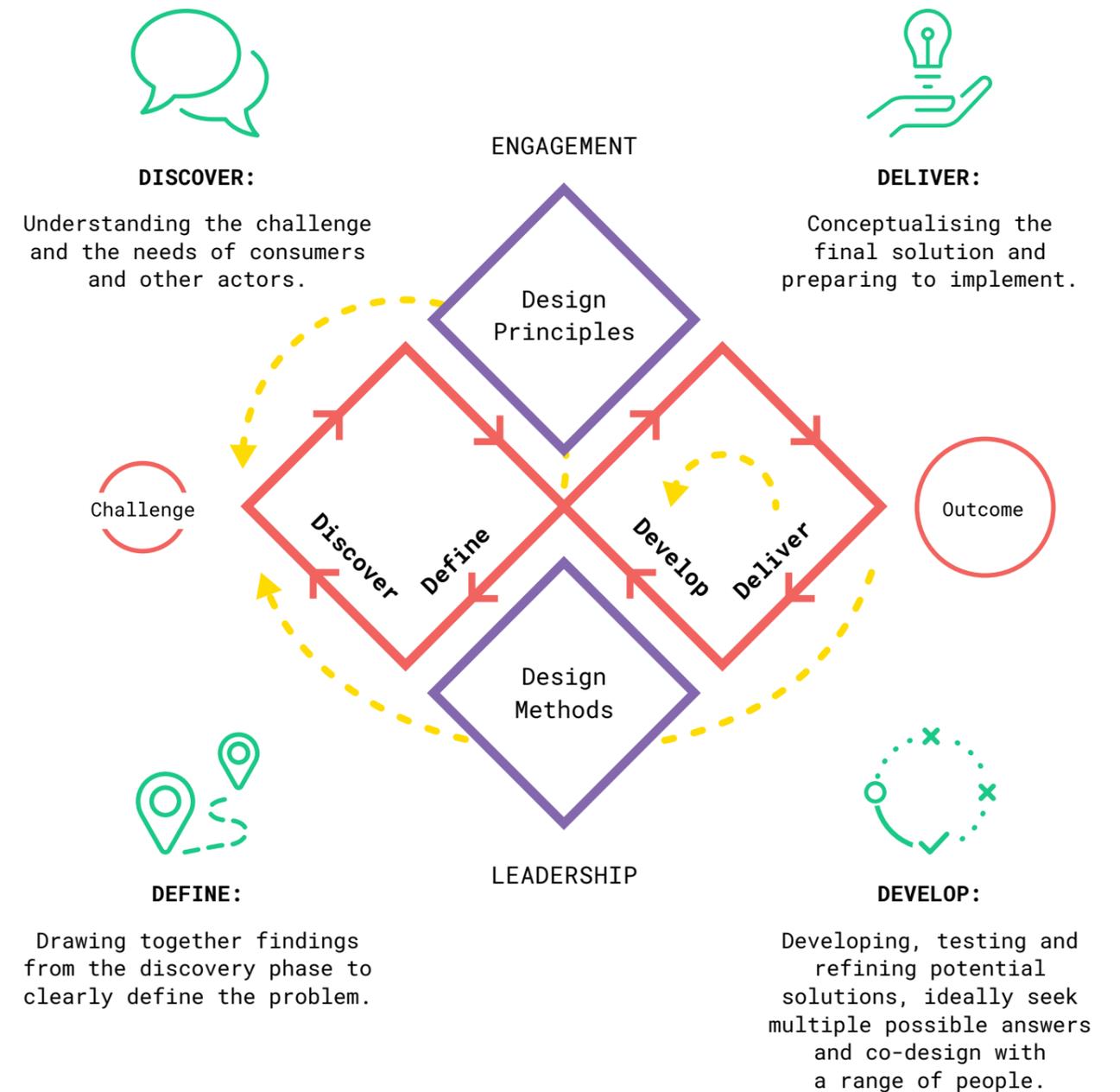


Figure 1. UK Design Council's Double Diamond model four stages of design

Source: Design Council 2019

### Essential ingredients for co-design

There is much variation in the who, what, when and how of co-design. One approach to co-design, **experience-based co-design**, is an interdisciplinary approach to working with experts by experience in the development and enhancement of health and social services. Experience-based co-design is an approach in which those with lived expertise share their experiences, positive and negative, and work together to design service improvements and/or innovations.

Aligned with this, our approach to designing the Centre is informed by guidelines developed by the Agency for Clinical Innovation (ACI) NSW Health<sup>41</sup> and according to international best practice for experience-based co-design.<sup>38</sup> These approaches set out to demystify and create the ideal conditions for co-design including capabilities and principles.

### Principles for co-design

At its core, co-design is a values-led process and as such, values are embedded in the principles that guide the co-design process. ACI has identified five guiding principles for co-design (Figure 2).

These values also broadly align with the **principles of trauma-informed care: safety, empowerment, choice, collaboration, trust and respect**.<sup>42-44</sup> Thereby, while we were guided by evidence-based co-design processes, our design was also a values-led process in which we aimed to embed the principles of trauma-informed care in the Centre from outset of the design.

- EQUAL PARTNERSHIP:** Working together from the beginning with an equal voice and shared ownership and control
- OPENNESS:** Working together on a shared goal, trust the process and learn together
- RESPECT:** Acknowledge and value the views, experiences and diversity
- EMPATHY:** Practice empathy and maintain an environment which feels safe and brings confidence to everyone
- DESIGN TOGETHER:** Working together to design, implement and evaluate improvements, activities, products and services.

Figure 2. Principles to guide co-design

Source Agency for Clinical Innovation (41)

### Our design process

The design of the Centre was undertaken across three phases (Figure 3)



Figure 3. Design phases, participants, methods and process

# Phase 1

## Understanding perspectives of experts by experience and other key stakeholders about what is needed to support recovery and healing from DFSV

The foundations of this phase emerged over several years, stemming from a gap identified by the Illawarra Women's Health Centre in local support services for women experiencing long-term impacts of DFSV. Initiated and led by the Illawarra Women's Health Centre, multiple stakeholders came together and developed a shared vision of developing and implementing a comprehensive "one-stop" trauma recovery service for women.

Following this, a Professional Advisory Group was formed to provide technical oversight, and a Consultative Working Group was formed to continue to drive momentum and garner support at the local, state and national levels. The Consultative Working Group was first convened in March 2019 and meets monthly, chaired by the Executive Director of the Illawarra Shoalhaven Local Health District, the group comprises both local Mayors, government and private sector representatives including from health, social services and police. Among members of both groups, there is diverse lived expertise of DFSV and DFSV frontline service provision, and collectively, these working groups have provided substantial insight to inform the initial concepts for the Centre.

In April 2019, the Illawarra Women's Health Centre and researchers from the School of Population Health at UNSW formed a partnership to develop a co-designed model of care for the Centre. Following, this in June 2020, we were successful in securing funding from the NSW Ministry of Health, administered through Women NSW, Department of Communities and Justice, to expand our co-design efforts and inform a business case for the Centre.

The first step of the co-design was to hear what experts by experience and other key stakeholders say is needed to support recovery and healing from DFSV. To do this, we undertook in-depth interviews with women with lived expertise of DFSV, as well as expert professionals, representatives from DFSV organisations and those that respond to DFSV.

Key questions that shaped the interviews included:

1. What are women's experiences of service navigation and recovery following DFSV?
2. What services and support do women say they need to recover from DFSV?
3. How can we address the barriers to accessing support and recovery with and for women impacted by DFSV?

Interviewees were asked about experiences accessing or providing support for recovery following DFSV, including existing models of care, programs and services. Interviews were between 30-150 minutes and were audio-recorded, transcribed and de-identified for analysis. Our analysis of the data was guided by the principles of experience-based co-design, focusing on identifying positive and negative experiences of service(s).<sup>37,41</sup>

### Who was interviewed?

The service model for the Centre is intended to be suitable for replication and adaptation to other contexts and communities, therefore it was important to understand and include the experiences and perspectives of women and services from within and beyond the Illawarra Shoalhaven. We took an intersectional approach to ensure that as many as possible voices and experiences were heard, including women from LGBTQI+ communities, Aboriginal and Torres Strait Islander women, women with a disability and women from culturally and linguistically diverse communities. We interviewed nineteen women with lived expertise and twenty-seven service providers and clinicians by telephone between July and December 2020. Interviewees were from Victoria, Queensland and New South Wales. Service providers were drawn from a range of organisations across health, social and family services, legal, specialist DFSV, housing and police. Deidentified quotes are presented from women who are experts by experience (EE) and DFSV service providers (P).

### What is needed to enable recovery and healing from DFSV?

Figure 4. Main themes identified from the interviews:

#### MULTIPLE AND INTERSECTING EXPERIENCES OF VIOLENCE, ABUSE AND TRAUMA

- > Trauma held in the body and mind
- > Intergenerational trauma and intersections between childhood trauma and experiences as an adult
- > Trauma of the system

#### WHAT WORKS IN RECOVERY AND HEALING FROM DFSV

- > Relationships are key
- > Timing is everything: the right support at the right time, for as long as needed

#### WHAT IS NEEDED FROM THE CENTRE

- > More than mental health care
- > Recovery, hopefulness and healing

### Multiple and intersecting experiences of violence, abuse and trauma

#### Trauma held in the body and mind

Women described how it feels in their bodies, and some of the physical health impacts, which tended to be long lasting and not well treated by mainstream models of primary or mental health care.

*"The thing is that you can talk about your experience. And it might help you process it, understand the workings of your neuro system, but it doesn't heal you and it doesn't help you to feel safe in your own skin again. Because that's the experience of trauma... your body is no longer a safe place to inhabit." (EE1)*

There were also considerable mental or cognitive impacts. Women described how it feels in the brain and the way it affects thinking, memory and cognitive tasks such as those required for employment, giving evidence and remembering appointments.

*"The way my brain was when I came out of that relationship it's like everything just exploded... What had been holding me together was the trauma and when I actually realised what it was and acknowledged it, I was just a mess, a total mess." (EE4)*

Women frequently reported hypervigilance and ongoing resistance to violence and abuse, that persists after the relationship has ended.

*"In the end I lost my shit and I belted him back, because I just couldn't hack it. But you just get to a point of, I'm so bruised. Bruises heal, but it's the emotional side of things that doesn't heal. Well, doesn't heal overnight." (EE17)*

*"Physically I feel sick, I don't want to leave my house, I have bad dreams, I have nightmares, I live my life in fear, I worry for my kids every day." (EE12)*

#### Trauma of the system

Healing cannot and will not happen when women do not have access to resources, particularly safe housing and money – deprivation of these essential resources that very often began in the context of violence is then perpetuated by systems that could and should mitigate this. In addition to the trauma stemming from violence and abuse, women linked their trauma directly with experiences of navigating services and systems for support.

*"The element of feeling trapped – I think recovery being holistic has to talk about long-term stability, and the reality of being in an abusive relationship is, so much of women's access to resources has been limited or damaged by that abusive relationship. The obvious ones – housing – but also financial counselling, getting sexually transmitted debt,*



*dealing with Centrelink, advocacy with fricking government services who are so poor at responding to this adequately” (EE3)*

*“The legal side is really important. Housing creates stability. Relationships, good relationships create stability. Stable finances create stability. You get some of those right and all those other things will kind of fall into place, because you have the mindset and you’re relaxed enough to be able to problem solve, not problem solving all the time.” (EE19)*

Further, services and practitioners that were not trauma-informed were considered to be potentially harmful.

*“Yeah, well the PTSD was actually, I shouldn’t say the word blame, but I actually blame the court system and the counselling for the PTSD.” (EE5)*

#### **Intergenerational trauma and intersections between childhood trauma and experiences as an adult**

There is increasing insight into how trauma manifests across generations, families and peoples lives. Practitioners spoke about the compounding impacts of multiple experiences of violence and abuse, especially with very early childhood trauma as well as experiences of separation from their parents or exposure to violence or abuse as a child. Such experiences can have profound long-term impacts and quite often, this can see people prescribed

medication for mental health diagnoses. Clinicians noted that while medication has a role, it is only one component of what people need for stabilising and healing in their lives.

*“Increasingly we’re acknowledging that actually a lot of it is due to very poor circumstances and exposure to trauma as kids. And the way that that manifests for people is kind of very poor coping styles, and not able to emotionally regulate, and that they might have highs and lows of emotion, outbursts of anger, often really intense attachment and then intense rejection. But ultimately medications don’t have that much of a role. They have some role, but actually long-term support and counselling is really critical in stabilising things in people’s lives.” (P23).*

This was mirrored in the experiences described by women, who felt that violence and abuse in childhood and as adults were very entwined and that we should not try to separate these experiences.

*“I can’t recover from the abuse I experienced as an adult, if I haven’t recovered from the abuse I experienced as a child. One is the blueprint for the other, in a way.” (EE3)*

Despite this, women reported that they were often told: “Oh no, no, we don’t want to hear about your kid stuff. When you were a kid – that’s not what we’re talking about.” (EE3)

## **What works in recovery and healing from DFSV**

### **Relationships are key**

The trauma of DFSV and the trauma of the system are at their core relational traumas – and key to healing this are the people that women encounter along the way and the relationships that develop.

*“What works well is relationship. Having a relationship with the woman is really vital. Because there is so much fear, there’s fear from the perpetration of the violence for the woman, and also there’s fear of not trusting the services around. I really believe they need to trust you as a practitioner. So at least there’s something to hang on to, even when the systems and the services around them may fall down... And to be honest it sort of does, like look at housing. Okay, we’ve got this service of housing, but in actual fact there may not be anywhere for this woman to go. So therefore, okay, we can’t actually trust the housing service, or that housing system. So if they can trust us as a worker to be really honest and transparent in that space and going, hey, there’s a long wait list but this is maybe what we could do, or we could try this.” (P19).*

Many people spoke about the concept of walking beside, and how this is critical to working in a way that is women-centred and trauma-informed.

*“The clinical services and the medical professionals are incredibly important. But what we found in our service is, as important as those things are, it is the holistic caseworker approach that is actually incredibly successful. It is that person who is walking alongside you. Like the very best workers in our network are women who are very good at sensing where somebody is up to, at any minute, they’re really good at taking someone’s emotional temperature, I call it. It’s like does this person need a bit of a push today, do they need some encouragement, do they need some kind of strong talk? Or is it a day where they’ve just had too much and what they need is a sympathetic ear that can provide that reflective listening and just the understanding of what they’ve been through. And who will also work towards them with their other goals, because so much of this stuff is so individual in terms of what women want to do, for themselves and their families in terms of getting out of this.” (P9).*

### **Timing is everything: the right support at the right time, for as long as needed**

The right timing can be about timely access to services, but it also relates to what women need at different time points throughout their life. For example, counselling and trauma healing is less effective when safety is a major concern.

**“If you’re walking alongside them that really works”.** (P19)

*“The accessing of services in the right time. I know everyone has waiting lists... but sometimes if you’ve got traumatised children, and you’re traumatised yourself, and you can’t access psychological assistance as a matter of urgency – that is a huge risk.” (EE19)*

It was also important for support to not be time limited. Many interviewees reported that while there might be that wrap around support in the crisis phase, later when women are rebuilding it can be very isolating and lonely and that support is not there.

*“After the initial crisis points, emotions are all up in the air, they’re still in shock that this happened. Then when the dust settles there’s no support around them. Everybody wants to deal with them and be involved at the start, but then there’s just not that support a few months down the track. When it might be that you’re forgetting about what the relationship was, and you maybe miss that person, and you are a bit isolated. So, something that would address practical needs, and then maybe the isolation as well” (P6).*

## **What is needed from the Centre?**

### **More than mental health care**

Interviewees described the shortcomings of current services, which centred on the siloing of services and the limitations of mental health treatment that did not address structural inequalities, deprivation of resources, and were not trauma-informed.

*“It was just like torture and all of the CBT in the world didn’t make any difference. I understood my story better, but it didn’t change my thinking” (EE4)*

*“You cannot work on one issue in isolation. Which is what I see happening quite a lot in the mainstream because it’s just the way how they organise themselves into bureaucratic silos. And so oftentimes people are in the mental health system, but no one is asking if there’s domestic violence. So, we work concurrently on mental health and domestic violence. We work concurrently on drug and alcohol and*

domestic violence. The person is everything that they bring, everything that they are." (P3)

Partnerships with ACCHOs and other health services, legal services and housing will be critical to comprehensively addressing needs. This may be through co-location or outreach, as well as services provided directly by staff employed in the Centre.

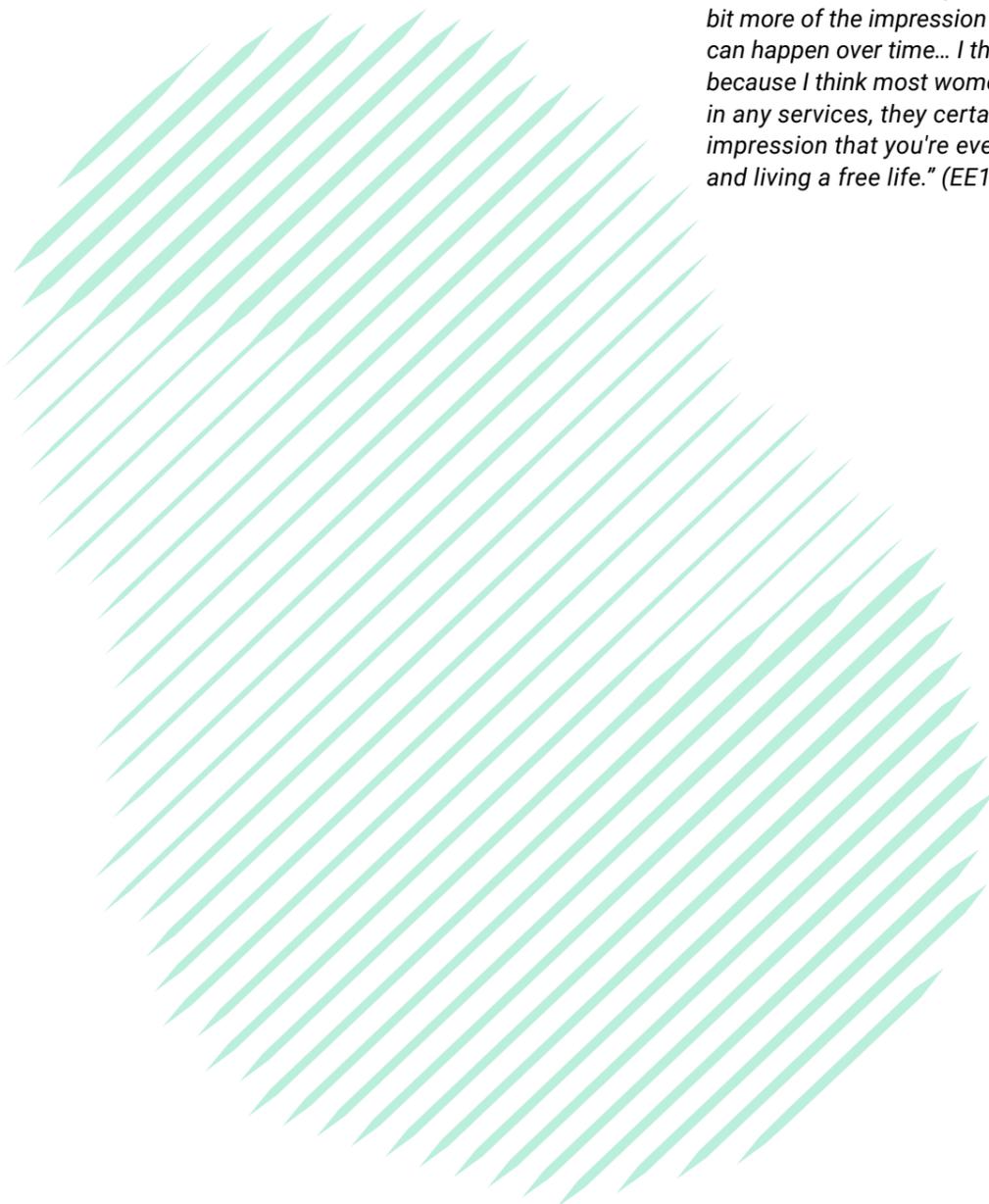
"I've got Aboriginal family support at the AMS (Aboriginal Medical Service), we've got the drug and alcohol counselling, and mental health support worker and they've been really great, like they've been understanding, and they've been really supportive and, I think, we need some people from that service to come across and maybe offer that bit more help and support." (EE12)

### Recovery, hopefulness and healing

Women were asked to reflect on their own experiences of healing and recovery and what these terms mean to them. Responses were mixed, however there was consensus that this is a continual and mostly lifelong process, which underscores the need for the Centre to be accessible to women when they need it, for as long as it takes.

"I think recovery is different to everybody... it's mainstream to think of recovery as just going to go away completely and we're going to be completely over it.... I don't think that's going to happen. I think recovery is learning to live with it and deal with it. For me, my recovery happened over twenty years. Only in the last couple of years have I become stable enough to be able to work in mental health and be able to follow what I want to do. So, it took a long time, but recovery is continual." (EE14)

"I like the word healing because I think it gives a bit more of the impression that it's a journey and it can happen over time... I think it offers a bit of hope because I think most women, when you're engaging in any services, they certainly don't give you the impression that you're ever going to be recovered and living a free life." (EE1)



### What are the important components to be included in the Centre?

In determining the important considerations for the Centre, we asked what interventions and support women say they need to recover from DFSV. Likewise, practitioners were asked for their recommendations and service priorities for the centre (Table 1).

Table 1 Interventions and other service priorities recommended from the interviews with experts by experience (EE) and practitioners (P)

DESCRIPTION	EXAMPLES
<b>Primary health care</b> services available to diagnose and treat women's holistic physical, emotional and psychological health. Women's general health is a basic physiological need that is essential to enable long-term healing and must be a priority for the Centre.	"One of the things we need to ensure is access to good general health care... We need to make sure that their general health is looked after. Because often what happens for people, is we concentrate very much on the obvious and for some people, their general health has been neglected." (P14)
<b>Soft entry pathways</b> to encourage early intervention and engage women in healing activities within the community.	"In terms of providing early support, I think it would be great to have a space that many people can drop in and it's like a soft entry point where there can be different kind of community activities or groups and it's not necessarily focused on violence or even focused on safety but that's a space that people can feel safe enough to go to, that that's a safe space for them, and then if there's a time when they feel more comfortable disclosing violence, then they know that there's somewhere that they can go." (P15)
<b>Cultural safety</b> is a priority, and the Centre must be a welcoming and accessible place for women from culturally and linguistically diverse backgrounds. This could include a multicultural officer, interpreters, information in a range of languages and images depicting cultural diversity in promotional materials. Aboriginal and Torres Strait Islander Health and Family workers will be essential staff.	"Making it accessible for people from migrant and refugee backgrounds, that they could be specialists, or spaces where it's okay to speak other languages or that's normalised or there are specific groups for people to come together if they speak particular languages so they can connect with each other and reduce that social isolation, it's about trust." (P15)
<b>Trauma and violence informed specialised staff</b> with extensive understanding of DFSV and training in trauma and violence informed care. Trauma and violence informed care recognises that people experience violence in many forms (interpersonal, structural, colonial), with additional burdens and layers of trauma, particularly for those who experience inequities and multiple axes of oppression. <sup>45, 46</sup>	"From the organisational perspective I think the recruitment of the right people is really important. It is not good enough to just have a qualification. You've actually got to have an understanding of the determinants of health, a trauma informed care approach. You've got to have an understanding of the dynamics of domestic and family violence... what we need is people who actually understand what trauma is. And how it permeates every part of a person's life." (P3)
<b>Referral pathways for children and families</b> who experience trauma themselves. Whilst the Centre will not be specialised in supporting children as individuals experiencing violence and abuse, there is a need for strong pathways with children's services to refer children of women who access the Centre.	"I've been the child experiencing the mother's abuse, and the parent managing my own trauma while parenting. And I think, I feel quite strongly that children should be addressed for their own experience of that violence that they have lived with in a home situation that was directed at a parent." (EE3)

<p><b>Accessible to all women.</b> The centre must take into account a range of accessibility domains, including physical, information, procedural and attitudinal. This involves ensuring information materials, including online content and communications, are suitable for people with different types of disabilities as well as ensuring the Centre is physically accessible, including wheelchair accessible. Some practical suggestions include providing peer support groups, specialised training for staff in supporting women with disabilities (e.g. supported decision making) and community activities such as art therapy.</p>	<p><i>“Thinking about all the different types of abilities that people have and all the different types of accessibility that needs to be considered from even your website, like these fantastic guidelines on website accessibility and ensuring that it's obviously wheelchair accessible but thinking about all the other types of accessibility. So sensory and visual stuff for deaf people, all that kind of stuff. So, making sure that it's, you're looking at ability, not just through physical ability.” (P12)</i></p> <p><i>“Peer support groups are really useful, where peers who had had similar experiences can be brought together and do some group work together around themselves as women with disabilities, and just the sort of issues that come up in their lives.” (P20)</i></p> <p><i>“Obviously, counselling, where the counsellors are skilled enough to understand how to work with women with disabilities, particularly intellectual disability, for example... things like art are an amazing tool for working with people who have experienced trauma” (P7)</i></p>	<p><b>Information</b> to educate and enable access to appropriate services. Some women need information about identifying DFSV in relationships and how it may be affecting them. It has been suggested this be delivered through education/awareness programs. Other women identified their need for consistent and reliable information around the services and supports available to them.</p>	<p><i>“I think just awareness programs, education programs about what is DFSV. Giving women that autonomy to be able to see for themselves– I think that my experience with domestic violence victims is that when they're in the midst of a traumatic environment... it's hard for them to recognise that is DFSV. And it's not until they get into a safe place where their needs are met, that they can reflect back on what their environment is like for them. So, I think that just having a safe place where they can go and have reflective moments outside of the trauma, is really important in bringing awareness to clients about what they're experiencing.” (P1)</i></p> <p><i>“I was just constantly solving problems... How am I going to get around – Who do I – Who do I talk to? And just chasing – speaking to people all the time and not getting a one-stop shop – a one-stop shop to deal with all these things would be – and somebody who knows because it seems like a lot of people tell you different information as well. So, consistency with information, whoever you access.” (EE2)</i></p> <p><i>“I feel sometimes like women are kind of just left on their own to find the services, and I don't know all the services, but I know one or two but then I hear about a new one that somebody else has come up with. Even just to have a place that has as much information as possible about those other services that feed in, like a one-stop-shop, it'd make a huge difference.” (P25)</i></p>
<p><b>Crisis support</b> in various forms including case management. Women may experience multiple crises and ongoing DFSV throughout their recovery, there is a need to recognise the role of effective crisis support in preventing further traumatisation and enhancing recovery.</p> <p>Women indicated they have found crisis hotlines helpful in the past. The Centre could partner with existing crisis hotlines, as well as advocate for clients to utilise them and act as a referral pathway.</p>	<p><i>“Knowing that in that crisis space you're probably going to be speaking to your case worker daily, if not multiple times a day, and as time goes on it might be a couple of times a week and then once a month. I still see my case worker... I'm actually seeing her tomorrow which makes me so happy, but I think just having that person who's been there from the start, who understands the whole journey, because I couldn't tell you everything that I went through that time.” (EE8)</i></p>	<p><b>After hours/telehealth/home visiting</b> for women who need support outside of business hours. There are also women who will face physical, mental or emotional barriers to accessing the Centre. This can be addressed by delivering services to women after hours and remotely, for example using telehealth or home visiting outreach models.</p>	<p><i>“Life doesn't just neatly fit around your treatment sessions, sometimes it all just happens, and you need to have that time to talk and it might be 3 o'clock in the morning.” (EE15)</i></p> <p><i>“In my opinion, one of the most important things – I used to work in the [deidentified medical service]; I worked there for 10 years, and probably the most effective services were the ones where you could actually visit people at home.” (P10)</i></p>
<p><b>Case management</b> with long-term, wraparound and highly practical support to meet clients' holistic needs, including safety, health, legal, financial, housing and employment.</p>	<p><i>“My case worker... she was the one who kept me going through it all. I was quite isolated... it was a very tough situation and she's the one that kept me going through it all. She was there at the end of the phone. She helped me to know where to go next. Where I could go for legal support or food or whatever it was I needed at that time.” (EE8)</i></p>	<p><b>Safe and secure housing</b> is a fundamental need and human right. This is critical to feel physically and emotionally safe. Women and practitioners reported that housing insecurity as a result of DFSV is a substantial barrier to healing, and consequently it is recommended that housing advocacy/support be delivered by the Centre.</p>	<p><i>“People who actually are specialists on sorting out leases, that know how to sort out leases, how to get things done...I couldn't access those things...I sorted out my lease by myself and how I could get out of my lease really quickly. The lawyer didn't know – they didn't give me that advice, I had a lot of battles.” (EE2)</i></p> <p><i>“One of the issues that I see and that occurs for people is housing. To be able to leave, you have to be able to find secure housing and you have to have financial advice to help you to be able to leave and have some way of conducting your life and looking after your children.” (P14)</i></p>
<p><b>Community connection</b> to facilitate strong social networks is critical for recovery. As DFSV can be a very isolating experience, the Centre will need to generate a sense of community and connection amongst clients. Practitioners and women recommend this be done through peer support groups centred around group activities (e.g. cooking, arts, yoga).</p>	<p><i>“I ended up in this trauma bond with this person... when I was feeling really scared and vulnerable and lonely. And the first time it ended, I ended up going to this single mothers' group. And then I started making friends, and then things started to get a bit better, a little bit better. I started making friends.” (EE10)</i></p> <p><i>“We've always used art and craft and those sorts of activities to create social connection because often women who have experienced that do become quite isolated.” (P20)</i></p>	<p><b>Employment and education support</b> including access to programs, services and pathways to help women enter or re-enter training or the workforce.</p>	<p><i>“How can we get employment services to offer opportunities for women where they might have been out of work for 20 years.” (EE8)</i></p>
<p><b>Legal support that is trauma-informed</b> to prevent an additional layer of traumatisation as women navigate the legal system and courts, both Criminal Justice and Family Law processes. Legal support must also be affordable or no cost.</p>	<p><i>“There needs to be a lot more legal support really. Especially with Legal Aid, like I've had problems just recently with disclosures with my son, and I found that it was a while trying to get legal advice, so I had to wait two to three days, to try to get some legal advice about what I can do.... someone who can communicate with the independent children's lawyer.” (EE12)</i></p>		

# Phase 2

## Online surveys and workshops to develop the goals, principles and operational framework of the Centre

Using purposive sampling, potential respondents were drawn from the in-depth interviews, as well as additional members of the Women's Trauma Recovery Consultative Working Group and Professional Advisory Group, and were invited to participate in a series of online co-design surveys. The research team made contact through recruitment email invitations with a link to the surveys. Development of the surveys was informed by the findings from Phase 1 and were presented using a modified Delphi approach to reach consensus on what is acceptable and feasible for the Centre.

The surveys were informed by two key questions:

1. What are the priorities for the Centre in terms of interventions, practitioners and physical features?
2. What should be the core principles and goals of the Centre?

Two rounds of the surveys were undertaken between February and May 2020. The survey asked respondents to identify priority areas for the Centre in terms of interventions, practitioners and physical features. Round 1 of the survey asked respondents

to rate lists of interventions, practitioners and physical features identified in phase 1 on a Likert scale from high to low priority. Round 1 of the survey also included free text questions to provide opportunities to explain a previous answer or introduce a new priority area not previously identified in Phase 1.

Round 2 of the survey was designed to clarify respondents' priorities identified in survey 1. Respondents were asked to identify how they would like to see each intervention provided; as a core-service, co-located service, referral pathway or not at all. Similarly, they were asked how they would like to see practitioners integrated within the Centre (core, co-located, referral pathway or not at all).

Women with lived expertise, DFSV practitioners and other key stakeholders (n=44) were invited to participate in the first round survey, of whom a total of 38 (86%) completed it (Table 2). Respondents from round 1 who provided consent in the first survey to be contacted to participate in the second round survey were invited to do so (n=28), of whom a total of 14 (50%) completed it (Table 2).

Table 2. Characteristics of respondent to the online surveys

	SURVEY 1 (N=38)	SURVEY 2 (N=14)
Female	34 (89%)	12 (86%)
Lived expertise of DFSV	24 (63%)	9 (64%)
Identify as Aboriginal or Torres Strait Islander*	<5	<5
Country of Birth Australia	32 (84%)	13 (93%)
Language other than English spoken at home*	5 (13%)	<5

\*Indicates less than five participants

## Interventions for the Centre

Respondents were asked to rate each intervention as a being a high priority (essential for the Centre), a medium priority (if funding permitted) or a low priority (unimportant irrespective of resources) (Table 3).

Table 3. Interventions to be potentially included in the Centre with priority rating of high, medium or low expressed as a % endorsed by respondents

INTERVENTION	HIGH	MEDIUM	LOW
Crisis support	98	2	0
Counselling	91	9	0
Legal advice and support	85	15	0
On-site child minding	78	22	0
Group therapy and support	78	20	2
Financial guidance, counselling and advocacy	78	20	2
Information and referral service	76	24	0
Therapeutic workshops and programs	76	24	0
Peer support groups	74	24	2
Clinical psychology	74	24	2
Women's health care	69	29	2
Education workshops and programs (e.g. parenting workshops)	67	30	2
Centrelink referrals	57	37	7
Psychiatry	50	43	7
Employment pathways and referral to employment services	48	43	9
Prison throughcare and case management	48	48	4
NDIS referrals	48	46	7
Sexual and reproductive health	47	53	0
Social/community activities and support	47	47	7
Primary health care services	44	53	2
Brain injury assessment	39	57	4
Mindfulness/meditation	39	46	15
In-patient care	28	41	30
Art therapy	26	48	26
Music therapy	22	52	26
Massage therapy	22	46	33
Therapy/emotional support animals	20	57	24
Physiotherapy	20	41	39
Horticultural therapy	17	57	26
Yoga	15	50	35
Exercise physiology	13	54	33
Nutrition/dietician	11	69	20
Acupuncture	11	26	63

**Services beyond face-to-face care**

Respondents were asked to rate the importance of providing additional services beyond face-to-face care. Most respondents perceived home visiting, after hours services, telephone support and community outreach to be priorities for the Centre.

**Home visiting**

- > 72% of respondents agreed that home visiting should be provided in addition to face-to-face care.
- > One respondent noted that "home visiting and support would be good. Isolation is a big issue for many women."
- > In contrast, another respondent commented that home visiting could pose a risk for women and their children: "Home visiting would need a safety assessment and may pose an increased risk for women and children if the POI has access to the home."

**After hours services**

- > 83% of respondents agreed that after hours services should be provided.
- > One respondent commented: "After hours may be best delivered in conjunction with existing after-hours services as maintaining a roster is complicated particularly if you are considering face to face (people need adequate time off after call outs, broken nights etc)."

**Telephone support**

- > 85% of respondents agreed that telehealth and/or telephone support including counselling and online educational programs to support recovery.
- > A respondent recommended using social media and non-traditional channels of engaging clients, particularly young women who are prolific users of smartphones: "90% of the women under the age of 24 are increasingly using phones and social media to engage with services that we would traditionally do face-to-face. Look at social media, intranet-based communication; community support hubs that are online. Even apps as a complementary service."

**Community outreach**

- > 72% of respondents agreed that other forms of community outreach e.g. engaging with schools or shopping centre safe spaces should be provided.
- > One respondent highlighted the need for outreach to prisons and shelters.

**Professional Practitioners for the Centre**

In the first round of the survey, respondents were asked to rate the types of practitioners they perceived to be a high priority (core workers), medium priority (ideal workers but optional) and low priority (unimportant) for working in the Centre. There was consistency in the types of practitioners that were highly prioritised. Findings from the second round of the surveys clarified whether respondents believed these should be core (on-site and integrated), ideal (on-site if funding permitted), co-located (in the same physical space but separate), connected through a referral pathway or not provided (Figure 4; Table 4).

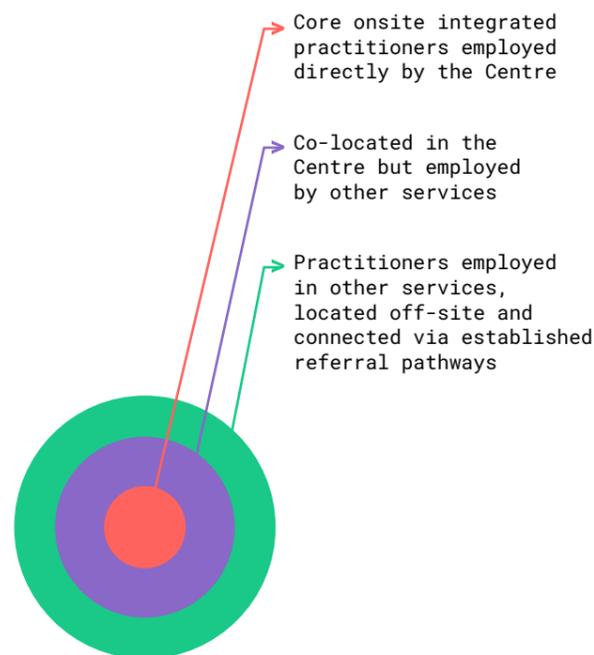


Figure 4. Organisation of practitioners for the Centre with core, co-located and externally located who are connected via referral pathways

**Core, ideal, co-located and referral practitioners**

Table 4. Practitioners to be considered for the Centre with priority of core, ideal, co-located, referral or not at all expressed as a % endorsed by respondents.

PRACTITIONERS	CORE	IDEAL	CO-LOCATED	REFERRAL	NOT AT ALL
Case manager specialised in crisis support and safety planning	100	0	0	0	0
Counsellor	85	15	0	0	0
Women's health nurse	69	23	8	0	0
Case manager for longer-term support	69	8	15	8	0
Social worker	46	46	8	0	0
Court advocacy support provider	46	23	23	8	0
Group therapy facilitator	39	39	23	0	0
Clinical psychologist	31	46	23	0	0
Physician specialised in sexual and reproductive health	31	15	31	23	0
General Practitioner	31	8	39	23	0
Multicultural specialist	23	39	31	8	0
Mindfulness/meditation facilitator	23	31	31	15	0
Art therapist	23	23	23	31	0
Disability care specialist	15	54	23	8	0
Massage therapist	15	39	15	31	0
Yoga instructor	15	31	23	31	0
Physiotherapist	15	31	23	31	0
Legal professionals (lawyer, paralegals)	15	15	62	8	0
Nutritionist/Dietician	15	23	31	31	0
Music therapist	15	23	23	39	0
Financial counsellor	8	15	69	8	0
Acupuncturist	8	15	54	23	0
Case manager specialised in prison through care	8	15	39	39	0
Exercise physiologist	8	15	39	31	8
Physician specialised in brain injury assessment	8	15	23	54	0
Psychiatrist	8	8	15	69	0
Horticultural therapist	0	39	46	15	0
Youth worker	0	25	58	17	0
Employment counsellor	0	8	58	33	0

## Physical space and setting for the Centre

Most respondents (55%) endorsed the Centre being a women's only space, whereas 25% disagreed and 20% were unsure. Several respondents voiced concerns that having men in the Centre would be triggering. On the other hand, some practitioners felt that having a policy precluding men meant that high quality male practitioners would be excluded to the detriment of service delivery. Practitioners also stated that it was important for the recovery process for women to be exposed to healthy men. The general consensus was that women should have a choice if they want to see a female or male practitioner.

Respondents were asked to identify the ideal setting for the Centre. The majority of respondents (70%) considered a community setting to be ideal. One respondent emphasised why the Centre should be separated from a hospital: *"The Trauma Recovery Centre needs to be at a separate location to the public hospital in the area. This would be important for both privacy, security and therapeutic reasons."*

### Physical safety measures

Respondents were asked to provide free-text suggestions for how the Centre can protect the physical safety of women in the Centre. The following physical safety measures were suggested:

- > **CCTV cameras** in common areas and around the perimeter: "Common room there needs to be CCTV footage and around the perimeter there needs to be CCTV footage of what police require a licensed facility to have... Police could provide that advice."
- > **Access codes** or passes into the Centre. Need to ensure the Centre is locked but still accessible, especially to people with disabilities: "Safe environment is a locked service not open to the public, that easily accessible for people with disabilities, are culturally safe for Indigenous people and flexible to accommodate people seeking services who have children, who work or who rely on after hours times to see services and are set up for women of all ages."
- > **Signage** signalling the Centre is a safe space and that police will be called if prohibited people enter: "Ensure there is a sign on the door signifying a safe space and the police can and will be called if entered by prohibited persons or dangerous persons. Security cameras. Sign in sheet. Confidentiality agreements in place."

- > Access to **transport services**.
- > **Security staff:** "Appropriate security staff able to act in the event of trouble but not an intrusive presence". One respondent recommended security be provided 24/7, and another identified security staff as the most important priority for physical safety.
- > **Wearable personal safety devices** (duress alarms) for staff and high-risk clients. Recommend those "linked to a high priority response from the police and not just a call centre as the current alarms are."
- > Education for staff and clients on how to identify and **remove tracking devices**.
- > **Easy access to police** either by having the Centre close to a police station or if needed, plain clothes police visiting the Centre: "Lots of work on building the relationship between police and the community so women feel supported to report to police."
- > **Single and monitored entry** to the Centre: "Everyone has to go through a reception area with doors to get into the actual centre"; "Front door should have a lock mechanism that can be activated by reception if required."
- > **Address** for the Centre concealed from public: "It should be treated similar to a women's refuge in that the actual address of the Centre should not be publicly available. That the address could be listed as a PO BOX or linked to the local hospital. Victim-survivors will want to feel safe and secure during their treatment."
- > **One way windows** so that staff/clients can see out of the building but the public cannot see in.
- > **Police to conduct a safety audit** of the security measures e.g. security screens/windows.
- > **Security fences and secure off street parking**.
- > **Outside features** need to comply with "safer by design" council requirements: "Anything that is outside needs to comply with safer by design; types of plants so people can't hide in them. Any application to the council has to comply with safer by design."
- > **Support to stop technology abuse:** "Assistance to change phone numbers quickly, help blocking perpetrators on social media, education of securing social media."

### Emotional safety measures

Respondents were asked to provide free-text suggestions for how the Centre can foster emotional safety for all in the Centre. The following measures were suggested:

- > **Strong referral pathways** so women do not have to retell their story and risk retraumatisation: *"Facilitation of safe and seamless referral pathways to other services and agencies so the woman does not have to tell her story 20 times and be endlessly retraumatised."*
- > **Positive and strength affirming language** in written messaging and staff communications.
- > **Validation from staff:** *"Being listened to and believed."*
- > **Private space** for consultations where women feel their privacy and confidentiality is enabled/respected.
- > **Safe and nurturing features** incorporated e.g. artwork, plants, comfortable chairs.
- > **A nurture room**, *"where all nurturing, comfort props are available e.g. - lavender pillows etc, weighted blankets, stress balls, calm music, etc."*
- > Policies around **confidentiality** in counselling records: *"Strict rules and regulations regarding the security of confidential counselling records."*
- > **Trauma and violence informed staff training:** *"All staff employed by or who consult with this Centre need to have completed a form of Family Violence/Sexual Assault training so that they are all trauma-informed. From the cleaners right through to the treating clinicians."*
- > **Positive colours:** *"Be aware of closed spaces, dark spaces where people might feel locked in."*

## Testing the goals, core components and principles of the Centre

In addition to the core components, the principles and goals were also presented to respondents in the second round of the survey, and open-ended questions asked respondents to provide feedback. Between survey rounds 1 and 2, we held two workshops in March 2021, to test the core components and further shape the guiding principles and goals. Participants from the earlier phases were invited to join the workshops, this also included additional members of the Consultative Working Group, the Professional Advisory Group and Executive staff from Waminda South Coast Women's Health and Welfare Aboriginal Corporation.

The workshops were facilitated by Lyla Rogan, a specialist facilitator in co-producing organisational strategy, culture and values. Each of the workshops commenced with Cleone Wellington and Lisa Wellington from Waminda's Executive team presenting the Waminda model of care and Balaang Healing Framework. This was an integral aspect of the workshops that stimulated discussion of how First Nations peoples and communities' holistic models of health and healing can be embedded within an organisational model of care, with practical examples of how this works at Waminda. Culture is the foundation of the Waminda model of care and Balaang Healing Framework, and women and their Aboriginal families are at the centre, which resonated strongly with workshop participants and shaped the ongoing discussions at the workshops.

In the first workshop, which included participants from Phase 1 and members of the Professional Advisory Group, two vignette cases were presented to the fifteen participants. Participants formed two smaller groups to work through the service experience of the women in the vignettes, from ways of working, identifying service needs, appropriate care within the Centre and referral pathways. In the second workshop, the focus was on further developing the operational framework and strategic partnerships that would be needed with eight members of the Consultative Working Group.

# Phase 3

## Bringing it all together: Goals, core components and guiding principles of the Centre

Drawing together results of phase 1 and 2 delivered the following goals, core components and guiding principles of the Centre.

### Goals

The primary goal is to establish a best practice and sustainable model of care that leads to recovery and healing from trauma of DFSV. To achieve this, the Centre will:

- > Be an integrated, specialised and dedicated service offering individualised multidisciplinary wrap-around support to women
- > Comprehensively address the impacts of DFSV to improve long-term health and psychosocial outcomes for women and families, including breaking the cycles of ongoing exposure to violence, abuse and intergenerational trauma
- > Provide opportunities for knowledge translation and community-led research partnerships to design innovative responses to DFSV

**Recovery is prevention** – by investing in the safety, health and healing of women we will address not only the longer-term impacts of trauma stemming from DFSV, but also work toward breaking pervasive cycles of violence and abuse and preventing intergenerational transmission of trauma.

### Core components

The Centre model comprises six core components:

**01:** Primary health care, legal support, mental health care, housing support, financial advocacy, delivered in one place at the right time for as long as needed.

**02:** Soft-entry pathways

**03:** Service integration and linkages (including co-location and referral pathways)

**04:** Case-management

**05:** Crisis support

**06:** Social and community connection

The core components are underpinned by key resources which are essential to the delivery of the model. These are broadly grouped into the physical space, the people and the partnerships.



**01**

Trauma and violence informed specialist staff, including peer workers with lived expertise.



**02**

Physically, emotionally and culturally safe space.



**03**

Partnerships to facilitate service integration and linkages.



## Guiding principles

"I would like to see a centre that focuses on the whole human experience and not just the symptoms of trauma"<sup>(P1)</sup>

The model for the Centre will be underpinned by eight guiding principles:



### 1. **Respect**

The dignity, integrity and lived expertise of every woman is respected.



### 2. **Self-determination**

Offering real choices and active support to make decisions.



### 3. **Compassion**

Caring, non-judgemental and person-centred approach that responds to each woman's individual circumstances compassionately.



### 4. **Integrity**

Honesty, transparency and trustworthiness are foundational to all relationships within the Centre and with the broader community.



### 5. **Safety**

A place where clients and staff feel culturally, emotionally and physically safe.



### 6. **Equity**

The Centre will work towards equitable distribution of power across the organisation to represent and value women's multiple diversities.



### 7. **Healing**

Aboriginal and Torres Strait Islander peoples' ways of knowing, being and doing are central to healing for women, families, communities and Country



### 8. **Community**

The Centre is community-led and responsive, and an integrated component of the public health system.

## Next stage

Our findings emphasise the intersection of DFSV with multiple health, economic and social consequences, and that it is integral that women have access to coordinated systems of care that support recovery. Holistically addressing experiences of DFSV with collaborative, wrap-around and place-based services, will ensure that services address the multiple and complex impacts of trauma. It will also ensure a focus on recovery, which reduces or prevents ongoing DFSV and intergenerational trauma.

In Australia, there are currently no integrated, comprehensive, and long-term support service models that facilitate recovery from DFSV. The proposed Women's Trauma Recovery Centre is such a model. It represents a practical, compassionate and timely solution to the lifelong impacts stemming from DFSV, including breaking the cycles of ongoing and intergenerational violence, abuse and trauma.

Over the past two years momentum and support for the Centre has grown, it is now significant and national. The concept has community, private sector, service provider, and multi-partisan political support, with recognition that the Centre represents an investment that will provide significant returns to the Government, economy, and community.

The House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into Family, Domestic and Sexual Violence report, specifically recommended the Commonwealth and NSW Government fund a five-year Women's Trauma Recovery Centre pilot project: Recommendation 77 *The Committee recommends that the Australian Government, in partnership with the New South Wales Government, fund a trial program of the Illawarra Women's Health Centre's Women's Trauma Recovery Centre. This funding could be part of a pilot program over a five-year period with a view, subject to positive evaluation, to rolling out similar services around the country.*

The Centre will be an Australian-first community-led initiative, co-designed with women with lived expertise, professional experts, and service providers. We continue to engage and advocate at the local, state and national level to have this new model adopted nationally and implemented locally in multiple settings, to compassionately and effectively respond to the epidemic of DFSV in Australia.

**'The Committee considers the establishment of a multi-disciplinary Women's Trauma Recovery Centre as a pioneering and evidence-based response to the health impacts of family domestic and sexual violence.'**

The House of Representatives  
Standing Committee on  
Social Policy and Legal  
Affairs Inquiry into Family,  
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