VISION/VAMHN 2025

Symposium on Supporting Survivor Wellbeing after Domestic Abuse.

Post Event Resources

Contents

TICA
Trauma Informed Community Action

Bringing a Human Rights Perspective to Trauma-Informed Approaches

Thursday, 6th February 2025

09:00 - 17:00

Oxford Town Hall, St Aldates, Oxford, **OX1 1BX**

"Because the violence at the source of trauma aims at domination and oppression …The suffering of traumatised people is a matter not only of individual psychology but also, always, of social justice."

(Judith Herman, 2023[1])

This infographic has arisen from the Human Rights and Trauma-Informed Approaches project. This identified the pressing need to address the profound impact of human rights and its interface with trauma among individuals and communities.

Trauma-informed approaches are a whole-systems approach that creates environments that promote healing and prevent retraumatisation. At the heart is a conceptual shift from thinking "what's wrong with you?" to "what happened to you?"[2]. Trauma-informed care approaches are not the same thing as trauma-specific therapies. They are relevant to multiple systems, including justice systems, benefits systems, education systems, social care systems and beyond. They are guided by the underpinning premise that 'trauma is everyone's business'.

Human rights are inherent rights for all human beings regardless of 'race', sex, nationality, ethnicity, language, religion or other status[3]. Violations are when a person or country disregards or fails to protect internationally recognised human rights. This is important to understanding trauma - particularly human-inflicted trauma; for example, interpersonal violence infringes an individual's right to safety, liberty, and dignity.

Trauma-informed approaches and human rights frameworks share a goal: creating systems that promote healing, dignity, and justice. To fully support healing after trauma, we need to understand trauma not only on an individual level. We need to understand it as something that affects communities and is linked with other forms of injustice, marginalisation and disadvantage. We can show this through an ecological model[4] which shows that efforts to support survivors to heal must address all the interconnected levels of their environment.
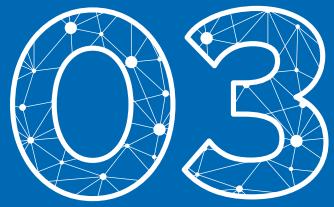
[1] Herman, J. 2023. Truth and repair: How trauma survivors envision justice. Hachette UK.
[2] Sweeney, A., & Taggart, D. (2018). (Mis) understanding trauma-informed approaches in mental health. Journal of Mental Health, 27(5), 383-387.
[3] Universal Declaration of Human Rights: https://www.un.org/en/about-us/universal-declaration-of-human-rights
[4] Bronfenbrenner, U. (1979). The ecology of human development: experiments by nature and design. Harvard university press.

ME
Individual

WE
Family, practitioners and people in my immediate world.

US
The community/communities I am part of or affected by.

SOCIETY
Services and settings that directly influence me, we and us. e.g., government, systems of care, media.

ANCESTRY
Legacies of events that are passed down through generations.

HISTORY
Historical evens, societal shifts.

Combining a human rights perspective and a trauma-informed approach starts with recognising that trauma affects communities and groups – not just individuals.

Here are some practical ideas to put this into practice.

1. Recognise trauma as more than an Individual Issue

Asking **"What happened to you?"** instead of **"what's wrong with you?"** in trauma-informed approaches is meant to be a conceptual or rhetorical shift and not a literal one. However, even shifting focus to 'what's happened to you?' risks neglecting the societal and historical causes of trauma, like racism, poverty, and colonialism, as well as ongoing and current sources of harm, like systemic racism and inequalities in access to and quality of care. To bring a human rights perspective, it is helpful to consider, 'What happened to your community in the past? What is happening to your community now?' and 'What do you and your community need?'. This can shift understanding to the communal. It should also recognise nuance; within families and communities there will not always be consensus about what will help.

Evolving solutions:

- Focus on systemic causes of harm, not just individual ones.
- Address shared traumas such as climate change and structural violence.
- Frame trauma as a human rights issue, emphasizing systemic accountability.
- Train professionals in both trauma-informed care and human rights.

2. Move Beyond Superficial Practices

Some organizations claim to be trauma-informed without making real changes, much like "greenwashing" in environmentalism. This needs deeper change and efforts to build integrated and shared visions for improvement which involve trauma survivors as well as minoritised and traumatised people and communities as partners in change. Trauma informed care rests on deeply held values which are enacted in a culture of continual learning.

Evolving solutions:

- Quality improvement and culture of learning
- Conduct audits to ensure practices align with trauma-informed values
- Train staff to identify and prevent retraumatising patterns
- Meaningful co-design with survivors from a range of backgrounds

3. Understand inequities and oppression

Trauma and human rights violations often intersect at an embodied level. People's identities can be politicised, and their rights denied or diminished. Individuals and communities facing racism, sexism, ableism and other inequalities require approaches that address these overlapping injustices.

Evolving solutions:

- Co- design systems, policies and services with survivors from diverse cultural and community contexts.
- Meaningfully embed human rights principles, like equality and non-discrimination, into trauma-informed systems.

To achieve justice, we must go beyond rhetoric and take healing from the individual to the collective. This means challenging oppressive systems and creating accountable systems with relationships at their heart. By combining trauma-informed care with human rights principles, we can build systems that not only heal individuals but transform society into one rooted in fairness, respect, and collective well-being.

Trauma-Informed Framework

July 2025

Contents:

Executive Summary

This document brings together learning from the Sussex Community of Practice and beyond. It provides a summary of some of the great practice already underway, ideas about overcoming some of the challenges, and suggested methods for evaluation and monitoring.

Trauma is common in our communities, with some areas facing even higher levels – especially coastal towns, places with high levels of poverty, and communities with complex needs. (Public Health Needs Audit)

Many of our staff and carers have also been affected by trauma, either in their personal lives or through the work they do.

We have a shared responsibility to look after each other with respect, kindness, and understanding. This work is about changing behaviours and through this changing the culture of how we work.

While training is a helpful starting point, we know that staff face many demands on their time. Frontline staff need to understand the ways in which trauma may affect people, and this understanding should shape their everyday practice. For trauma-informed practice to truly take root, we must also focus on changing systems – not just individuals.

Sussex has a growing **Trauma-Informed Practice (TIP) Community of Practice,** with around 300 members from 70 organisations including people with lived experience, frontline staff, service leads, and system leaders. We also have a **Collaborative Implementation Group** made up of leaders from across the Health and Care partnership in Sussex that helps build shared learning and keeps up momentum for change. Sussex has strong knowledge and experience in this area, and we're combining it with learning from across the UK.

It also sets out a Call to Action to act to help guide future work across Sussex:

- To champion dedicated coordination capacity to embed trauma-informed approaches across complex systems.

- To unite diverse expertise – from frontline workers to strategic leaders – to co-create inclusive, effective solutions.

- To build and act on robust evidence to sustainably embed peer support and relational care into the fabric of our services.

Our goal is to create lasting, high-quality trauma-informed practice across the region.

Introduction

This document is for anyone who wants to help make positive changes in their community. It is especially useful for people working in health and care services across Sussex such as frontline staff, community groups, and people who have experienced trauma.

It's also for leaders, decision-makers, and those who help shape policies. The aim is to give clear ideas and practical steps to help bring trauma-informed thinking into everyday work, policies, and organisations.

A big part of this document is about supporting and encouraging local leaders – whether they have official roles or are trusted voices in their community or service. Real change happens when everyone feels they have the power and permission to make a difference.

This document, therefore, is here to give people permission and support to take action and help build a more trauma-informed community in Sussex.

Our vision

A responsive Sussex community and workforce that prevents further harm, supports recovery, addresses inequalities and improves life chances by recognising and responding alongside people who are affected by trauma and adversity.

Trauma-informed practice should be embedded across policy, commissioning, and service design to tackle inequalities, improve outcomes, and support staff wellbeing. System leaders must lead with kindness, enable collaboration, and involve people with lived experience meaningfully.

Frontline staff and managers play a vital role in recognising trauma, building trust, and creating psychologically safe environments. Reflective practice, consistent communication, and healthy boundaries all contribute to safer, more compassionate care. Everyone – regardless of role – can help foster safety, understanding, and healing through small everyday actions. Being trauma-informed is a collective responsibility, and it starts with awareness, connection, and care for ourselves and others.

We now have a chance to create a strong Sussex-wide trauma-informed framework.

To make this happen, we will:

- Clearly define what trauma-informed practice means for Sussex.

- Share useful materials and knowledge to enable the workforce to orientate towards working in a trauma-informed way.

- Build a supportive environment where people and organisations feel confident to make real changes – and challenge the system when needed.

- Help you consider what YOU can do to make our community more trauma-informed in the **Call to Action on pages 35-37.**

Trauma and its impact

Trauma happens when someone **experiences** something deeply upsetting, harmful, or life-threatening. This could be one **event**, several events over time, or ongoing difficult circumstances. These experiences can have long-lasting **effects** on a person's physical and mental health, relationships, emotions, and sense of safety or identity.

This definition is often described as the "Three Es":

- **Event(s)**
- **Experience** of the event
- **Effect** on the person

> **" Trauma can occur with any experience that overwhelms your ability to cope. "**
>
> (Liz Mullinar, Heal for Life)

> **" Traumatic events… overwhelm the ordinary human adaptations to life. "**
>
> (Judith Herman, 1992)

> **" Trauma is not what happens to you, but what happens inside you. "**
>
> (Gabor Mate, The Myth of Normal, 2022)

There are **different categories of potentially traumatising experiences** that can impact people differently:

Single event trauma: this is a single, unexpected event, such as a physical or sexual assault, an accident, or a serious illness or injury. Experiences of loss can also be traumatic, for example, the death of a loved one, a miscarriage, or a suicide.

Complex trauma: this refers to prolonged or multiple traumatic events, usually connected to personal relationships, such as domestic violence, bullying, childhood neglect, emotional abuse, sexual abuse, or torture.

Vicarious trauma: this can arise after hearing first-hand about another person's traumatic experiences. It is most common in people working directly with traumatised people. Family members and close friends may also experience vicarious trauma through supporting a loved one who is traumatised.

Structural: the emotional and psychological harm from inequity enforced through public policies, institutional practices, cultural images and behaviours which are built into the structure of a culture, and which reinforce social inequity.

System: generally refers to trauma that can be created and reinforced by specific systems, such as a child having multiple foster care moves

Historical: complex and collective trauma experienced over time and across generations by a group of people who share an identity, affiliation, or circumstance, such as slavery or war.

Organisational: when an organisation itself becomes unhealthy, trauma-inducing or traumatised and creates trauma for the people who work there and the people whom it serves through adverse organisational experiences, such as workplace bullying.

Inter: or transgenerational trauma: Inter-or transgenerational trauma comes from cumulative traumatic experiences inflicted on a group of people that can continue to affect the following generation(s).

! It is important to remember that there is **no hierarchy of trauma or suffering.** No one type of trauma is necessarily worse than another, rather it is a combination of personal, situational and social factors which affect how people are able to manage or cope with distressing events.

Trauma and Safeguarding

Trauma is an important factor in many Safeguarding Adult Reviews in Sussex. These reviews happen when someone with care or support needs has died or been seriously harmed. The reviews look at how different organisations worked together to keep people safe and what we can learn to do better.

Trauma impacts people at different life stages and in different ways: difficult childhood experiences; challenges during the move from childhood to adulthood; the role it plays in complex needs like having children taken into care; worsening mental health; challenges in older adulthood such as worsening physical health and increasing need for care.

Because trauma is so common and affects many parts of a person's life, it is clear that professionals need to use a trauma-informed approach when working with people who need care and support.

You can find short case studies about some individuals involved in Safeguarding Adult Reviews from Brighton & Hove, East Sussex, and West Sussex in the resource pack that goes with this framework. There are also links to the Safeguarding Adults Boards across Sussex, where more information is available.

Guy Jackson, Safeguarding Adults Board Manager,
Brighton and Hove City Council

Trauma is very common – especially among people facing poverty, discrimination, or poor access to health and support services.

Domestic violence is the third most reported reason for [voluntary] homelessness in Sussex

1.7 million people reported experiencing violent crime in England & Wales in 2020-2021
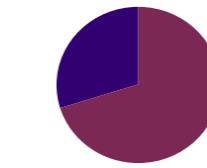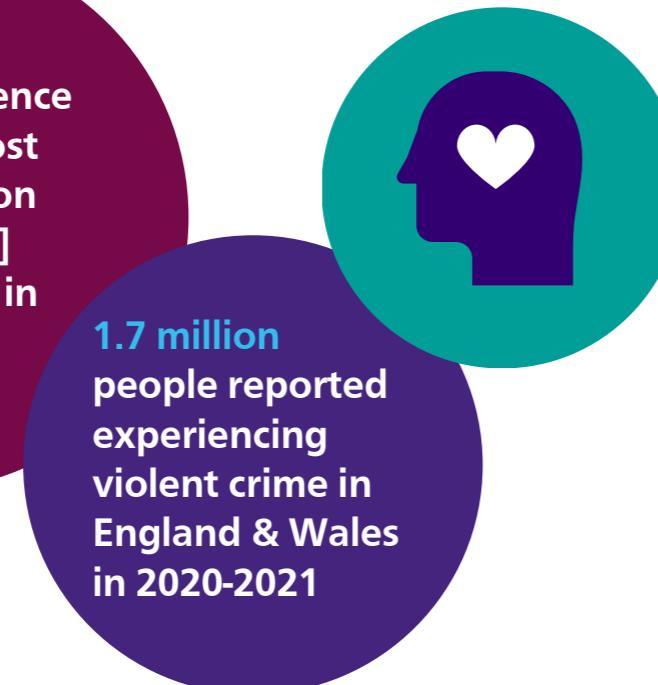
At least **50-70%** of people will experience at least one trauma in their lifetimes

(PTSD UK 2023)

1 in 5 children have experienced severe maltreatment

(NSPCC, 2018)

Child cruelty offences **more than doubled** in five years 2017-23 (police forces in England)

More than 1 in 5 women and 1 in 20 men have experienced rape or sexual assault as adults

(Rape Crisis, 2022)

1 in 4 women will experience domestic abuse at some point in their lifetime

(Crime survey England & Wales)

1.4m women experienced domestic abuse in 2023

(ONS)

2 in 5 transgender people have experienced hate crime in the past year

186% increase in the last 5 years

(Stonewall, 2019)

1 in 3 Muslim students have experienced abuse whilst at university (NUS, 2018)

Muslims are **the most targeted faith group** for religious hate crimes (Home Office, 2023)

Adverse Childhood Experiences (ACEs) refer to events that occur during childhood (0–17 years) and can have long-term impacts on health, wellbeing, and development.

There is overlap between ACEs and types of traumatic experience, such as abuse or neglect. ACEs also include household dysfunction – such as exposure to domestic violence, parental substance misuse, mental illness, parental separation or incarceration. ACEs can disrupt a child's sense of safety and attachment, increasing stress levels and affecting brain development.

- **67% of people in the UK have had at least one Adverse Childhood Experience (ACE)**
- **12.5% of people have had four or more ACEs**

1 in 20 children in the UK as a whole have experienced sexual abuse involving physical contact

(Rape Crisis, 2022)

Increase risk of associated harms for those individuals with 4+ ACE's compared to those with no ACEs

- **3 times more likely** to develop heart disease or have attended or stayed overnight in a hospital
- **4 times more likely** to be a high-risk drinker
- **6 times more likely** to have ever received treatment for mental illness
- **6 times more likely** to be a smoker
- **6 times more likely** to have had or caused an unplanned teenage pregnancy
- **15 times more likely** to have perpetrated violence in the last year
- **16 times more likely** or have used substances (i.e. Heroin, or crack)
- **20 times more likely** to have been incarcerated

However, ACEs are not destiny. Protective factors like strong relationships, safe environments, and early support can build resilience and buffer the impact. Understanding ACEs is essential for trauma-informed approaches in education, healthcare, and social services to promote healing and prevent further harm.

Although difficult to make accurate estimates locally, data shows (West Sussex County Council Joint Strategic Needs Analysis):

- **37% of secondary school aged pupils, and 25% of primary school aged pupils feel anxious or stressed almost every day/most days** (Understanding the effects of trauma on mental health and enablers for effective prevention, ESCC Public Health, 2025)
- **6,500 children are exposed to domestic abuse each year in East Sussex**
- **The most common crimes in East Sussex are the traumatic events of violence and sexual offences.**

Trauma can have lasting effects on a person's body, mind, behaviour, and relationships. It activates the body's stress response, which may lead to ongoing issues like sleep problems, chronic illness, and physical tension. Trauma can cause anxiety, depression, emotional numbing, and flashbacks, making it harder to regulate emotions or feel safe.

People may use coping mechanisms like drinking or using drugs. Trauma also affects relationships, trust, and social connection, often leading to isolation or conflict. It can impact work, school, and family life. Structural and cultural factors – like poverty, racism, and systemic injustice – can deepen trauma's effects, especially when passed between generations. Those people who face systemic discrimination are more likely to experience traumatic events and have greater barriers to seeking help for the impact of these.

Trauma can affect **brain development,** learning, memory, and emotional regulation – especially when trauma happens in childhood. This can impact education and long-term wellbeing.

Trauma can lead to a range of **mental health issues.** Some people develop **P**ost-Traumatic **Stress Disorder (PTSD),** but most do not. Those who do, often experience other mental health challenges at the same time. Trauma can also be linked to depression, anxiety, and emotional difficulties in the absence of PTSD.

Through the Changing Futures Programme, the earlier work developed within clinical services evolved into a broader, cross-sectoral effort, with Local Authorities becoming key partners. The emphasis has shifted from training alone to cultivating a workforce culture that values curiosity, openness, and continuous learning. This systemic approach recognised that trauma-informed practice must be embedded deeply into organisational values, leadership, and service design.

The work is ongoing, with 2025 offering new energy and opportunities to build on this strong foundation. While structural challenges remain, there is increasing momentum, with trauma-informed conversations now taking place across multiple sectors and professional groups. The journey highlights the importance of sustained, multi-layered commitment to culture change, and the power of co-produced leadership in driving lasting impact.

Louise Patmore, System Change Lead, Changing Futures Programme

What is Trauma-Informed Practice?

Trauma-Informed Practice (TIP) is an approach that recognises the widespread impact of trauma and understands potential paths for recovery. It emphasises physical, emotional, and psychological safety for everyone and seeks to create environments where people feel safe, supported, and empowered. TIP is based on key principles: **safety, trustworthiness, choice, collaboration, and empowerment.** It involves recognising the signs of trauma, avoiding re-traumatisation, and responding with compassion as well as the importance of viewing someone through the lens of their cultural and historical background.

TIP is not a specific intervention, but a cultural shift in how services are delivered – valuing relationships, co-production, and equity. It is relevant across all sectors, helping build resilience and improve long-term outcomes.

National Policy and strategy

Trauma-Informed Practice (TIP) is becoming more widely recognised across England, the UK, and globally. Sussex is part of a **National Community of Practice** hosted by Essex Partnership University NHS Foundation Trust. Trauma-informed approaches are being built into key health, social care, and criminal justice policies. Some examples include:
The **Office for Health Improvement and Disparities** promotes TIP through its **All Our Health programme**, 2024, which focuses on personalised and population health.

The **NHS Long Term Plan** 2019, and **Mental Health Implementation Plan** 2019 both support the move toward trauma-informed mental health services.

In **Scotland and Wales**, there has been national-level progress to become fully trauma-informed nations (**National Trauma Transformation Plan** and **Trauma-Informed Wales**)

The **2022 Public Health England guidance**, **Vulnerabilities: applying All Our Health**, highlights trauma-informed approaches as a key part of frontline health work.

Local strategy

Locally, we use tools like **Joint Strategic Needs Assessments** and learning from **safeguarding reviews** to help guide our work. Our **Collaborative Implementation Group** brings people together from across the system to share learning and plan how to put trauma-informed approaches into practice.
Aligned with the Integrated Care Board (ICB) Strategy for **Violence Prevention and Reduction** (2025), our trauma-informed approach recognises that safety is a **shared priority** for both service users and staff. Sometimes the intuition is to be reactionary to incidents in services. We know that reactive principles such as "zero tolerance" can increase the likelihood of incidences in services. Trauma-informed practice uses empathy and coproduction to create improved environments including de-escalation and use of language to reduce re-traumatisation in services.

Working within NHS Sussex Integrated Care Board, Lynette reflects on the profound impact of trauma-informed practice on her professional mindset and approach. The core principles of **trust, safety, collaboration, choice, and empowerment** are no longer just theoretical – they are deeply embedded in how she operates day to day. "It's always in my head now, even before I speak to someone, I'm thinking about it – how I approach them, how I collaborate."

Trauma-informed practice has become second nature, shaping not only her interactions but her wider professional confidence. It enables her to understand and respond effectively, even outside of Sussex: "It's not just the Sussex system… I can go into different areas of the country and understand what's going on, because of the work we've done together."

Lynette Haley, Programme Lead NHS Sussex Violence Prevention Strategy

Key principles include:

- Moving beyond behavioural management to explore **underlying causes** of violence such as relational and environmental factors.

- Supporting staff by equipping them with policies and training, while valuing their lived experiences of risk and harm.

- Co-developing support plans and de-escalation strategies with both staff and service users.

- Using transparent data, reflective practice, and continuous learning to inform adaptive organisational action plans.

- Facilitating workshops and spaces for co-production and relational approaches to safety and wellbeing.

- Our goal is to build a **compassionate system** where violence prevention is integrated into everyday practice rather than just policy

What are the benefits of working in this way?

Trauma-Informed Practice (TIP) brings significant benefits to individuals, staff, organisations, and wider systems. For service users, TIP improves trust and engagement by focusing on "what happened" rather than only "what's wrong," creating safer, more empowering environments. It reduces re-traumatisation and supports better mental health, lower substance use, and greater housing stability. Trauma-informed practice supports sustainable, compassionate systems that foster resilience and recovery at all levels.

Individual Benefits:

- Builds trust and enhances engagement
- Reduces the impact of 'trauma triggers' and emotional harm
- Increases choice and empowerment
- Improves mental health and life outcomes

Organisational Benefits:

- Strengthens staff empathy and understanding of the impact of trauma
- Encourages inclusive, culturally sensitive care
- Helps prevent vicarious trauma among staff
- Promotes a collaborative, safety-focused culture

Systemic Benefits:

- Reduces reliance on crisis services and improves efficiency, (SAMHSA (2014), Hopper et al. (2010) National Changing Futures evaluations (2024)
- Generates long-term cost savings, National Changing Futures evaluations (2024)
- Connects services and communities through shared understanding
- Embeds a holistic, healing approach across care pathways

I believe embedding trauma-informed practice into local authority structures through organisational development is essential particularly when it comes to supporting staff exposed to distressing incidents, such as unexpected deaths or suicides. For me, trauma-informed practice must include workforce wellbeing, and I feel strongly that we need better systems to support staff through these experiences.

At West Sussex County Council, we're currently reviewing our serious incident processes to enable more collaborative, reflective learning and to provide meaningful support to those affected. I'm exploring existing debrief and supervision models, like those used by Partners in Sussex to help shape an approach that works for us.

The aim is to adopt a structured model where trained debrief facilitators are also supported through their own supervision. This kind of dual-layer support will help us embed a sustainable, trauma-informed response to critical incidents, strengthen organisational resilience, and ensure that staff wellbeing is a key part of our cultural change.

Vicky Clarke, Head of assurance and practice, Adult Services, West Sussex County Council (WSCC)

The diagram below, from NHS Education for **Scotland's National Trauma Transformation Programme**, represents the importance of creating a trauma-informed workforce built on the principles of choice, empowerment, safety, trust, and collaboration.

There are four key steps, called the "4 Rs," to make sure we practice TIP properly:

1. **Realise** how common trauma is – both among the people using services and the staff working in them.

2. **Recognise** how trauma affects people. It can lead to poorer health outcomes, bad experiences with care, low staff retention, and more staff sickness.

3. **Respond** to trauma by changing how services work across the whole system, making sure care is supportive and healing.

4. **Resist** re-traumatisation – this means not causing more harm through the way services are delivered, which can happen by accident. We need to notice this and act to stop it.
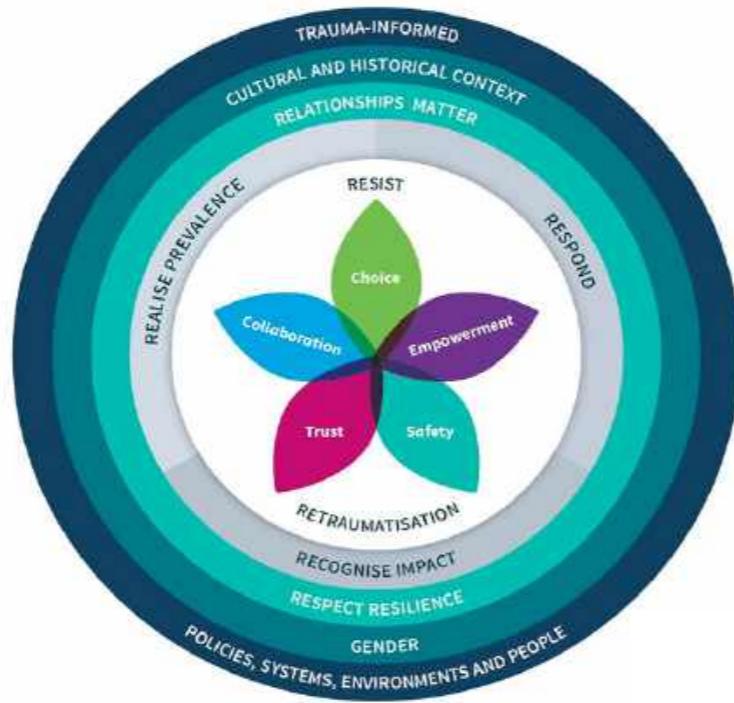
All of this must be done with respect for people's culture and history.

Relationships are central to trauma-informed practice, acting as the foundation for healing, safety, and trust. A trauma-informed framework recognises that trauma often occurs in the context of relationships – and so can recovery. Supportive, consistent, and respectful interactions help rebuild a sense of control and connection.

Practitioners need to focus on empathy, and collaboration, valuing each person's story without judgement. Boundaries are clear yet compassionate, creating predictable and empowering environments. Relationships extend beyond individuals to teams, organisations, and systems – where a culture of psychological safety, shared power, and mutual respect ensures that everyone feels seen, heard, and supported in their roles and recovery.

Culturally responsive trauma-informed care recognises that trauma is shaped by a person's cultural, ethnic, and historical background. Experiences of racism, discrimination, and colonisation influence how trauma is experienced and the support people can access. Practitioners must practise **cultural humility,** approaching each person with curiosity and respect, while recognising the limits of their own knowledge. Trauma-informed care also addresses **structural inequities,** acknowledging that marginalised communities face systemic barriers in healthcare, education, and justice. By embedding cultural awareness and actively challenging power imbalances, services can offer more equitable, respectful, and effective support for all individuals and communities.

Lived Experience and Co-Production

Much of the progress toward a trauma-informed system depends on the knowledge and expertise of clients and service users. Co-production in trauma-informed frameworks is about valuing lived experience as essential expertise and embedding it into all levels of the system. This includes paid roles for peer support workers, involvement in service design, and shaping policy. It means ensuring the voices of those with lived experience influence not only the relational interactions – how people are treated, listened to, and documented – but also the strategic direction of services.

True co-production goes beyond tokenism; it's about building shared power and making sure decision-making is collaborative.

- Participating in benchmarking exercises
- Conducting service walk-throughs to assess and provide feedback on physical environments and service user experiences
- Reviewing patient correspondence to ensure trauma-informed communication
- Contributing trauma-informed insights to the design of new hospital facilities

If you're a lived experience leader, "bringing others with you" means mentoring, supporting, and championing peers to have influence too – creating a culture where lived experience isn't just heard, but integrated. This is system change from the ground up, sides in and top down.

Trauma-Informed Training Co-Produced with CAPITAL and Alcohol Change UK:

Lived experience contributors worked in partnership with professional trainers to co-produce a training programme for professionals supporting individuals affected by alcohol misuse. The training was designed to promote trauma-sensitive practices in services as requested by people with lived experience of drug and/or alcohol harm.

Lived experience shaped the training structure, content, and tone. The sessions were developed with peer support, psychological safety, and transparency. There was an emphasis on practical tools to reduce re-traumatisation and build trust. This included systemic awareness of stigma, inequality, and institutional trauma.

Sara Shephard, Capital

Communication and Relationships

Effective communication is a core pillar of trauma-informed practice. It must be intentional, relational, and sensitive to diverse needs, ensuring emotional and psychological safety for all. Communication should adapt to different learning styles and cultural contexts, aiming to empower, include, and build trust. Language and tone matter – honest, calm, and inclusive dialogue creates safer environments for both clients and staff. See **NHS Sussex language guide**.

Key trauma-informed communication practices include:

- Use open-ended questions to invite safe dialogue
- Avoid blame; respect boundaries and individual coping styles
- Honour cultural diversity and systemic imbalances
- Adapt tone, body language, and wording to build connection
- Replace terms like "hard to reach" with "underserved"
- Use positive signage and shared spaces to reinforce safety

Trauma-informed communication extends beyond words – creating welcoming, supportive physical spaces is just as vital.

Beyond words: The physical environment also speaks volumes. Signage, posters, and leaflets reflect the organisation's values, expectations, and commitment to supportive care. Use positive, reassuring messages that explain the purpose behind rules rather than simply prohibiting behaviours.

For example:

> We want this to be a safe area. If you have any concerns or feel anxious, please talk to us.

We are building on good Foundations

In Sussex, we've built a strong Community of Practice with over 300 members from 70 organisations across health, social care, and the voluntary sector. Our leadership group includes partners from the NHS, local authorities, primary care, and community organisations, working together with a shared purpose.

We are taking a networked, democratic approach to leadership – making sure that everyone affected by decisions has a real say. This means sharing power, creating safe spaces where people feel heard, and role modelling the values of trauma-informed practice in everything we do.

While systems and structures matter, we know that relationships and culture are just as important. That's why we're focusing more on the human, relational side of change.

Key achievements include:

- Developing a broad range of training materials and resources tailored for trauma-informed implementation.
- Delivering training to nearly 4,000 people over 2.5 years with consistently positive feedback.
- Raising awareness and building strong networks and communities.
- Embedding Trauma-Informed Practice within the Violence Prevention and Reduction (VPR) strategy group.
- Co-produced West Sussex MH JSNA – ensuring trauma-informed practice is embedded.
- Contributing to health inequalities and health inclusion frameworks.
- Reviewing and embedding trauma-informed recommendations into policies.
- Supporting intervention pathways and prevention strategies.
- Gathering insights from diverse stakeholders.
- Influencing and supporting national drivers and strategies for trauma-informed care.
- Several organisations have begun establishing Trauma-Informed Care Working Groups, bringing together diverse expertise, authority, and lived experience to lead strategic change and provide ongoing guidance for trauma-informed clinical and support services.

Challenges and Obstacles

Our Integrated Care System (ICS) which includes Health and Social Care is undergoing significant change and pressure. For example, the West Sussex Public Mental Health Joint Strategic Needs Assessment (PMHNA) highlights the system as "under pressure," emphasising the urgent need for **more co-ordinated strategic thinking and integrated structures** to improve services for those experiencing **multiple and compound needs** (including mental health challenges, homelessness, domestic violence, criminal justice involvement, and substance misuse).

System in constant flux

While there are many "islands of excellence" – areas of high-quality trauma-informed practice – these pockets often struggle to connect or maintain sustainability when key individuals leave, or organisational changes occur. Factors such as **short-term funding cycles, competitive tendering, and focus on quick wins** can hinder the ability to sustain long-term improvements and remove systemic barriers.

Further examples of systemic challenges and obstacles include:

- Siloed working
- Staff capacity
- Lack of training and development resource and priority
- Drivers and inappropriate KPI's and metrics (efficiency vs effectiveness)
- Long term impact of COVID-19

Finance, Commissioning and Procurement

- **Values/Outcomes-Based Commissioning:** Embedding trauma-informed principles within commissioning specifications and job roles to ensure consistency and accountability.

- **Pooled Funding:** Encouraging alliances and partnerships to pool budgets, enabling co-produced service delivery models that reflect trauma-informed values.

- **Shared/Top-Slice Funding:** Collaborating across the system to allocate combined resources for key areas such as staff wellbeing access.

- **Ensuring services are co-developed** and designed ensuring lived experience representation at specification planning stage and are included in procurement panels.

- **Collaborative bidding and alliance shared delivery:** Smaller organisations are supported to deliver services at root level.

There are pockets of good practice such as the Drug and Alcohol procurement in West Sussex and Social Care procurement in Brighton and Hove City Councils.

Staff Health and Wellbeing

Trauma doesn't only affect people who use services – it also affects **staff.** Health and care workers may be exposed to traumatic situations at work, especially if they don't have the right support. This can lead to stress, burnout, and even increased risk of aggression or inappropriate behaviour if not addressed.

Moral injury means feeling deep emotional, psychological, or spiritual pain because you believe you have done something wrong – or failed to stop something wrong – even if it was out of your control. This can cause feelings like guilt, shame, anger, and losing trust in yourself or others. It can also happen when workers feel that the care they provide may harm the people they are trying to help or make things worse.

Some of ways in which we can address these issues are through:

- Trauma-informed supervision
- Accessible and meaningful debriefs
- Critical incident support
- Cultivating an environment where staff feel safe to speak up
- Promoting compassionate leadership

Integrating compassionate leadership with trauma-informed practice

Michael West's research and book, Compassionate leadership: Sustaining Wisdom, Humanity and Presence in Health and Social Care (West, 2021) highlights how compassionate leadership improves staff well-being and performance. In Mersey Care NHS Foundation Trust, initiatives like leadership training, staff well-being support, inclusive policies, and open feedback channels have boosted morale, reduced absenteeism, and improved patient care. When combined with trauma-informed practice, this creates a culture of safety, trust, and empathy. Training leaders in trauma awareness, fostering safe spaces, encouraging collaboration, and supporting recovery helps both staff and patients thrive.

This integrated approach not only strengthens individual resilience but also enhances service quality – building a more compassionate, effective, and responsive healthcare system for all.

Trauma-informed practice is a golden thread running through the work of Connect, Sussex Community NHS Foundation Trust's (SCFT) staff support service. Fundamentally, Connect acknowledges that staff wellbeing is a precursor to delivering trauma-informed care with service users – the latter cannot happen without the former. Therefore, supporting staff to be healthy and well, knowledgeable and skilled, reflective and safe, is a priority.

Connect delivers a variety of support interventions for staff, including 1:1 wellbeing conversations, team reflective practice, post incident support and mediation. All of these interventions are guided by the trauma-informed principles of safety, choice, trust, collaboration and empowerment. For example, in our 1:1 support we not only work hard to make sure staff feel safe, understand their options and are collaborative partners in the support, but we help staff to think about whether these are available to them in their workplaces and, if not, how this could be addressed on an individual, team and service level. Our reflective practice sessions draw on these principles to explore scenarios, paying particular attention to where they are missing and potential consequences.

We empower our workforce to understand that it is often what has happened to someone rather than what is wrong with them that underlies complex presentations, including their own struggles and challenges. We empower our workforce to view situations through the lens of regulation and to understand that the conditions we create for our staff will impact on how well they can do their job and look after themselves and others.

Dr Marianne Seabrook Interim Director of Psychological Professions, Sussex Community Foundation Trust

Putting TIC into practice within Sussex Community Foundation NHS Trust

The connect service within SCFT has been delivering TIC training to its NHS staff over the past few years. A recent evaluation of the longer-term impact of TIC training found it had improved the following areas:

- **Changing Team Practice:** Enriching multidisciplinary discussions and incorporating TIC into patient care planning

- **Enhancing compassionate, personalised care:** Changing the type of language used with and about patients, giving more choice, being curious rather than judgemental when people do not attend appointments

- **Improving staff wellbeing:** Learning to take breaks without feeling guilty, updating a staff outdoor space, routinely having wellbeing conversations in supervision

- **Creating TIC champions & network:** Post-training support to implement and sustain change

Training and Workforce Development

The **Sussex Transformative Model of Training for Trauma-Informed Practice** aligns with **NHS Education for Scotland's Transforming Psychological Trauma Knowledge and Skills Framework** and their national Training Plan, We are developing and delivering training across four levels in co-production with our system partners including West Sussex County Council, Brighton and Hove County Council, Sussex Partnership NHS Foundation Trust and Sussex Community NHS Foundation Trust with Development alongside East Sussex Healthcare NHS Trust and South East Coast Ambulance service and lived experience:

- Trauma-Informed Awareness
- Trauma Skilled
- Trauma Enhanced
- Trauma Specialist

We have also developed training for those in leadership roles to equip them with a clear understanding of trauma-informed practice, to enable them to effectively support its implementation and model trauma-informed leadership.

Key elements of the model:

1. **Trauma Awareness and Sensitivity:** Developing practitioners' self-awareness to avoid re-traumatisation and foster compassionate care.

2. **Holistic Understanding:** Recognising trauma's impact across physical, emotional, social, and cognitive domains, and its diverse effects based on individual backgrounds and circumstances.

3. **Empowerment and Agency:** Co-creating solutions with those affected by trauma, emphasising shared decision-making and transparency.

4. **Practical, Skills-Based Learning:** Providing actionable tools for recognising trauma symptoms, fostering resilience, and applying trauma-informed practices.

5. **System-Wide Collaboration and Transformation:** Encouraging multi-sector partnership across health, social care, justice, and beyond.

6. **Sustainability and Long-Term Impact:** Supporting ongoing reflection and the creation of trauma-informed cultures within organisations.

Beyond training: we will develop a training model based on organisational development, creating learning loops in the system to promote human learning systems and support people to set up communities of practice and other arenas of continuous learning and improvement.

Transformative training model
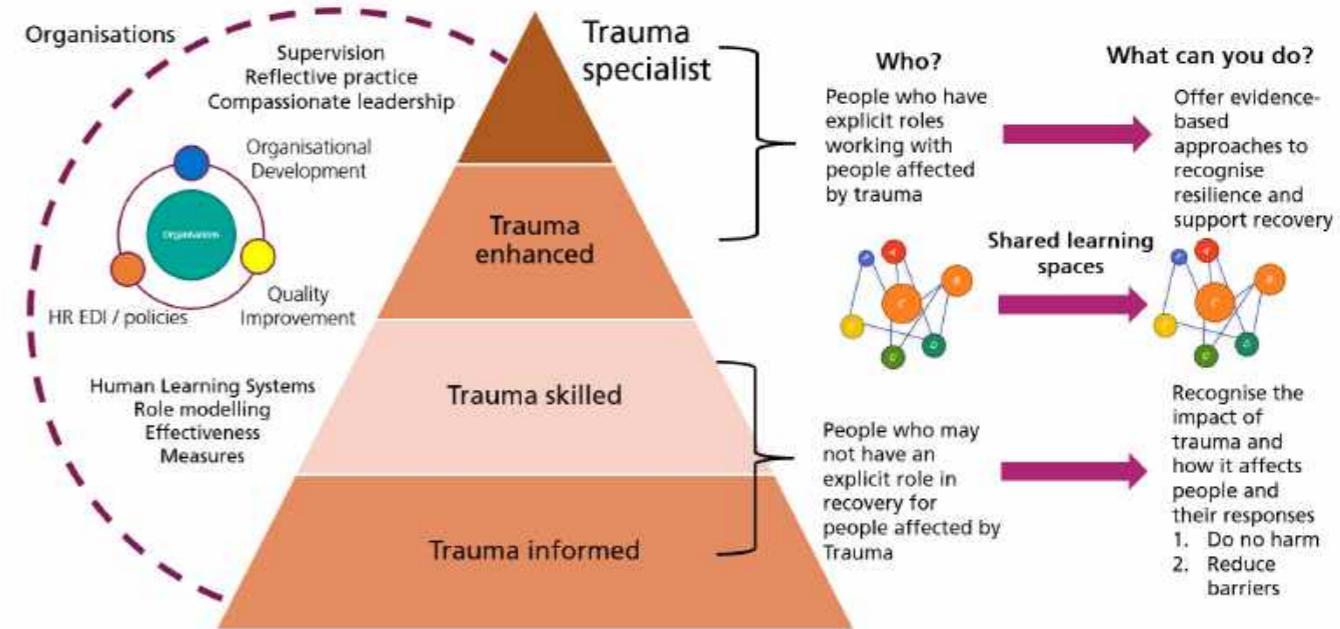
Pan Sussex Health and Social Care Practice Network – engaging workers across Sussex

The Practice Network engages frontline workers across the county. Its purpose is to bridge the gap between theory and practice by supporting workers from various sectors – particularly the VCSE sector – to learn together and apply trauma-informed approaches in their everyday roles.

The network has helped roll out training to a wide range of practitioners, creating shared understanding and building confidence in Trauma-Informed Practice. Participants have not only valued the content of the training but also the chance to connect with peers, put faces to names, and strengthen cross-sector relationships.

The network has also developed informal learning spaces that focus on applying theory to real-world practice. These include reflective practice sessions on specific topics such as "ending well" & "vicarious trauma".

These spaces allow workers to share insights, support one another, and explore strategies for self-care and team wellbeing, making trauma-informed practice a living, evolving part of daily work life. To support this work the Networks Team also: host a website; share regular newsletters; and produce podcasts, shining a light on best practice locally.

Kate Standing: Network and Partnership Manager, Justlife Brighton

Mental Health Clinical Pathways

We have identified that the integration of trauma-specific interventions within mental health pathways, is essential. Including embedding trauma-informed practice into pathways for mental health provision by resolving overlap issues with trauma, personality disorder and complex emotional need and neurodiversity.

- Providing better access to trauma-focused therapies such as trauma-focused cognitive behavioural therapy (tf-CBT) and eye movement desensitisation and reprocessing (EMDR).

- Strengthening links with mental health neighbourhood teams, crisis teams and other multiple compound needs provision and Integrated Care Teams and other ancillary services.

Sussex Partnership NHS Foundation Trust provided trauma-informed care awareness training for multiprofessional staff in Adult Mental Health as part of wider community transformation initiatives. This is aligned with the need for such services to be trauma-informed as part of the NHS Long Term Plan. The training was 60-90 minutes, depending on size of the team/group (on average about 10) and co-led by a clinician and an expert by experience. The training introduced the principles of TIC and guides staff to consider TIC in their services and any improvements that might be helpful. 550 staff attended the training, with more than half providing feedback. 98% said the training was relevant to their work, 97% would recommend the training to colleagues; and 94% intended to make changes to their practice as a result of the training.

There has been further specific training provided across other parts of the Trust such as Patient Experience Teams, Rehab teams; Sussex Eating Disorders Service; Trauma Skills Training in Adult Havens services; various psychological practitioner trainings. There is now a new training programme for Mental Health Nurses in Child and Adolescent Mental Health Services starting in Autumn 2025. This will include a wider range of training opportunities including not only the trauma awareness level but also trauma skilled and specific trauma-informed leadership training.

Finally, the SPFT Board and Senior Leadership Team have committed to a development session on trauma-informed care which is due in Autumn 2025.

Nick Grey, Associate Director of Psychological Professions, SPFT

Utilising trauma-informed practice (TIP) to reduce impact on urgent care services and health inequalities – example

Trauma-Informed Practice (TIP) serves as a golden thread throughout urgent and emergency care, embedding compassion, psychological safety, and collaboration into every stage of the patient and staff experience. TIP reduces distress-driven presentations, improves outcomes, and enhances workplace wellbeing through system-wide changes in environment, culture, leadership, and care pathways.

Clear pathways for accountability across the system must be established. These pathways are critical to ensure both system accountability and the sustainability of trauma-informed initiatives, supporting stakeholders at every level.

Key Interventions Include:

- **Alternatives to Admission:** Streamlined pathways like Same Day Emergency services care in the NHS (SDEC), senior triage, and psychologically informed spaces.

- **Training & Culture Change:** Bite-sized TIP training, reflective supervision, and TIP champions embedded in teams.

- **Trauma-Sensitive Design:** Improved signage, noise reduction, privacy, and calmer, welcoming environments.

- **Collaborative Pathways:** TIP embedded across medical day units and frailty hubs, tackling multiple disadvantages via housing and care integration.

- **Community Integration:** Leveraging models like UOK and MHNT for complex, high-need users.

- **Quality Improvement:** Use of Patient Recorded Outcome Measures (PROMs)/ Patient Recorded Experience Measures (PREMs) to capture lived experience data.

Jacquie Fuller, Assistant Director HR – People Engagement Team East Sussex Healthcare NHS Trust.

Evaluation and Monitoring

A major challenge in trauma-informed practice, co-production, and prevention is **defining and measuring success.** We are synthesising existing evidence and exploring appropriate metrics aligned with tools such as the Trauma-Informed Lens to monitor system improvements and outcomes effectively.

Quality Improvement and Continuous Improvement must be part of implementation and evaluation, with involvement from those using and working within services to be truly trauma-informed.

Sussex Universities – including those in Chichester, Brighton, and Sussex – are important stakeholders in advancing trauma-informed practice through research partnerships.
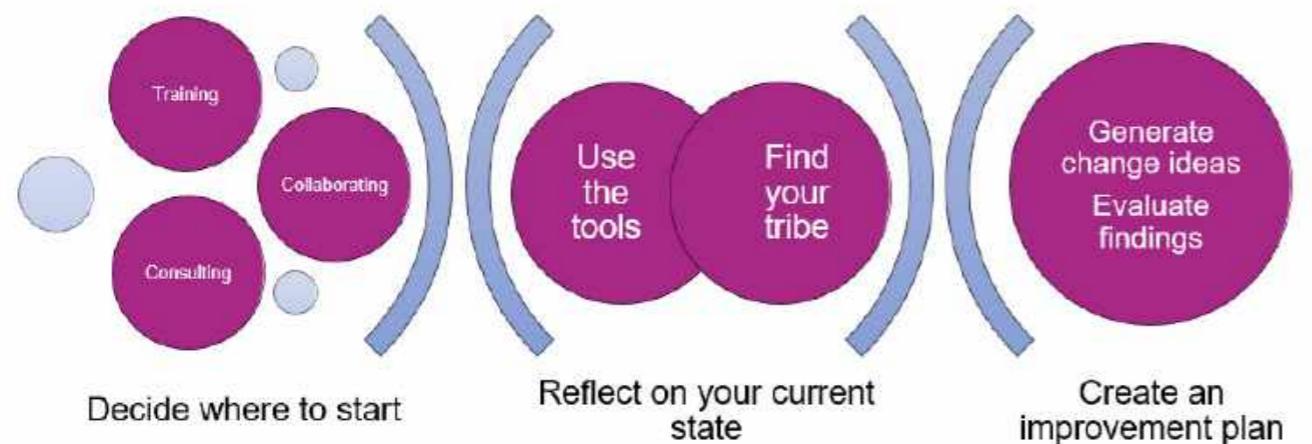
Suggested indicators and guidance on metrics

We have developed self-assessment guidance informed by a broad range of global resources, particularly those from Scotland, Oregon, SAMHSA, and in England, models from Surrey and the North of England. The Sussex model presented below brings together these insights into a system-wide framework for outcomes, offering a shared approach to understanding and measuring success.

(Please refer to the **Surrey and Borders Framework and toolkit** for a comprehensive self-assessment tool).

Domains	Expected Outcomes	Suggested Metrics
Staff health	• Foster trusted peer support through buddy systems and psychologically safe spaces. • Prevent overburdening by promoting realistic workloads and compassionate workforce and job planning. • Embed trauma-aware supervision and coaching across teams. • Ensure appraisals are strengths-based and support development. • Provide timely access to debriefs, reflective practice, and critical incident support.	• % of staff who feel safe to speak up without fear of blame. • Uptake of wellbeing and reflective offers. • Improved staff retention and reduced sickness absence. • Team cohesion and peer support levels (via survey or narrative). • Staff trauma disclosure policies (voluntary and safe). • Wellbeing champions in each team. • Monitoring of psychological safety trends over time.
Organisational change/health	• Promote transparency and openness. • Leaders are visible, approachable, and curious. • Embrace a "learning not blaming" culture. • Wellbeing metrics tracked at organisational level. • Leaders on tap not on top. • Promote "how can I help" • Permission giving and learning culture. • Increased volume of informal resolution via learning forums rather than formal HR routes.	• Senior leader participation in reflective sessions. • Staff perception of organisational culture (via narrative feedback). • The volume of informal resolution via learning forums vs formal HR routes. • Publish transparent "You Said, We Did" logs from staff feedback. • Psychosocial risk assessments embedded in annual reviews.
Co-production and collaboration	• Ensure client experiences are included and recorded and that the Lived Experience groups are working alongside and invited in decision making processes. • People are part of their care and support plans. • We understand the role of the unheard and disenfranchised in our services.	• % of projects that are co-produced with input from people with lived experience. • Lived experience co-authorship of internal reports or strategies. • Active lived experience [paid] roles such as peer workers and EbE's. • Increased inclusion of unheard and marginalised voices.

Domains	Expected Outcomes	Suggested Metrics
Governance and leadership	• Align organisational values with trauma-informed principles. • Leaders are able to model and give permission to working in a trauma-informed way. • Support organisational visions for trauma-informed practice. • Move away from performance-only metrics to client centred effectiveness measures.	• Density and strength of collaborative connections between teams/organisations. • Move away from performance-only metrics to quality/effectiveness measures. • Leader stories demonstrating openness, humility, and change in style. • Stories from staff and service users showing compassion-led responses during stress or crisis.
Communication and relationships	• All communications are important, internally and externally. • Move away from zero tolerance language. • Be cognisant of language and its power when communicating. • Seek help and support to get communication right, drawing on lived experience. • Signage as well as letters, calls and other methods of communication need frequent review and observation.	• % of users who feel communications are clear and respectful. • Number of co-produced or user-tested communications. • Frequency and quality of feedback responses (e.g., "you said, we did"). • Use of inclusive language audits. • Incorporate visual and auditory alternatives for all messages. • Lived experience reviews of communications before major changes. • Language preference flags in records to personalise communication.
Financing and commissioning	• Commissioning to include trauma responsiveness in profiling. • Include provision for reflective practice and training opportunities. • Use of new KPI and metrics to understand trust and client experience as outcomes.	• More values/outcome-based decision making. • Improved comprehension of prevention and client led outcome measures. • More positive risk taking in prevention arena. • Increased prevalence of lived experience on all procurement panels involving service change.
Training and workforce development	• Updated and evolving training is available, resources are shared. • That we seek trainers and knowledge from Sussex and create a sustainable plan for delivery. • We develop a directory of reflective practice facilitators. • That training is coordinated and shared appropriately, and smaller organisations or teams have appropriate access to both. • We use a transformation and organisation development model of training.	• Numbers of attendees. • Where the attendees are from. • Feedback loop creation – start stop – continue. • Partnered training opportunities. • Improved confidence in delivering. • Improved levels of understanding and competence. • Increased reflective practice and debrief opportunities and trained staff. • Improved compassionate leadership, HR processes and Employee Assistance Programmes.
Mental Health trauma pathways	• Move away from risk assessments to safety plans. • Screening for right service at the right time focusing on prevention. • Available evidence-based therapeutic interventions for clients and staff. • Bridging and working in an MDT approach across organisations and ICTs.	• Evidence of safety plans in use and shared decision making. • Evidence of improved partnership working across domains (MCN). • Less reported barriers to services. • Transparently reported outcomes. • Less demand on acute services. • Increased demand on Peer Support.
Physical environment	• Design of areas, colours, sound, access, natural light and geographical placement considered. • Utilise 15 step/trauma walkthroughs and observations to determine improvements.	• Number of settings making physical/environmental changes to support sensory safety. • Evidence types of changes and resulting improvements in service delivery. • Decreases in behaviour escalations (VPR).
Policies and procedures	• Ensure all policies and procedural decisions are made through a trauma-informed lens and include appropriate recommendations and caveats with the right signposting to the latest information. • Accessible helpful documentation and resources available such as guidance, evidence, and training.	• % of services adapting care in response to inequality feedback. • Noticed increase in prevalence of trauma-informed practice in procedures and guidance • Evidence of lived experience involvement. • Number of organisations who have TIP visible in their corporate structure, comms and embedded into guidelines and procedures.

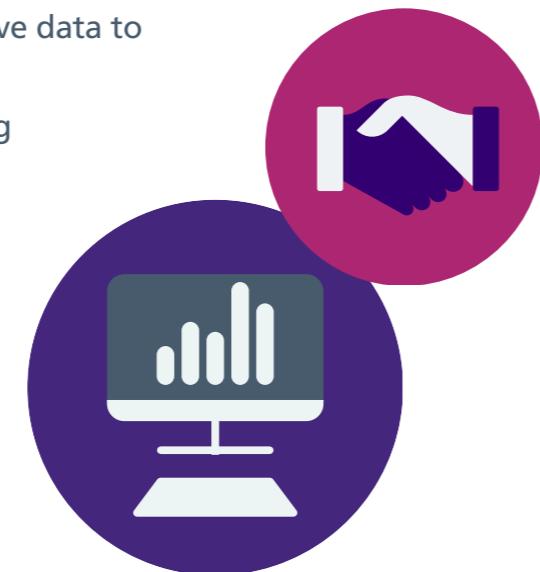**Embedding Trauma-Informed Practice in Local Authority Services**

Over the past year, significant strides have been made in embedding trauma-informed practice (TIP) within the council. Organisational intelligence has been gathered through training delivery, reflective feedback, and direct engagement with services. There is growing awareness and visible commitment to TIP across the organisation, underpinned by alignment with council-wide priorities around health, wellbeing, and psychologically safe working environments.

Support for trauma-informed approaches has been confirmed by all **directorate leadership teams**, and the **senior leadership team** has been formally briefed. There is clear recognition that TIP aligns closely with the council's values, strategic objectives, and its commitment to compassionate, person-centred services.

Tim Wilson, Brighton and Hove City Council (BHCC)

Tools to Gather Data

- **Ripple Effect Mapping:** To visually capture and understand the ripple effects of trauma-informed culture change across systems.

- **Reflective Journals:** Maintained by leaders, staff, and lived experience partners to document learning and shifts in practice.

- **Learning Loops/Quality Improvement (QI) Methodologies:** To systematically track progress and embed continuous improvement.

- **Experience-Based Co-Design (EBCD):** Engaging service users and staff in co-creating improvements.

- **Narrative Inquiry:** Collecting stories and qualitative data to capture nuanced experiences and impacts.

- **Social Network Analysis:** Mapping and measuring collaborative relationships across teams and organisations.

- **Adaptive Outcome Tracking:** Monitoring evolving outcomes to guide responsive changes.

Call to Action:

Embedding trauma-informed practice across Sussex

Now is the time to move from awareness to action. We are calling on partners across Sussex to commit to a trauma-informed future – where services understand adversity, prioritise safety and dignity, and drive better outcomes for people and professionals alike.

We will:

- Champion dedicated coordination capacity to embed trauma-informed approaches across complex systems.

- Unite diverse expertise – from frontline workers to strategic leaders – to co-create inclusive, effective solutions.

- Build and act on robust evidence to sustainably embed peer support and relational care into the fabric of our services.

- Join us. Shape a system that heals, not harms

For System Leaders
(Policy, Strategy, Commissioning, Senior Leadership)

Your Role:

- Make trauma-informed care a key part of your plans and policies. Link it to issues such as tackling health inequalities, improving urgent care, and preventing violence.

- Lead with kindness. Build a learning culture where people feel safe, included, and are able to speak up.

- Use funding in a way that supports long-term, trauma-informed services and supports staff wellbeing.

- Keep the big picture in mind. Help different services work together, break down barriers in data and service design, and lead change with honesty and responsibility.

- Involve people with lived experience in real and meaningful ways – not as a tick-box, but as equal partners in making decisions together and thought of at the beginning of change.

You are the permission givers that can help create the right environment and resource for trauma-informed practice to grow and succeed.

For Frontline Staff, Managers, and Practitioners

You are there for the people you support, and you must also be there for each other.

Your Role:

- Spot signs that someone may be affected by trauma and respond with care. Be kind, stay curious, and keep healthy boundaries to avoid causing more harm.

- Build trust and safety through your actions. Being consistent, offering choice, and working together makes a big difference.

- Take time to reflect and talk things through. For example, in supervision, personal development planning, reflective practice and training. This can help you manage stress, stay strong, and give better support.

- Think about how your words, your work environment, and your team affect people and other services around you.

- Be a champion for trauma-informed practice. Speak up for safe ways of working, and help others do the same.

- Familiarise yourself with the five key principles of trauma-informed practice (Trust, Safety, Collaboration, Choice, Empowerment, with an awareness of the cultural and historical context) and the four steps to achieve this (realise, recognise, respond, resist re-traumatisation; whilst also attending to the importance of relationships) and reflect on how to apply them to your practice

- Resist (re)traumatisation by taking the time to read the person's notes (if available) before meeting them

For Everyone

Your Role:

- Be aware of how trauma can affect people. A kind word, a bit of patience, or simply listening can make a big difference.

- Don't judge people by their behaviour (or in any other way!). Try to understand what might be behind it.

- Help make spaces feel welcoming and safe – whether it's in your workplace, local community, or online.

- Take care of your own wellbeing too. Being trauma-informed means looking after ourselves as well as others.

- Keep learning. The more we understand about trauma, the better we can support each other.

The roadmap

To embed trauma-informed practice sustainably, we need a stable platform supported by clear leadership and system-wide commitment. Drawing on resources from the **Scottish National Trauma Transformation Programme**, we aim to replicate their Trauma-Informed Practice Roadmap within our local system and organisations. Central to this roadmap is positive role modelling in leadership, which underpins successful, lasting cultural change.

Trauma-informed work should never be done in isolation. It's essential to recognise the support, resources, and opportunities already available. Once you understand a problem and the need for change, you can begin to address it. The tools provided here are designed to guide you through this process, but don't hesitate to reach out for help if needed. Joining our **Community of Practice** can offer valuable networking opportunities and access to shared knowledge.

- What does the culture look and feel like?
- Is there commitment from leadership?
- Does the environment feel safe and supported?
- Is the organisation ready to work in new, trauma-informed ways?

This is **not a short-term training initiative**, but an embedded process of cultural change.

Most improvements do not require extra resources but rather a shift in ways of working, fostering better partnerships and relationships to facilitate trauma-informed practice

Appendix 1: Glossary

- **Trauma-Informed Practice (TIP):** A model grounded in understanding how trauma exposure affects an individual's neurological, biological, psychological, and social development. TIP emphasises creating services that promote safety and trust, aiming to prevent re-traumatisation.

- **Trauma-Aware:** The initial phase in becoming trauma-informed, where organisational staff and leadership recognise the prevalence of trauma among service users and the workforce. This awareness enables them to explain and advocate for trauma-informed care.

- **Trauma-Informed:** An approach where organisations integrate knowledge about trauma into policies, procedures, and practices. This involves recognising the signs of trauma, understanding its widespread impact, and responding by fully integrating this knowledge to resist re-traumatisation.

- **Trauma Responsive:** An advanced stage where organisations not only understand and integrate trauma-informed principles but also actively respond to the needs of those affected by trauma. This includes implementing practices that promote healing and resilience, ensuring that services are responsive to the specific trauma-related needs of individuals.

- **An Integrated Care System** (ICS) is a collaborative partnership that brings together health and care organisations within a specific geographic area to plan and deliver coordinated services. The goal is to improve health outcomes by ensuring that care is well-connected, effective, and efficient, focusing on the comprehensive needs of the population. In Sussex this is the Sussex Health and Care Partnership more information can be found here:

The core components of an ICS typically include:

- **Integrated Care Board (ICB):** Responsible for the strategic planning and allocation of NHS resources within the system. In Sussex this is NHS Sussex

- **Integrated Care Partnership (ICP):** A committee that brings together a wider set of partners, including local authorities and voluntary organisations, to address broader health determinants and inequalities

Appendix 2: References

ACE Hub Wales & Trauma Stress Wales. (n.d.). Trauma-Informed Wales. Available at: **https://traumaframeworkcymru.com/** (Accessed: 24 March 2023).

Academic Health Science Network North East and North Cumbria. (2020). Developing Real World System Capability in Trauma-Informed Care: Learning from Good Practice. Available at: **https://www.ahsn-nenc.org.uk/wp-content/uploads/2021/06/summit-report-developing-real-world-system-capability-in-tic-learning-from-good-practice.pdf**

Azeem, M. W., Aujla, A., Rammerth, M., Binsfeld, G. and Jones, R. B. (2011). 'Effectiveness of six core strategies based on trauma-informed care in reducing seclusions and restraints', Psychiatric Services, 62(5), pp. 477–483.

Bailey, S. and West, M. (2020). 'COVID-19: Why compassionate leadership matters in a crisis', The King's Fund, 30 March. Available at: **https://www.kingsfund.org.uk/blog/2020/03/** (Accessed: March 2025).

Bellis, M. A., Hughes, K., Leckenby, N., Perkins, C. and Lowey, H. (2014). 'National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England', BMC Medicine, 12(1), p.72.

Understanding the effects of trauma on mental health and enablers for effective prevention, ESCC Public Health, Ben Brown, 2025

Care Inspectorate. (n.d.). Trauma-Informed Practice: A Toolkit for Scotland. Available at: https://hub.careinspectorate.com/media/4362/trauma-informed-practice-a-toolkit-for-scotland.pdf (Accessed: March 2025).

Changing Futures. (n.d.). Creating Safer Spaces: Trauma-Informed Practice for Customer Service. Unpublished training material.

Changing Futures. (n.d.). Creating Safer Spaces: Trauma-Informed Practice for Managers and Leaders. Unpublished training material.

Changing Futures. (n.d.). VPR Leads Workshop – TIP Approaches and Power and Coercion. Unpublished workshop material.

Domino, M. E., Morrissey, J. P., Chung, S., Huntington, N. and Larson, M. (n.d.). COVID-19 Crisis and Compassionate Leadership. [Publication details missing].

West, M. A. (2021). Compassionate Leadership: Sustaining Wisdom, Humanity and Presence in Health and Social Care. London: Jessica Kingsley Publishers.

Muskett, C. (2014). 'Trauma-informed care in inpatient mental health settings: A review of the literature', International Journal of Mental Health Nursing, 23(1), pp. 51–59.

National Institute for Health Research (NIHR) and Changing Futures. (n.d.). Evaluations (ongoing); including local case studies such as the Mersey Care Six Core Strategies implementation.

Health Foundation. (n.d.). Driving Better Health Outcomes: Policy Brief. 2nd ed.

FLSE. (2020). Clinical Supervision Research. 14 December.

Office for Health Improvement and Disparities. (n.d.). Working Definition of Trauma-Informed Practice. Available at: **https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice** (Accessed: 1 March 2025).

Office for Health Improvement and Disparities. (2022). Vulnerabilities: Applying All Our Health. Available at: **https://www.gov.uk/government/publications/vulnerabilities-applying-all-our-health/vulnerabilities-applying-all-our-health** (Accessed: March 2025).

Yatchmenoff, D. K. (2017). Learning Collaborative: Trauma-Informed Care. Oregon Health Authority. Available at: **https://www.oregon.gov/oha/HPA/DSI/QHOCMeetingDocuments/5-8-2017%20Learning%20Collaborative%20Trauma%20Informed%20Care.pdf** (Accessed: March 2025).

Plymouth Alliance. (n.d.). Human Learning System: A Case Study.

Plymouth Alliance. (n.d.). Plymouth Passport Project – Focus Group Findings.

ROOTS Partnership. (2021). The ROOTS Framework – User Manual. 29 March.

ROOTS Partnership. (n.d.). Roots Workshop Info Leaflet.

SAMHSA. (2014). Concept of Trauma and Guidance for a Trauma-Informed Approach.

Hopper, E. K., Bassuk, E. L. and Olivet, J. (2010). 'Shelter from the storm: Trauma-informed care in homelessness services', The Open Health Services and Policy Journal, 3(2), pp. 80–100.

SHCP. (n.d.). Values-Based Commissioning. Internal strategic guidance.

Sussex and Brighton ICS. (2023). Trauma-Informed Framework. Final version dated 30 October.

Sweeney, A., Clement, S., Filson, B. and Kennedy, A. (2016). 'Trauma-informed mental healthcare in the UK: what is it and how can we further its development?', Mental Health Review Journal, 21(3), pp. 174–192.

NHS England. (2019). The NHS Long Term Plan. Available at: **https://www.longtermplan.nhs.uk** (Accessed: March 2025).

NHS England. (2019). Mental Health Implementation Plan 2019/20–2023/24. Available at: **https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf** (Accessed: March 2025).

NHS. (n.d.). Roadmap for Trauma-Informed Change – Appendix A.

Bliss, A., Williamson, S. and Alayo, L. (2024). The State of Integrated Care Systems 2023/24: Tackling Today While Building for Tomorrow. (Accessed: April 2025).

NHS Education for Scotland. (n.d.). Trauma Informed Lens Tool. (Accessed: 26 September 2024).

Scottish Government. (2021). National Trauma Training Programme: Online Resources.

National Survivor User Network. (2018). The Principles of Peer Support Charter.

ImROC. (n.d.). Briefing Paper 26.

Scottish Government. (n.d.). Trauma-Informed Practice Toolkit. Available at: **http://www.gov.scot/publications/trauma-informed-practice-toolkit-Scotland/** (Accessed: 1 February 2023).

Triesman, K. (2021). A Treasure Box for Creating Trauma-Informed Organisations. London: Jessica Kingsley Publishers.

West Midlands Trauma. (n.d.). Trauma-Informed Commissioning Guidance.

West Yorkshire ICS. (n.d.). Trauma-Informed Language Guidance. Final version 3.

Langhoff, K. (2023). Trauma-Informed Evaluation Report. Available at: **https://sussex.figshare.com/articles/report/Trauma_informed_evaluation_report/23456900?file=41165252** (Accessed: March 2025).

Think Local, Act Personal. (2021). The Ladder of Co-Production. Available at: https://www.thinklocalactpersonal.org.uk/latest/co-production-the-ladder-of-co-production/ (Accessed: 1 March 2025).

The King's Fund. (2019). Tackling Poor Health Outcomes: The Role of Trauma-Informed Care. Available at: **https://www.kingsfund.org.uk/blog/2019/11/trauma-informed-care** (Accessed: 1 March 2025).

TICPOT. (2018). TICPOT Print Stage 2-3 V1-20181119-FINAL. (Accessed: March 2025).

TICPOT. (n.d.). TICPOT Stage 1. (Accessed: March 2025).

SAMHSA. (n.d.). Trauma and Violence. Available at: **https://www.samhsa.gov/trauma-violence** (Accessed: 1 March 2025).

Appendix 3: Sussex Trauma-informed Logic Model

Inputs	Activities	Short term outcomes	Medium term outcomes	Long term outcomes
Leadership and organisational commitment to continuous improvement and long term culture change Safe and supportive workforce and people culture Time and resource for engagement in training, implementation and development. Clear links with other system drivers Link to System performance prerogatives (Reductions in crisis care, Violence and incident reduction, Health inequalities)	Building awareness and training opportunities. Participation cross over – coproduction and inclusion Developing recommendations and Appropriate materials (VPR, Cultural, Language . Support information and signposting) Improving access to learning materials Developing communities of practice within organisations Training and readiness for senior leaders Trauma lens to environment and system activities, policies and procedures. Onboarding internal structures EDI, OD HI	Staff are likely to feel more comfortable raising issues and reaching out for support and guidance. Staff will have more recognition of trauma and its impact on clients and themselves. Staff will recognise more the importance of coproduction and collaboration in service design and delivery. Staff will report more knowledge and skills of impact of trauma and be able to respond in better recovery promoting ways, reducing harm and re-traumatisation Staff will be more culturally and diverse aware People with trauma in their histories or experiencing traumatic events will be offered more trustworthy and safer services that are flexible, sensitive and collaborative that support confidence building and choice driven. People with lived experience of trauma are more likely to report welcoming services and that they feel heard in services Leaders and System drivers are more likely to articulate and help drive trauma informed practice by role modelling, sponsorship and ensuring alignment and modular integration by dovetailing leader and continuous improvement training as well as visible allyship and support mechanisms within organisations and services.	Staff will feel safer and supported in their work with recognisable wellbeing offers, improved supervision and support. Staff are supported with being able to make practical and tangible changes to services and tacit level change projects are recognised and sponsored. Staff are able to advocate for clients effectively and feel heard. There are more lived experience roles supporting services Increase in positive experiences reported back, less unhelpful discharge from services and re-traumatisation. More clients and service users have access to the right service at the right time and spend less time in crisis services and can receive treatment closer to home Improved sharing of data, more MDT working and transparent coproduced services. That social determinants are more prominent in understanding client journey	Improved overall health and wellbeing of people with lived experience in trauma Reductions in intergenerational trauma Improved community and social outcomes, employment, reductions in Criminal justice Improved equity and equity across services and improving public services. Including schools Policies and frameworks are produced, easy to access and trauma informed practice is common place. Trauma informed Practice is an ongoing conversation in all organisations that are delivering health and social care. There is a national underpinning in recommendations and adjustments in law People can grow up feeling loved and connected to supported communities where they can flourish, feel respected and live with dignity to realise their potential

TIC Trauma Informed Sussex

Sussex Health&Care

NAVIGATING THE LABYRINTH

VOICES FROM THE PATHWAYS STUDY ON SUPPORT FOR COMPLEX TRAUMA

October 2025

2

NAVIGATING THE LABYRINTH

VOICES FROM THE PATHWAYS STUDY ON SUPPORT FOR COMPLEX TRAUMA

October 2025

Project team

Angela Sweeney, Bethan Mair Edwards, Camila Graterol Munoz, Charlotte Rowe, Eliana Michaels, Frank Rohricht, Jacqueline Sin, Jane Chevous, Jessica Jones Nielsen, Lewis Benjamin, Lulwah Alhajji, Mitali Kothari, Roz Etwaria, Siofra Peeren, Xiaomin Lai, Steve Gillard.

PATHWAYS TO SUPPORT FOR COMPLEX TRAUMA
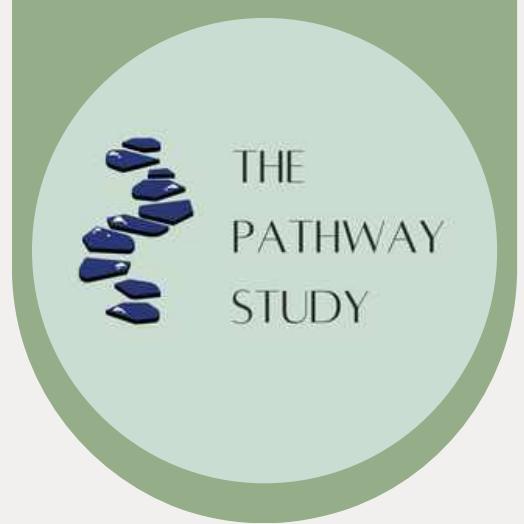
THE PATHWAY STUDY

Findings *so far* from the Pathway study

Introduction

This report is for everyone who contributed to the Pathway Study, whether as a **participant**, a member of our **Clinical Advisory Group** or **Lived Experience Advisory Group**, a **student**, a **researcher** or as a **project team member**. We want to share what we've learned in a way that feels accessible and reflects the contributions of everyone involved. We also want to say a huge thank you for being part of this work

Our core team

Our core team was made up of:
- researchers with lived experience from King's College London
- mixed-disciplinary researchers from City St George's University of London, including a lived experience researcher
- researchers, activists, and peer supporters from Little Ro and Survivors Voices
- and staff from East London NHS Foundation Trust.

THE PATHWAY STUDY

Our Advisory Groups

We worked with two advisory groups.

- The Lived Experience Advisory Group (LEAG) was made up of people with direct experience of complex trauma. Members brought many additional skills to this group, including as artists, researchers and peer supporters.

- The Clinical Advisory Group (CAG) was made up of practitioners who support people with complex trauma. Some members also have their own lived experiences of complex trauma.

The CAG met three times and received occasional study updates. The CAG advised us on how we should carry out our research with staff, including who we should speak to and the questions we should ask.

The LEAG met multiple times as a whole group and in smaller working groups. The LEAG advised us on how to carry out our research safely and sensitively. They also advised on the questions we should ask people with lived experience of complex trauma, and helped us to understand and interpret the emerging findings.

A huge thank you to everyone who took part in these groups, your contributions have been invaluable.

Thank you

What we aimed to do

The aim of Pathway was to understand pathways to support for people who have experienced complex trauma. Our key goals included:

- understanding pathways from different people's perspectives

- hearing from Black participants and others who are often underrepresented in research

- exploring what trauma-informed care pathways might look like

- and learning the best ways to recruit and interview people with trauma histories.

We defined **complex trauma** as trauma that often begins in childhood and is ongoing and repeated.

We defined **care pathways** as the typical processes of assessment, referral and treatment that enable people to access support for the impacts of complex trauma.

THE PATHWAY STUDY

The four projects

To understand care pathways for people who have experienced complex trauma, we undertook four projects.

- We reviewed literature on people's experiences of seeking support for the mental health impacts of complex trauma

- We interviewed people with lived experience of complex trauma about their experiences of care pathways. We presented findings back to people in a feedback meeting.

- We held a focus group with people with lived experience about their views on research with clinical records.

- We held focus groups with staff to understand their experiences and perspectives.

The literature review

We reviewed the literature on people's lived experiences of the wide range of services that they sought for mental health support.

We screened over 23,000 records. We found 108 papers that helped us to understand how people experience mental health support. Findings from these 108 papers were brought together using an approach called narrative synthesis.

We found that seven key factors affect people's experiences of support services.

1 External stigma: people were often judged negatively by others and experienced broken relationships.

2 Internal stigma: people often felt different, and as though they did not belong.

3 Staff attitudes: no discussion or support following trauma disclosures.

4 Staff skills and training: including a lack of knowledge or awareness of trauma services and how to access them.

5 Therapeutic relationships: included practitioners not listening to people and victim-blaming.

6 Treatment flexibility: services were hard to access, with multiple cultural barriers and rigid service remits.

7 Peer support: people reported a nearly (but not quite) universally positive experience of peer support.

Whilst people's experiences were largely negative, some found support that helped them to experience safety, connection and validation to journey towards healing.
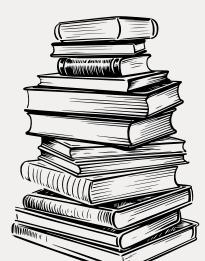
Interviews

We recruited participants through adverts shared by trauma survivor and mental health service user groups.

We carried out interviews with **29** people who have experienced complex trauma.

Half of the participants were aged 20 to 35, and half were 36 to 59.

20 participants identified as female, and 9 as male.

Half of the participants identified as LGBTQIA+, and half as heterosexual.

Sixteen participants were Asian, Black African or Caribbean, or mixed heritage, and thirteen were White British or White Other.

Just over half of the participants identified as disabled.

THE
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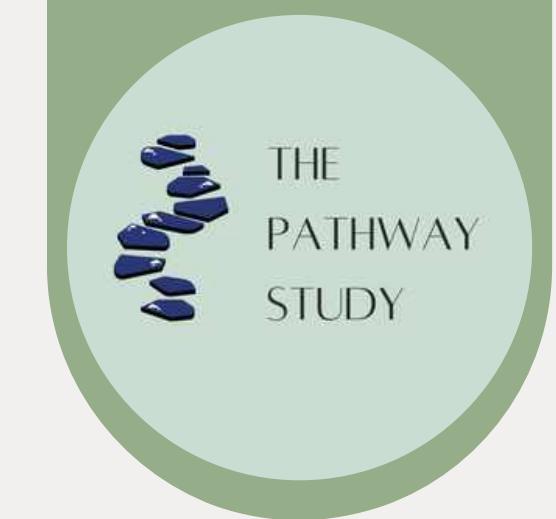
Interviews were carried out by **four researchers with lived experience of complex trauma**, either online or in-person.

Most people took part in **two interviews** of around one hour each. People shared their experiences of seeking support for the impacts of complex trauma and considered what did and didn't help, support for people from marginalised communities and recommendations for services.

We used **thematic analysis** to help us understand common themes in people's experiences of seeking mental health support.

Survivors Voices Charter

We followed the Survivors Voices Charter for Organisations Engaging Abuse Survivors in Projects, Research and Service Development*.

The Charter contains seven principles for engaging with people with lived experience:

- safety
- empowerment
- amplifying survivors' voices
- self-care
- accountability & transparency
- liberation
- creativity & joy.

You can find out more about the Charter here:
survivorsvoices.org/charter/

*Perôt, Chevous & the Survivors Voices Research Group, V2 2018.

THE PATHWAY STUDY

The early findings

Postgraduate students helped us to analyse interviews. One student focused on young people, another on men, and a third on people who identified as LGBTQ+. A fourth student and lived experience researcher focused on Black participants.

Early findings were presented to the LEAG to help us interpret them. Findings were also shared with participants in a feedback meeting. This added detail and nuance to the themes.

Findings are organised into **seven themes**. Although the findings probably won't surprise you, they can still be upsetting to read. Please take care, and know that **it is ok not to read the findings**, especially if today is not the right day.

You can find information on **peer support** on page 13.

SURVIVORS VOICES

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1 The labyrinth: Pathways to support are often fragmented, chaotic, confusing and inconsistent. This leaves people disorientated, neglected and unsupported. Service eligibility criteria often excludes most people. Some people had better experiences in community orgs than they did in NHS services.

2 The need for self-advocacy: Many people had to fight for support. Without support, they relied on personal coping strategies, which was exhausting and not by choice.

3 Another person on a file: There was a lack of holistic and individualised support. Practitioners typically lacked curiosity and empathy. Consequently, people felt like a number in a system.

4 The dominance of western psychiatry: There was an over-reliance on medication and symptom-focused approaches. Black participants were unable to bring their full selves to therapy due to cultural misunderstandings.
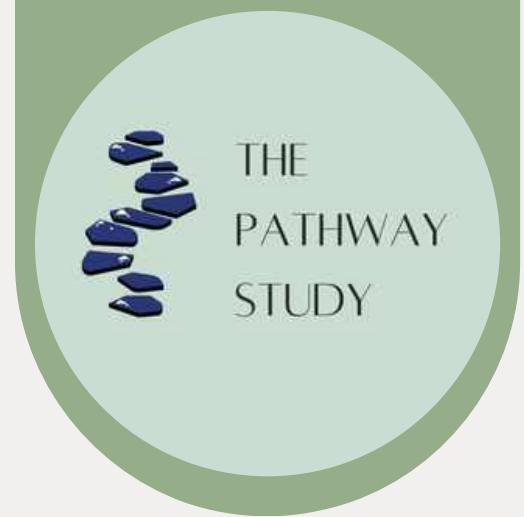
5 Inadequate assessments: Black participants reported culturally insensitive assessments that failed to consider their cultural and gendered experiences. This caused some people to disengage from services.

6 The whole situation was a mess: Young people often experienced either extreme interventions or received little to no support.
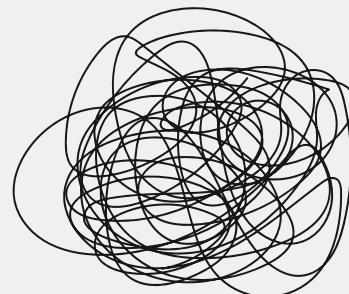
7 The diamonds in the rough: Despite these systemic and intpersonal barriers to effective care pathways, some participants found exceptional staff members who made a difference.

THE PATHWAY STUDY

Our feedback meeting

In the feedback meeting, and two 1-to-1 meetings, people (who had been interviewed) shared their thoughts on the findings so far. Here, we highlight some of key issues that people shared.

- **Inadequate support**: Trauma is often ignored or misdiagnosed, delaying proper care. There is a focus on symptoms rather than causes.

- **Poor access**: Long waits, limited resources, and cultural insensitivity also hinder support.

- **Community organisations & the NHS**: Community orgs can fill some of the gaps left by the NHS, but these orgs can be inconsistent and limited.

- **Cultural barriers**: Cultural insensitivity and systemic inequalities means that people of colour are often excluded from services.

- **Medicalisation:** A medicalised, target-driven system prioritises quick fixes over long-term solutions.

- **Change is urgently needed**: There were calls for trauma-informed care, holistic inclusive approaches, and honesty about the limitations caused by capacity and resources.

- We also heard that **being interviewed by people with lived experience** is meaningful and validating.

Research with clinical records

Researchers sometimes look at mental health care records (or clinical notes) to help them understand patterns and trends in who gets to access services and what their outcomes are.

We wanted to understand what people who have experienced complex trauma think about this.

- How can research with care records be done ethically?
- What safeguards might need to be in place?

We held **one focus group with seven people** to discuss these issues. We are planning further work.

THE PATHWAY STUDY

The early findings

Concerns about taking part in clinical records research included privacy invasions and inaccurate records containing incomplete, judgemental & biased information.

Good research with care records should:

- Be opt-in, respecting people's autonomy.
- Make clear how records will be used, who by, and for what purpose.
- Be transparent, with clear and consistent communication.
- Acknowledge the bias and subjectivity of clinical notes
- Give participants opportunities to correct their records.
- Interpret findings with care.
- Remember the person behind the record.
- Involve lived experience researchers.
- Acknowledge inequities in access to services e.g. language barriers.

Staff focus groups

We held three focus groups with a total of twelve people. Participants worked in diverse disciplines and service settings. Some were fairly newly qualified and others very senior with decades of experience.

A King's postgraduate student is carrying out a thematic analysis of these focus groups.

The findings so far resonate strongly with the findings from the interviews with people with lived experience of complex trauma.

THE
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STUDY

The early findings

Clinicians are told to be trauma-informed without meaningful training or support, and without wider system changes.

Services are almost '**anti trauma-informed**' including:
- No care pathways for trauma.
- Fragmented services focused on disorders and symptoms.
- A lack of holistic care.
- Gatekeeping through rigid service eligibility.
- Difficult physical environments.
- Long waiting lists.
- Time limited support.
- High caseloads.
- Staff shortages.
- Unhelpful risk assessments and
- A lack of resources.

This contributes to frustration, burn-out, moral injury and feelings of helplessness among staff as they are unable to meet people's needs.

Bringing it all together

Overall, we found that pathways to support for people who have experienced complex trauma are chaotic and messy, and trauma is often ignored & misdiagnosed.

Care pathways are shaped by many factors including:
- External and internal stigma
- Fragmented, rigid, short-sighted systems
- Medicalised approaches
- A lack of individualised, holistic and trauma-informed support
- Cultural insensitivity
- Inadequate assessments
- Rigid eligibility criteria
- A lack of resources and
- A lack of trauma services.

Because services are 'anti trauma-informed', staff are often burnt-out and demoralised whilst people with lived experience are abandoned and have to fight for support.

But, some people find *the diamonds in the rough* and experience safety, validation and connection, showing that staff can make a difference.

Peer support was also often vital.

Peer support after Pathways

Little Ro and Survivors Voices have offered peer support to the participants and researchers on this study. Both organisations offer ongoing forms of peer support, including a facebook group and online peer support groups on Monday, Tuesday and Wednesday evenings.

To find out more, please visit:

littlero.org/black_bipoc_support/

and

survivorsvoices.org/support/
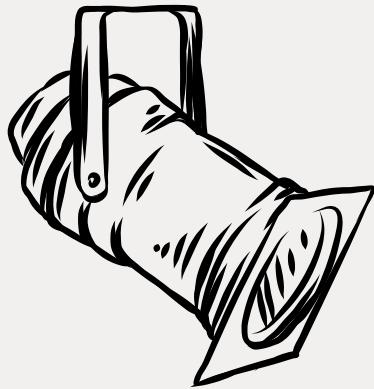
COMPLEX

COMPLEX is a new play inspired by Pathways. It has been co-created by survivors with Response Ability Theatre under the direction of founder Nell Hardy.

"COMPLEX unpacks the Kafkaesque phenomenon of being told you are "too complex" for complex trauma treatment. Calling on sci-fi, nonsense poetry, melodrama and music where realism just isn't real enough, we might have to sing to you once or twice - but only when we really don't know what else to do".

About COMPLEX:
Ilo thinks she's about to save lives. Oli thinks they're about to be saved. Two letters arrive on the same day, leading them both into a labyrinth that stretches even their overactive imaginations, and turns everything they thought they knew about themselves upside down - in all the wrong ways.

Staying in touch

We hope to publish some of our findings as academic papers.

But we don't want our findings to sit on dusty shelves. We are hoping to work with our LEAG and others to develop ways of sharing our findings that aim to contribute to change.

To receive a copy of any outputs we publish, please email Angie on angela.sweeney@kcl.ac.uk

You can also sign up to the Response Ability Theatre newsletter to be notified of upcoming performances: responseabilitytheatre.com

THE PATHWAY STUDY

ACKNOWLEDGEMENTS

A huge thank you to everyone who contributed to this work including...

All our participants

The advisory groups

The researchers

The project team

Placement staff

Peer supporters

Professional services staff

&

King's College London students

Thank you

Cochrane Library

Psychological therapies for women who experience intimate partner violence (Review)

Hameed M, O'Doherty L, Gilchrist G, Tirado-Muñoz J, Taft A, Chondros P, Feder G, Tan M, Hegarty K

WILEY

[Intervention Review]

Psychological therapies for women who experience intimate partner violence

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A B S T R A C T

Background

Intimate partner violence (IPV) against women is prevalent and strongly associated with mental health problems. Women experiencing IPV attend health services frequently for mental health problems. The World Health Organization recommends that women who have experienced IPV and have a mental health diagnosis should receive evidence-based mental health treatments. However, it is not known if psychological therapies work for women in the context of IPV and whether they cause harm.

Objectives

To assess the effectiveness of psychological therapies for women who experience IPV on the primary outcomes of depression, self-efficacy and an indicator of harm (dropouts) at six- to 12-months' follow-up, and on secondary outcomes of other mental health symptoms, anxiety, quality of life, re-exposure to IPV, safety planning and behaviours, use of healthcare and IPV services, and social support.

Search methods

We searched the Cochrane Common Mental Disorders Controlled Trials Register (CCMDCTR), CENTRAL, MEDLINE, Embase, CINAHL, PsycINFO, and three other databases, to the end of October 2019. We also searched international trials registries to identify unpublished or ongoing trials and handsearched selected journals, reference lists of included trials and grey literature.

Selection criteria

We included randomised controlled trials (RCTs), quasi-RCTs, cluster-RCTs and cross-over trials of psychological therapies with women aged 16 years and older who self-reported recent or lifetime experience of IPV. We included trials if women also experienced co-existing mental health diagnoses or substance abuse issues, or both. Psychological therapies included a wide range of interventions that targeted cognition, motivation and behaviour compared with usual care, no treatment, delayed or minimal interventions. We classified psychological therapies according to Cochrane Common Mental Disorders's psychological therapies list.

Data collection and analysis

Two review authors extracted data and undertook 'Risk of Bias' assessment. Treatment effects were compared between experimental and comparator interventions at short-term (up to six months post-baseline), medium-term (six to under 12 months, primary outcome time

point), and long-term follow-up (12 months and above). We used standardised mean difference (SMD) for continuous and odds ratio (OR) for dichotomous outcomes, and used random-effects meta-analysis, due to high heterogeneity across trials.

Main results

We included 33 psychological trials involving 5517 women randomly assigned to experimental (2798 women, 51%) and comparator interventions (2719 women, 49%). Psychological therapies included 11 integrative therapies, nine humanistic therapies, six cognitive behavioural therapy, four third-wave cognitive behavioural therapies and three other psychologically-orientated interventions. There were no trials classified as psychodynamic therapies. Most trials were from high-income countries (19 in USA, three in Iran, two each in Australia and Greece, and one trial each in China, India, Kenya, Nigeria, Pakistan, Spain and UK), among women recruited from healthcare, community, shelter or refuge settings, or a combination of any or all of these. Psychological therapies were mostly delivered face-to-face (28 trials), but varied by length of treatment (two to 50 sessions) and staff delivering therapies (social workers, nurses, psychologists, community health workers, family doctors, researchers). The average sample size was 82 women (14 to 479), aged 37 years on average, and 66% were unemployed. Half of the women were married or living with a partner and just over half of the participants had experienced IPV in the last 12 months (17 trials), 6% in the past two years (two trials) and 42% during their lifetime (14 trials).

Whilst 20 trials (61%) described reliable low-risk random-sampling strategies, only 12 trials (36%) described reliable procedures to conceal the allocation of participant status.

While 19 trials measured women's depression, only four trials measured depression as a continuous outcome at medium-term follow-up. These showed a probable beneficial effect of psychological therapies in reducing depression (SMD −0.24, 95% CI −0.47 to −0.01; four trials, 600 women; moderate-certainty evidence). However, for self-efficacy, there may be no evidence of a difference between groups (SMD −0.12, 95% CI −0.33 to 0.09; one trial with medium-term follow-up data, 346 women; low-certainty evidence). Further, there may be no difference between the number of women who dropped out from the experimental or comparator intervention groups, an indicator of no harm (OR 1.04, 95% CI 0.75 to 1.44; five trials with medium-term follow-up data, 840 women; low-certainty evidence). Although no trials reported adverse events from psychological therapies or participation in the trial, only one trial measured harm outcomes using a validated scale.

For secondary outcomes, trials measured anxiety only at short-term follow-up, showing that psychological therapies may reduce anxiety symptoms (SMD −0.96, 95% CI −1.29 to −0.63; four trials, 158 women; low-certainty evidence). However, within medium-term follow-up, low-certainty evidence revealed that there may be no evidence between groups for the outcomes safety planning (SMD 0.04, 95% CI −0.18 to 0.25; one trial, 337 women), post-traumatic stress disorder (SMD −0.24, 95% CI −0.54 to 0.06; four trials, 484 women) or re-exposure to any form of IPV (SMD 0.03, 95% CI −0.14 to 0.2; two trials, 547 women).

Authors' conclusions

There is evidence that for women who experience IPV, psychological therapies probably reduce depression and may reduce anxiety. However, we are uncertain whether psychological therapies improve other outcomes (self-efficacy, post-traumatic stress disorder, re-exposure to IPV, safety planning) and there are limited data on harm. Thus, while psychological therapies probably improve emotional health, it is unclear if women's ongoing needs for safety, support and holistic healing from complex trauma are addressed by this approach. There is a need for more interventions focused on trauma approaches and more rigorous trials (with consistent outcomes at similar follow-up time points), as we were unable to synthesise much of the research.

P L A I N   L A N G U A G E   S U M M A R Y

Psychological therapies for women who experience intimate partner violence

The review question

Domestic violence (physical, emotional, sexual abuse and controlling behaviour by a partner or ex-partner) is common worldwide and causes long-lasting emotional and physical health problems. Psychological therapies (counselling by trained people) may improve women's mental health and enable them to focus on making safety plans, accessing resources for themselves and their children, and ultimately to escape the domestic violence.

We searched scientific literature worldwide up to the end of October 2019 for trials comparing a group of female domestic violence survivors who received psychological therapy with those who did not, to understand whether such therapies are safe and effective.

Trial characteristics

Women had been randomly placed in one group (the intervention) or the other (comparison). We found 33 trials involving 5517 women, with an average age of 37 years, and two-thirds of them were unemployed. Half of them were married or living with a partner, and for half of them the domestic violence was in the last 12 months. Psychological therapies were mostly delivered face-to-face but varied by the length of treatment (2 to 50 sessions) and the staff who delivered the therapies (social workers, nurses, psychologists, community health workers, family doctors, researchers). Women were invited from healthcare settings, community centres and domestic violence refuges and shelters. Nineteen trials measured women's depression, two assessed self-efficacy (if women believed they were capable of making

changes in their lives) and all measured dropout from the groups. We used the number of dropouts to measure harmful effects. Most trials followed up on the women within six months of starting the trial.

Key results

We found evidence that psychological therapies probably reduce depression and may reduce anxiety symptoms for women who have experienced domestic violence (six to 12 months after the therapy). Psychological therapies do not appear to cause any harm. However, we are uncertain whether psychological therapies improve self-efficacy, mental health, quality of life, social support, uptake of healthcare and domestic violence services, safety planning or reduce post-traumatic stress disorder and re-exposure to any form of domestic violence.

Overall, there is a need for more trials with consistent outcomes at similar follow-up time points as we were unable to combine much of the research to give an overall picture. Thus, while women experiencing domestic violence may be helped by psychological therapies to improve their emotional health, which may in turn help their ongoing needs of safety, support and holistic healing from complex trauma, we are uncertain whether psychological therapies improve these aspects of their lives.

Support for Researchers

Survivors Charter
Principles of survivor involvement and trauma-informed practice

Survivor Involvement Ladder
Plan & evaluate good survivor involvement

Linking Service
We help you connect with survivors for your project and advise on good survivor participation

LEAGs
We can recruit, facilitate and support your Lived Experience Advisory Group

Peer Support
We can provide 1:1 and group peer support for your researchers and participants

Survivor Researcher Community
Monthly online community for survivors involved in research

Bid partners
We can be PPI partners on your bid and support your trauma-responsive projects

Publications
We can publish your findings through our indie print, Survivors Voices Press

Implementation
Our activist network can help you to implement your findings and increase impact

Training
We can provide training & consultancy on trauma-responsive practive

OXFORD

Healthcare professionals as domestic abuse survivors: workplace impact and support-seeking

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Background: Healthcare professionals (HCPs) are expected to identify and respond to domestic abuse (DA) among their patients. Although research suggests that a high proportion of HCPs are affected by DA, the impact of their experiences has been under-researched.
Aims: To assess UK HCPs' experiences of DA and develop a broad understanding of its impact on work and HCPs' support needs.

Methods: An online cross-sectional survey was promoted via multiple professional channels (October to December 2022). We adopted convenience sampling and analysed data descriptively.

Results: Among the 192 HCP survivors who responded, all abuse subtypes—psychological, sexual, economic and physical—were common. Ninety per cent of abusers were male (ex)partners. Eighty-five per cent reported abusers directly interfered with their work and 92% reported their work and career were affected. Almost all reported physical and mental health consequences. Eighty-nine per cent reported their own experiences shaped their responses to patient survivors. On average, per year, HCP survivors reported they had 13 sick days, 5 days' leave, 10 days' lateness and 6 days' early departure due to DA. Only 20% reported their workplace had a staff DA policy, and over 50% were unsure what workplace support mechanisms were available. Just over half disclosed at work; concerns that others would question their fitness to practice were common. Twenty-two per cent reported aspects of work, for example, long hours, stopped them from seeking support outside work.

Conclusions: HCPs face unique barriers to DA disclosure and support-seeking and may benefit from tailored support from specialists who understand both DA and the healthcare context.

INTRODUCTION

In England and Wales, 20.5% of adults (27% women, 13.9% men) have lifetime domestic abuse (DA) experience, and 4.4% of adults (5.7% women, 3.2% men) have past-year experience [1]. File 1 (available as Supplementary data at *Occupational Medicine* online) contains contextual information about DA. DA survivors face increased depression, anxiety, post-traumatic stress disorder [2,3], suicide and suicide attempt risks [4]. Physical consequences are wide-ranging and long-lasting, including gynaecological, cardiac, and gastrointestinal problems and chronic pain [5]. Three to four domestic homicides happen in England and Wales weekly [1].

Specialist advocacy and psychotherapeutic support improve survivors' physical and mental health and safety [6]. As trusted professionals, healthcare professionals (HCPs) are especially likely to receive DA disclosures and have opportunities to refer survivors for this specialist support [7]. Primary and community care HCPs, in particular, have multiple opportunities to engage with both perpetrators and survivors [8]. Thus, for 20+ years, UK [9] and international [10] policy has emphasized that HCPs

should enquire about DA. Healthcare-based training interventions have significantly increased enquiry, identification and referral rates [11–14].

Against this backdrop, HCPs' personal DA experiences have been side-lined. Yet, a global meta-analysis indicates 42% of female HCPs have experienced DA [15]. UK research with nurses has shown a higher prevalence than in the general population [16] and a 10-year femicide census identified HCPs as one of the commonest 'victim occupations' [17]. DA disproportionately affects women [1], and the UK National Health Service (NHS) is a highly feminized workforce: many NHS staff are likely affected. Recent studies highlight that HCP-perpetrated sexual misconduct towards colleagues is common but links to DA are unreported [18,19].

The UK Domestic Abuse Act 2021 statutory guidance [9] highlights a duty of care on employers to consider how DA affects employees. NHS England has a DA policy for its own staff, and NHS Employers [20] has a template policy for NHS workplaces to adopt, recognizing that 'abusive and violent behaviour … can frequently cross over into the workplace … [and] work can be

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Key learning points

What is already known about this subject:

- DA is highly prevalent in England and Wales, leads to wide-ranging and long-lasting mental and physical health consequences, and can end in suicide or homicide, but advocacy and psychotherapeutic support can improve mental health and safety.
- Healthcare professionals are likely to receive disclosures of domestic abuse and have opportunities to refer survivors for support, so national and international policy emphasizes their role in asking and responding, but despite a high percentage of healthcare professionals experiencing domestic abuse themselves, research and policy has side-lined the work-related impact of their own experiences.
- Employers have a duty of care to consider how domestic abuse affects their employees, but UK-based research on this topic is lacking: the scant research indicates that staff domestic abuse policies in hospital trusts are uncommon, and that doctors, nurses and maternity professionals face unique barriers to seeking support.

What this study adds:

- We explored the experiences of a range of healthcare professionals and found that abusers directly interfered in respondents' work (e.g. pre-work sleep deprivation, harassment), that abuse harmed day-to-day productivity and career advancement, and that abuse led to an average of 13 sick days annually.
- Most respondents were unsure whether their workplace had a staff domestic abuse policy, and over half reported they did not know what workplace support was available for domestic abuse: very few indicated the types of support that were available, and these were largely short-term practical support mechanisms.
- Despite the impact on work, few respondents sought support at or outside of work, many faced work-related barriers, and not all respondents felt believed when disclosing: colleagues and managers were the most common sources of support, and less than 10% sought support from occupational health.

What impact this may have on practice or policy:

- UK policy-makers and professional regulators recognize that healthcare professionals are experiencing all-time highs of stress, mental ill health, burnout and suicide ideation, leading to a declining workforce: domestic abuse contributes to these phenomena and UK policy-makers are starting to acknowledge the importance of a UK National Health Service response to affected staff.
- Our study highlights an immediate need for: wider implementation of basic support, particularly related to leave options and support following sick leave; longer-term/emotional support options; support options to be codified in policy; campaigns to make healthcare professional survivors aware of available options and policies; and the exploration of tailored support interventions.
- Underscoring earlier calls for domestic abuse to be seen as an occupational health issue, domestic abuse training for, and improved support from, occupational health staff, well-being services, and employee assistance programme staff could lead to benefit for healthcare professional survivors, their patients and their workforces.

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a lifeline to independence and survival'. Work can bring social, financial and other support, and a sense of agency, strength and positive self-identity, but HCP survivors unsupported at work can feel further traumatized [21]. NHS Employers' template policy targets managers who support employees. It recommends support mechanisms that should be available, predominantly practical measures to address acute risk situations. However, 2 years after the template's original publication, 32% of secondary care trusts and health boards had not implemented a policy, and just 1% of policies implemented listed all the support mechanisms recommended [22].

HCPs can face unique barriers to disclosure and support-seeking [15], which increases risks of further harm and death [6]. Three qualitative studies (only one peer-reviewed [23]) of UK doctors, nurses and maternity HCP survivors of DA highlight fears of fitness to practice or regulator reviews as barriers. This research also shows that survivors can 'shut down' when faced with patients experiencing DA [23–25]. With just three small-scale studies, little UK-based research has explored HCP survivors' experiences and work impacts. Therefore, we aimed to assess HCPs' DA experiences, particularly across primary and community specialities, to develop a broad understanding of work impacts and support needs.

METHODS

The study team comprised primary and community healthcare clinical academics and HCP survivors. We developed an anonymous, confidential, cross-sectional survey to explore the experiences of HCP survivors and staff who support colleagues (e.g. line managers). Respondents could complete it as a survivor, supporter or both. This article provides an overview of HCP survivor data. The survey targeted survivors who had already framed their experiences as DA so we could explore their support-seeking experiences. Thus, we anticipated most respondents to have past, rather than current, experience. No criteria excluded participation except not working in the UK.

Survey items for HCP survivors captured demographic details, types of DA experienced, impact on work and health, and support-seeking experiences. One item asked whether experiences were current or 'within last 12 months/1–5/6–10/11+ years ago'. We drew on the validated Abusive Workplace Disruptions Assessment tool [26], earlier research [15] and team suggestions to develop survey items regarding abusive behaviours that directly interfered with work. Survey items included questions about support measures, including measures that the NHS Employers [20] template policy and the NHS England in-house staff DA policy list, and measures that HCP

survivors within the study team highlighted as important. Most questions were multiple choice: respondents could tick all those that applied. The study team fed back on survey drafts that SD and AG developed. Following revisions, we migrated the survey online. Study data were collected and managed using REDCap electronic data capture tools hosted at University of Bristol. Fifteen people, including four HCP survivors, piloted it and gave more detailed feedback. Final revisions were made.

We launched the survey on 29 September 2022 following approval from University of Bristol's Faculty of Health Sciences Research Ethics Committee (1139) (see File 2 for survey, available as Supplementary data at *Occupational Medicine* online). Although it was online, information pages detailed alternative access options (no one took these up). Information pages encouraged respondents to skip questions, take breaks, or stop if needed, and detailed the data withdrawal process. We used convenience sampling. To advertise the survey, we circulated the web link to primary care network directors, who cascaded the information to general practices in their areas, safeguarding and communications leads at English community hospitals, and via social media, tagging relevant accounts with large followings (e.g. Pulse Today, Royal Pharmaceutical Society, College of General Dentistry). Advertisements used the terms 'domestic abuse/coercive control' to capture HCP survivors who used one or both terms to define their experience. We, moreover, raised study awareness during dentistry staff training, a regional pharmacist networking event and general practice journal discussion article [27]. We primarily targeted primary and community HCPs as these professionals often engage with survivors in their work, and from England, to make NHS England-specific recommendations, but we did not exclude respondents from other areas. We also included responses from HCPs who were not working in healthcare at the time of DA, as abuse has long-lasting health sequelae. Given the wide advertisement for the survey, determining the numbers our survey reached and thus a response rate was not possible. The survey closed on 9 December 2022 coinciding with the end of '16 days of activism against gender-based violence', a global campaign. We report frequencies and means, calculated within REDCap. Denominators fluctuate, as not all respondents completed the survey, and are indicated in tables. We round percentages to whole numbers. We used a largely deductive basic content analysis [28] to code and categorize free-text answers to 'other: please specify' questions, which we illustrate with quotations. Forthcoming articles will present detailed free-text analysis.

RESULTS

One hundred and ninety-two HCPs who had experienced DA responded: 21% ($n = 41$) also had a role supporting staff who had experienced DA. Forty-eight completed the survey partially. We received no requests to withdraw data. Ninety-eight per cent of respondents were England based (with 1% [$n = 2$] Scotland based, and <1% [$n = 1$] each Wales based and Northern Ireland based). Most (96%, $n = 132$) were women, 3% ($n = 4$) were men and <1% ($n = 1$) was non-binary. Participants were heterosexual (90%, $n = 122$), bisexual or gay/lesbian (3%, $n = 4$ each), pansexual (2%, $n = 3$), or preferred not to say (2%, $n = 2$).

Table 1 details areas of work, age ranges and ethnicity: 91% were White. Thirty respondents worked outside health care when they experienced DA.

Ninety per cent ($n = 171$) of respondents' abusers were male (ex)partners. Twenty-one per cent ($n = 40$) had a male partner and one or more other abusers (mainly parent(s)) totalling 251 abusers, and 11% (27/251) of abusers worked in health care. All abuse subtypes—psychological, sexual, economic and physical—were common. Over 1 in 10 (37%, $n = 70$) respondents reported currently experiencing DA. The remainder reported experiencing DA within the last 12 months (4%, $n = 8$), or 1–5 (16%, $n = 30$), 6–10 (19%, $n = 37$) or 11 or more (24%, $n = 46$) years ago.

Of respondents who worked in health care at the time of the abuse, 85% ($n = 125$) reported that the abuser directly interfered in their work in one or more ways, including pre-work sleep deprivation, harassment at work and accusations of infidelity with colleagues or patients. Table 2 contains more details.

Free-text comments described economic abuse: being coerced into particular roles or working hours: for example, into working more to earn more, even when ill, or into working less to do childcare and domestic labour. Free-text comments additionally described abusers making, or threatening to make, malicious allegations to colleagues and professional regulators, and creating conflict or bruising to upset or 'embarrass' respondents pre-work. Nine said in free text that they lost or resigned from their jobs due to abuse and its consequences.

Of the total sample, 97% ($n = 166$) reported physical and/or mental health harms and 92% ($n = 158$) indirect effects on work, detailed in Table 3. These were commonly impaired performance related to concentration, confidence in abilities, memory and pace. Respondents were also triggered, and felt unsafe, at work. Results were similar for the subsample working in health care at the time of the abuse. Free-text comments described how the abusers' constant belittling and subtle psychological abuse harmed respondents' confidence around their responsibilities at work.

Annually, due to abuse, based on respondents' self-reports on the survey, they took a mean of 13 sick days (95% CI 7.9–17.7, range of 0–183, $n = 150$) and 5 annual leave days (95% CI 3.6–6.9, range of 0–75, $n = 147$), and had 10 days' lateness (95% CI 5.8–14.3, range of 0–235, $n = 147$), and 6 days' early departure (95% CI 3.5–8, range of 0–100, $n=145$). Free-text comments highlighted that direct physical injury, longer-term physical and mental health problems, sleep deprivation, and childcare resulted in time off, and accusations of infidelity and 'guilt-tripping' around childcare and domestic labour pressured respondents to leave work early.

Eighty-four per cent ($n = 123$) of respondents had seen at least 1 patient experiencing DA and 39% ($n = 57$) had seen 11 or more within the past 5 years. Of these respondents, most (89%, 110/123) reported their identification and response to patients were affected, mostly improved recognition of DA, and a more empathic and knowledgeable response. However, free-text comments illustrated that negative reactions often accompanied these positive outcomes: being triggered, re-traumatized, overwhelmed and drained. Others reported *only* negative reactions, including acute trauma responses such as freezing, shaking and

Table 1. Respondents' areas of work, age ranges, and ethnicities

Area of healthcare practice	*n* (%) of total sample (*n* = 190)
Community hospital or service	59 (31)
General practice	51 (27)
Dentistry*	23* (12)
Secondary care trust	18 (9)
Pharmacy	12 (6)
Commissioning or administration	6 (3)
Safeguarding/criminal justice within a healthcare trust	5 (3)
Sexual health; ambulance services; palliative/hospice care; mental health; 'other' with no further detail	2 (1 each)
Musculoskeletal; other nursing; screening/immunisations; substance misuse; charity; domiciliary	1 (< 1 each)
Job role	***n* (%) of total sample (*n* = 190)**
Nurse	34 (18)
General practitioner (GP)	24 (13)
Healthcare support worker/assistant	15 (8)
Non-clinical administrative roles: two were also counsellors	13 (7)
Pharmacist	11 (6)
Non-clinical managers; dentists	9 each (5 each)
Dental hygienist or therapist	8 (4)
Dental nurse/technician	6 (3)
Allied healthcare professional; community hospital nurse practitioner	5 each (3 each)
Staff grade/speciality doctor; general practice managers; safeguarding leads/advisors; non-clinical informatics/educator roles	4 each (2 each)
General practice nurse practitioner; health visitor; consultant (doctor); community paramedic; care coordinator	3 each (2 each)
Pharmacy assistant/technician; doctor-in-training; other nurse; mental health worker/practitioner; physicians' associate; social worker; anonymized roles	2 each (1 each)
Practice nurse; midwife; psychologist	1 each (< 1 each)
Age	***n* (%) of total sample (*n* = 137)**
36–45; 46–55	42 each (31 each)
56–65	26 (19)
26–35	24 (18)
18–25	2 (1)
66+	1 (< 1)
Ethnicity	***n* (%) of total sample (*n* = 137)**
White: English/Welsh/Scottish/Northern Irish/British	120 (88)
Other White	4 (3)
Prefer not to say, Indian	3 each (2 each)
Black African, Bangladeshi	2 each (1 each)
Black Caribbean, other mixed, other Black	1 each (< 1 each)

**n = 9 in a fully private practice: otherwise, respondents worked for the NHS or in an NHS England commissioned service.

nausea. Seventy-two per cent (*n* = 107) received DA training during or after their own experience: again, many were triggered ('It reignited … anger grief fear and rage'); others realized, for the first time, what was happening to them ('[It] first sowed the seed … that I may be experiencing [DA]').

When asked whether their workplaces had current staff DA policies, most respondents were unsure (67%, *n* = 78), 21% (*n* = 25, including *n* = 6 general practice, *n* = 2 dentistry, *n* = 1 pharmacy, *n* = 1 community hospital/service) said yes, and 12%

(*n* = 14, including *n* = 6 general practice, *n* = 2 dentistry, *n* = 1 pharmacy, *n* = 1 community hospital/service) said no.

Regarding workplace support mechanisms available, 51% (*n* = 83) were unsure what was available. Others indicated that specific types of support were available: Table 4 contains more details and shows that for each support mechanism, only small percentages said it was available. 'Confidentiality assurances' aside, the commonest mechanisms were 'changes to working times/days/patterns', occupational health (OH) referrals and

Table 2. DA behaviours that directly interfered with HCPs' work and percentage and number that experienced the different behaviours

Behaviour	n (%) of subsample working in healthcare at time of abuse (n = 147)
Did not let me sleep, or sleep well, before I went to work	76 (52)
Emailed, called, or messaged me many times a day while I was at work [harassment]	66 (45)
Accused me of having romantic relationships with, or sleeping with, colleagues or patients	63 (43)
Prevented me from accessing the opportunities or education I needed for my career	53 (36)
Made it difficult to leave my children when I needed to work	47 (32)
Did something else that interfered with my work [free text]	43 (29)
Did something to affect my means of getting to work	36 (24)
Followed me when I went to work or hung around outside where I was working [stalking]	28 (19)
Interacted with my colleagues in an inappropriate or abusive way	23 (16)
Came to work and interacted with patients in an inappropriate or abusive way	1 (<1)

special leave (of the total sample, 17%, 14%, and 12% said these were available respectively).

Looking at Table 4's 'current DA' subsample, for most support mechanisms, a slightly higher percentage said the mechanism was available compared with the total sample, suggesting that mechanisms were becoming more common, but percentages were still relatively small (e.g. 22% said changes to working times/days/patterns). Of the 'past DA' subsample, 2% (n = 2) reported workplace counselling was implemented since their own experience.

Ten per cent (n = 14) of the total sample reported a current DA worker who provides staff support, although not formally part of their (patient-facing) role in a third of cases.

Ninety per cent (137/152) faced barriers to disclosing and/or seeking support from someone at work, organized into themes (Table 5) relating to perceptions of professionalism, fear (of colleagues' reactions, impact on career; abuser retaliation) and HCP identity ('DA should not happen to HCPs').

Some respondents eventually disclosed and/or sought support at work despite these barriers: 54% (83/154) reported doing so; 44% (67/154) did not. Those who did mostly sought support from colleagues (38%, n = 58/154) and managers/supervisors (37%, n = 57/154). Just 7% (n = 11), 6% (n = 9) and 3% (n = 5) sought OH, staff well-being and employee assistance programme support, respectively. Four free-text comments were about OH: three GP respondents would have found

OH input helpful, but one community nurse felt 'persecuted' by her OH doctor. Linking to this finding, upon disclosure of abuse, 22% (n = 17) were unsure whether the person believed them, and 5% (n = 4) felt disbelieved. Free-text comments indicated that simply being believed and listened to were helpful aspects of support following disclosure. Of the 44% (n = 67) who did not disclose and/or seek support from someone at work, most did not know what support was available, but 21% (14/67) indicated that although support was available, they chose not to take it up. Types of support that were not available but were described as potentially helpful are summarized in Figure 1.

Elements of work affected the ability to seek support from outside of work for 22% of respondents (n = 33), including working hours (16%, n = 24), worries about seeing patients at specialist services (8%, n = 12) and ineligibility for certain support types (3%, n = 3). Free-text comments highlighted respondents wished not to be 'clients' of services with which they had professional relationships and felt pressured to retain a 'highly functional' HCP image.

DISCUSSION

Current DA was reported by over 1 in 10 respondents, was perpetrated mainly by male partners and 11% of abusers were healthcare workers. Abuse affected work and health, and led to absence and lateness. Abuse rippled out to others in the workplace (accusations of infidelity with patients/colleagues, abusive interactions with colleagues, malicious allegations to colleagues and regulators). An adverse impact on patient care was reported. Personal experience improved identification and response to patient survivors, but, along with DA training, led to being triggered at work. Respondents, moreover, felt unsafe at work. Policies and support options were lacking and numerous barriers to disclosure and support-seeking related to respondents' roles as HCPs.

Our study is the first to describe the impact of DA on a range of UK HCPs. A greater number of survivors currently experiencing abuse may have responded if study advertisements avoided the terms 'DA/coercive control', as recognising and naming DA can take time. We could not determine a response rate. Experiences might have been many years ago: nevertheless, these were relevant as consequences can be long-lasting. Not all respondents completed the survey, but offering a 'stop partway' option was important to protect participant well-being. Few men and people of minoritized ethnicities, sexualities and genders, and from pharmacy and sexual health, participated, limiting generalizability and ability to capture intersecting harms (e.g. institutional racism). Our sample size outweighed that of a comparable UK survey for maternity HCPs [24] but was too small for meaningful subgroup analysis. The small sample size also limits the breadth of experience captured.

Our research complements earlier research. Regarding sleep deprivation as an abusive form of work interference, a Finnish study with HCP survivors showed that DA also *indirectly* affects sleep, and sleep quality mediates the relationship between DA and depression [29]. Thus sleep deprivation intensifies the impact of other abuse types, and is linked to burnout and physical and mental health problems for HCPs

Table 3. Indirect impact on work and percentage and number that experienced these effects

Impact on work	*n* (%) of total sample (*n* = 171)	*n* (%) of subsample working in healthcare at time of abuse (*n* = 147)
I could not concentrate at work	123 (72)	108 (73)
I did not feel confident about my ability to do my job	106 (62)	93 (63)
I had difficulty remembering what tasks to do at work	78 (46)	71 (48)
I had a noticeably slower pace when completing tasks	72 (42)	66 (45)
I was triggered at work	62 (36)	58 (39)
I did not take promotions or opportunities for advancement	61 (36)	55 (37)
I felt unsafe at work	39 (23)	35 (24)
It affected me in another way [Free text]	32 (19)	31 (21)

Table 4. Workplace support mechanisms, policy of origin and percentage and number who reported these were available

Workplace support mechanism	*n* (%) who indicated it was available		Recommended in …?
	Total sample (*n* = 163)	Current abuse (*n* = 59)	• NHS Employers template • NHS England policy • Both • Neither
Working hours and duties			
Changes to working times, days, or patterns	27 (17)	13 (22)	Both
Changes to specific duties (e.g. to avoid contact with the abuser(s))	9 (6)	5 (8)	NHS England
Not being asked to do the usual return-to-work process after sick leave	8 (5)	3 (5)	Both
The option for redeployment or relocation	4 (2)	1 (2)	Both
Leave			
Special leave provisions including unpaid leave	20 (12)	7 (12)	Both
Permission to attend appointments related to DA during work hours	14 (9)	7 (12)	Neither
Permission to use private spaces at work to hold relevant appointments	7 (4)	5 (8)	Neither
Safety planning			
Measures to ensure safety at work (e.g. screening calls, security alerted)	15 (9)	8 (14)	Both
Permission to use work phones and computers to access information and support	13 (8)	6 (10)	Neither
Review of personal information held by the workplace, e.g. address	10 (6)	6 (10)	NHS England
Measures to ensure safety while travelling to and from work	8 (5)	5 (8)	Both
Training for security and reception staff about what to do if the abuser(s) show up	6 (4)	4 (7)	Neither
Option to stay at work for safety (e.g. to stay late or to sleep at work)	5 (3)	2 (3)	Neither
Referrals and signposting			
Referral to OH	23 (14)	13 (22)	Both
Support from qualified professionals (e.g. staff counsellors, therapists)	17 (10)	10 (17)	Neither
Referral to an employee assistance programme	12 (7)	6 (10)	Both
Signposting to an in-house independent domestic violence advisor or advocate	11 (7)	7 (12)	NHS England
Pay			
Referral to a credit union or financial advisory service	2 (1)	0 (NA)	NHS England
Changes to pay arrangements	2 (1)	2 (3)	NHS Employers template
Confidentiality			
Reassurance that disclosure would be kept confidential	44 (27)	19 (32)	NHS Employers template

Table 5. Barriers to disclosure at work and percentage and number that experienced the different barriers

Barrier	Theme	n (%) of total sample (n = 152)
I felt that I should keep my work and home life separate	Perceptions of professionalism	99 (65)
I thought that people at work would judge, blame, or think less of me	Fear of colleagues' reactions	91 (60)
I didn't think that it was anyone's role to support with DA	Perceptions of professionalism	64 (42)
I felt that DA should not happen to someone in my role, or to a HCP	HCP identity	58 (38)
I worried that it would affect my professional registration or make people question my fitness to practice	Fear of impact on career	57 (38)
I didn't think people at work would believe me	Fear of colleagues' reactions	55 (36)
I worried that it would affect my career direction or progression	Fear of impact on career	55 (36)
I was scared that the abusive person/people would find out	Fear of abuser retaliation	40 (26)
I experienced other barriers [from free text: commonly worries about children being taken into care, not recognizing my own experience as DA, non-supportive work environment, fear of consequences to the abuser(s)]		22 (14)
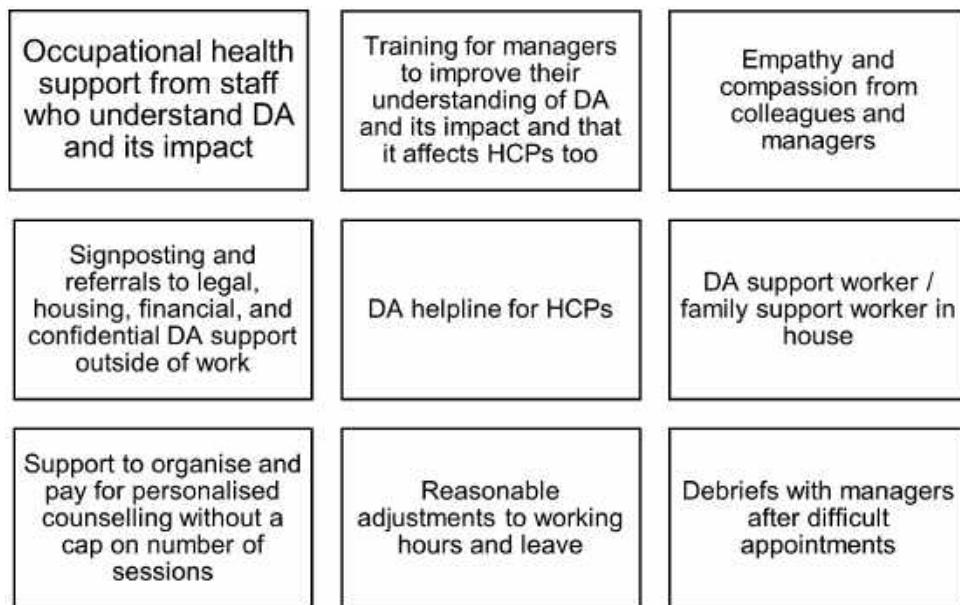
Figure 1. Support that was not available but would have been helpful: in addition to those listed in Table 4.

[30, 31]. A UK Trade Unions Congress (TUC) survey also highlighted abusers' interference with work (e.g. stalking), barriers to disclosure in the workplace, and impact on lateness, leave and performance, as important issues [32]. Estimated annual DA-related costs to the England and Wales economy are £14m from lost output and £2m from treating healthcare sequelae: HCPs' DA experience is thus an expensive problem for the NHS [33].

Echoing an earlier secondary care-based investigation [22], we found patchy implementation of staff DA policies and that implemented policies rarely cited the support mechanisms recommended by NHS Employers [20]. This finding is concerning given that abuse extended to the workplace. Less than 10% of respondents indicated current safety measures for work-related travel, putting community HCP survivors at particular risk, for example. Adjustments to the post-sickness return-to-work process were infrequently available, despite sick leave being one of the few recourses HCP survivors had. Longer-term and/or emotional support (e.g. therapy, counselling) was also infrequently accessed, even though responding to and attending training about DA was a common part of HCP survivors' jobs. Financial support mechanisms were almost non-existent despite HCP survivors experiencing economic abuse and the economic consequences of time off.

Likely related to the patchy implementation of policy and support, less than half of respondents disclosed and sought support at work. Commonly, they spoke to managers, who may lack DA training, and colleagues, who may additionally lack the power to put support mechanisms in place. Support may have thus been inadequate or ineffective at enhancing safety and protecting health. The TUC moreover points out that unaware or unsympathetic managers may discipline or dismiss survivors, and that losing an 'independent source of income is a disastrous outcome'(p.6) [32].

Our results support existing studies with UK HCP survivors [23–25], which identified barriers to disclosure and support-seeking at work, including unclear available support, 'professionalism' and fear. Our results show that the healthcare role, moreover, hindered support-seeking from sources outside work. Donovan and colleagues [23] similarly found that the HCPs and social workers caring for doctor survivors missed cues that these doctors were experiencing abuse and thus missed opportunities to refer them for support. Participants felt that they missed these because doctor survivors are not stereotypical victims. Other HCPs and social workers threatened to report doctor survivors to their regulator or employer [23]. The current provision of DA support, therefore, likely underserves HCP survivors.

Recent Australian research [34] has called for strengthened support and advocacy specifically for HCP survivors. A precedent for tailored support exists in England: NHS Practitioner Health provides effective mental health and addiction care specifically for HCPs [35, 36]. An OH-based trauma therapy for emergency service professionals, including those with personal or secondary DA experience has also shown promise [37].

UK policy-makers and professional regulators have recognized that HCPs are experiencing all-time highs of stress [38], mental ill health, burnout [39] and suicide ideation [40], contributing to a declining workforce [41,42]. DA contributes to these phenomena, and UK policy-makers are starting to acknowledge the importance of an NHS response to affected staff. The Women's Health Strategy [43] specifically commits NHS England to ensure that employers, and the NHS more broadly, support survivors. NHS England has appointed a DA lead whose remit includes developing internal policies and support options. Our study contributes to these policy discussions, by highlighting what is needed immediately: wider implementation of basic safety support (as recommended by NHS Employers); support related to leave options; longer-term/emotional support options (either in-house, or signposted to); support options to be codified in policy; campaigns to make HCP survivors aware of available options and policies; and tailored support interventions delivered by specialists who understand DA and the healthcare role. These changes would convey a clear message that DA *does* happen to HCPs and that managers and other NHS staff groups, including OH and well-being services, have a role in supporting affected employees. In turn, these messages may help to dispel barriers to disclosure related to perceptions of professionalism and fears of colleagues' reactions. Underscoring an earlier call for DA to be seen as an OH issue [44], our study also highlights that staff groups working for OH, well-being services, and employee assistance programmes, need basic training about DA, its work-related impact, and how to respond without judgement, disbelief, or victim-blaming. Training should educate these staff groups on how to support employees in safely maintaining employment if they wish to do so [45]. Their support could benefit survivors, their patients and workforces more broadly. Other barriers to disclosure require attention: specifically, professional regulators need to give clear guidance about DA and fitness to practice.

Further research should explore acceptable and effective interventions for HCP survivors. Improved support is urgently needed: DA affects HCP survivors' work and health, which has a wider impact including on patient care, but HCPs face unique barriers to seeking the support that is essential for safety and well-being.

COMPETING INTERESTS

None declared.

REFERENCES

1. Office for National Statistics. *Domestic abuse prevalence and victim characteristics, England and Wales: Year ending March 2023.* 2023. https://www.ons.gov.uk/file?uri=/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseprevalenceandvictimcharacteristicsappendixtables/yearendingmarch2023/domesticabuseprevalenceandvictimcharacteristics2023.xlsx (1 June 2024, date last accessed).

2. Chandan JS, Thomas T, Bradbury-Jones C *et al.* Female survivors of intimate partner violence and risk of depression, anxiety and serious mental illness. *Br J Psychiatry* 2020;**217**:562–567.

3. Trevillion K, Oram S, Feder G, Howard LM. Experiences of domestic violence and mental disorders: a systematic review and meta-analysis. *PLoS One* 2012;**7**:e51740.

4. Kafka JM, Moracco KE, Pence BW, Trangenstein PJ, Fliss MD, McNaughton Reyes L. Intimate partner violence and suicide mortality: a cross-sectional study using machine learning and natural language processing of suicide data from 43 states. *Inj Prev* 2023;**30**:125–131.

5. Campbell JC. Health consequences of intimate partner violence. *Lancet* 2002;**359**:1331–1336.

6. Trabold N, McMahon J, Alsobrooks S, Whitney S, Mittal M. A systematic review of intimate partner violence interventions: state of the field and implications for practitioners. *Trauma Violence Abuse* 2020;**21**:311–325.

7. Heron RL, Eisma MC. Barriers and facilitators of disclosing domestic violence to the healthcare service: a systematic review of qualitative research. *Health Soc Care Community* 2021;**29**:612–630.

8. Sharp-Jeffs N, Kelly L. *Domestic Homicide Review (DHR) case analysis. Report for standing together.* 2016. standingtogether.org.uk/s/STADV_DHR_Report_Final-6r9x.pdf (3 November 2023, date last accessed).

9. Home Office. *Domestic abuse statutory guidance.* 2022. gov.uk/government/consultations/domestic-abuse-act-statutory-guidance (3 November 2023, date last accessed).

10. World Health Organization. *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence. A manual for health managers.* 2017. iris.who.int/bitstream/handle/10665/259489/9789241513005-eng.pdf?sequence=1 (3 November 2023, date last accessed).

11. Price S, Baird K, Salmon D. Does routine antenatal enquiry lead to an increased rate of disclosure of domestic abuse? Findings from the

Bristol Pregnancy and Domestic Violence Programme. *Evid Based Midwifery* 2007;**5**:100–106.

12. Feder G, Davies RA, Baird K *et al.* Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *Lancet* 2011;**378**:1788–1795.

13. Jackson J, Lewis NV, Feder GS *et al.* Exposure to domestic violence and abuse and consultations for emergency contraception: nested case-control study in a UK primary care dataset. *Br J Gen Pract* 2019;**69**:e199–e207.

14. Sohal AH, Feder G, Boomla K *et al.* Improving the healthcare response to domestic violence and abuse in UK primary care: interrupted time series evaluation of a system-level training and support programme. *BMC Med* 2020;**18**:48.

15. Dheensa S, McLindon E, Spencer C *et al.* Healthcare professionals' own experiences of domestic violence and abuse: a meta-analysis of prevalence and systematic review of risk markers and consequences. *Trauma Viol Abuse* 2023;**24**:1282–1299.

16. Cavell Nurses' Trust. *Skint, shaken yet still caring. But who is caring for our nurses?* 2016. cavell.org.uk/wp-content/uploads/2019/06/Skint-shaken-yet-still-caring-Cavell-Nurses-Trust-Final.pdf (3 November 2023, date last accessed).

17. Long J, Harvey H, Wertans E, *et al. UK femicides 2009-2018.* 2021. femicidecensus.org/wp-content/uploads/2020/11/Femicide-Census-10-year-report.pdf (3 November 2023, date last accessed).

18. Searle RH. Sexual misconduct in health and social care: Understanding types of abuse and perpetrators' moral mindsets. https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/sexual-misconduct-in-health-and-social-care-understanding-types-of-abuse-and-perpetrators-moral-mindsets.pdf?sfvrsn=630f7420_2 (3 November 2023, date last accessed).

19. Begeny CT, Arshad H, Cuming T *et al.* Sexual harassment, sexual assault and rape by colleagues in the surgical workforce, and how women and men are living different realities: observational study using NHS population-derived weights. *Br J Surg* 2023;**110**:1518–1526.

20. NHS Employers. *Supporting NHS staff with domestic violence and abuse.* 2022. nhsemployers.org/publications/supporting-nhs-staff-domestic-violence-and-abuse (3 November 2023, date last accessed).

21. MacGregor JCD, Naeemzadah N, Oliver CL, Javan T, MacQuarrie BJ, Wathen CN. Women's experiences of the intersections of work and intimate partner violence: a review of qualitative research. *Trauma Violence Abuse* 2022;**23**:224–240.

22. British Medical Association. *Support for doctors affected by domestic abuse.* 2019. bma.org.uk/advice-and-support/nhs-delivery-and-workforce/creating-a-healthy-workplace/domestic-abuse-in-the-health-profession-report (3 November 2023, date last accessed).

23. Donovan E, Santer M, Morgan S, Daker-White G, Willcox M. Domestic abuse among female doctors: thematic analysis of qualitative interviews in the UK. *Br J Gen Pract* 2021;**71**:e193–e200.

24. Royal College of Midwives. *Safe places? Workplace support for those experiencing domestic abuse. A Survey of Midwifery Leaders, Midwives and Maternity Support Workers.* 2018. rcm.org.uk/publications/?query=safe+places (3 November 2023, date last accessed).

25. McGregor K, Stephens-Lewis D, Richards C, Gilchrist E, Taylor-Dunn H, Jones R. *An exploration of healthcare professionals' personal and professional experiences of domestic violence and abuse.* research.brighton.ac.uk/files/22350298/An_Exploration_of_Healthcare_Professionals_Personal_and_Professional_experiences_of_Domestic_Violence_and_Abuse_FINAL_.pdf (3 November 2023, date last accessed).

26. Showalter K, Bosetti R. The IPV-Wdomestic abuse: developing an abusive workplace disruptions assessment using item response theory. *J Fam Viol* 2022;**37**:1195–1205.

27. Gregory A, Howell A, Johnson M, Potter LC, Dheensa S. 'I felt paralysed to ask for help for myself': domestic abuse experienced by healthcare professionals. *InnovAiT: Education and inspiration for general practice* 2023;**16**:203–207. doi:10.1177/17557380221148770

28. Drisko J, Maschi T. *Content analysis.* Oxford: Oxford University Press, 2015.

29. Siltala HP, Holma JM, Hallman M. Family violence and mental health in a sample of Finnish health care professionals: the mediating role of perceived sleep quality. *Scand J Caring Sci* 2019;**33**:231–243.

30. Granner JR, Seng JS. Using theories of posttraumatic stress to inform perinatal care clinician responses to trauma reactions. *J Midwifery Womens Health* 2021;**66**:567–578.

31. Gates M, Wingert A, Featherstone R, Samuels C, Simon C, Dyson MP. Impact of fatigue and insufficient sleep on physician and patient outcomes: a systematic review. *BMJ Open* 2018;**8**:e021967.

32. Trade Union Congress (TUC). *Domestic violence and the workplace: A TUC survey report.* 2014. tuc.org.uk/sites/default/files/Domestic_Violence_And_The_Workplace_0.pdf (3 November 2023, date last accessed).

33. Oliver R, Alexander B, Roe S, Wlasny M. *The economic and social costs of domestic abuse: Research Report 107.* 2019. assets.publishing.service.gov.uk/media/5f637b8f8fa8f5106d15642a/horr107.pdf (3 November 2023, date last accessed).

34. McLindon E, Diemer K, Kuruppu J, Spiteri-Staines A, Hegarty K. 'You can't swim well if there is a weight dragging you down': Cross-sectional study of intimate partner violence, sexual assault and child abuse prevalence against Australian nurses, midwives and carers. *BMC Public Health* 2022;**22**:1731.

35. Brooks SK, Gerada C, Chalder T. Doctors and dentists with mental ill health and addictions: outcomes of treatment from the Practitioner Health Programme. *J Ment Health* 2013;**22**:237–245.

36. Sathanandan S, Abrol E, Aref-Adib G, Keen J, Gerada C. The UK Practitioner Health Programme: 8-year outcomes in doctors with addiction disorders. *Res Adv Psychiatry* 2019;**6**:43–49.

37. Tehrani N. Evaluation of a trauma therapy programme within emergency service organizations. *Occup Med (Lond)* 2019;**69**:559–565.

38. General Medical Council. *The state of medical education and practice in the UK workplace experiences.* 2023. gmc-uk.org/-/media/documents/somep-workplace-experiences-2023-full-report_pdf-101653283.pdf (3 November 2023, date last accessed).

39. Karuna C, Palmer V, Scott A, Gunn J. Prevalence of burnout among GPs: a systematic review and meta-analysis. *Br J Gen Pract* 2022;**72**:e316–e324.

40. Riley R, Spiers J, Chew-Graham CA, Taylor AK, Thornton GA, Buszewicz M. 'Treading water but drowning slowly': what are GPs' experiences of living and working with mental illness and distress in England? A qualitative study. *BMJ Open* 2018;**8**:e018620.

41. Owen K, Hopkins T, Shortland T, Dale J. GP retention in the UK: a worsening crisis. Findings from a cross-sectional survey. *BMJ Open* 2019;**9**:e026048.

42. Long L, Moore D, Robinson S *et al.* Understanding why primary care doctors leave direct patient care: a systematic review of qualitative research. *BMJ Open* 2020;**10**:e029846.

43. Department of Health & Social Care. *Women's health strategy for England* 2022. gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england (3 November 2023, date last accessed).

44. Varney J. *Why domestic abuse is an occupational health issue.* 2018. som.org.uk/why-domestic-abuse-occupational-health-issue (3 November 2023, date last accessed).

45. Borchers A, Lee RC, Martsolf DS, Maler J. Employment maintenance and intimate partner violence. *Workplace Health Saf* 2016;**64**:469–478.

SAFE+EQUAL

Standing strong against family violence

PLANNING BEST PRACTICE ENGAGEMENT WITH SURVIVOR ADVOCATES

"The ones that stand out to me as good engagements, are the ones that prepare you, establish a safe and supportive environment and provide the opportunity for feedback"

This guide has been co-produced with the **Safe and Equal Expert Advisory Panel,** a panel of experienced survivor advocates with diverse backgrounds, expertise and perspectives. Use this guide to plan, deliver and reflect on your engagement with survivor advocates. The guide includes our direct quotes and an engagement checklist.

Drawing on our experiences working as survivor advocates, we reflected on the things that contribute to good engagements and the things that contribute to poor engagements.

✓ Do's Things that contribute to good engagements	✗ Don'ts Things that contribute to poor engagements
"Ensuring we have all the information required to be informed. A checklist of who the audience is and what needs to be talked about." *"Take time to set up a supportive safe space."* *"By sharing your pronouns and asking what pronouns they use, you will create safe space for the survivor."* *"Providing opportunity for debriefing. Having access to a trauma informed support person from the organisation who knows us well or having the choice of bringing our own support person."* *"To be involved in the process from the beginning and of course being adequately renumerated for our time."*	*"Don't assume someone's gender by their appearance and use wrong pronouns. If you don't know what pronouns they use, just ask!"* *"When organisations take the positive feedback only and not the constructive feedback."* *"When there are no considerations in place about triggers or safe space. For example, the impact of walking into a space and being confronted with uniformed Police. That's a big trigger for me."* *"Any information can be detrimental and compromise safety. When we say we don't want our location to be disclosed, for some reason it gets disclosed anyway."*

✓ **Do's** Things that contribute to good engagements	✗ **Don'ts** Things that contribute to poor engagements
"Good engagements plan for how to manage disclosures. While we often get disclosure, this should not be the responsibility of survivor advocates."	*"Having an engagement opportunity is not an invitation into my private life or for professionals to hunt me down on social media."*
"Asking survivor advocates about triggers and boundaries and respecting those boundaries."	*"Not supporting new advocates. In the beginning I would disclose too many details of my story, there needs to be a level of understanding from the support person in where a survivor advocate is at in their journey."*
"Allow us to determine what is safe and what is not safe. Ensure you are led by us as to how to support and maintain our safety throughout the engagement."	*"Sometimes consulting with us is used like a checklist 'tick– we got their input' and they interpret our words to fit the answers they desire. That can have serious consequences."*
"Providing flexibility and allowing to be human beings – being survivors it's not just something we are reading from a book, it's something we are living."	*"Engagements that see us as only able to offer a story or case study feel tokenistic. We are more than our experiences of violence and abuse."*
"Being clear about how our information and experiences are going to be used and share –having transparency around that."	*"We don't like surprises."*
"Understanding that lived experience is not the past tense but it is continuing – even though we may not be in a violent situation, the risk factors can be high."	*"Small things can have big impacts on power imbalances. For example, providing survivor advocates sticker name tags if the other participants are not wearing them."*
"Provide clear parameters or limitations. Articulating what you want and what you don't want is a matter of respect when it comes to engagement. This doesn't mean coming with all the answers, but ensuring there is clarity on the direction, outcomes or where you hope to get to."	*"When we don't receive feedback or hear about the outcome. Too often, we are forgotten after an engagement."*

For more guidance on supporting good engagements, refer to the best practice principles of the Family Violence Experts by Experience Framework.

SAFE+EQUAL

SURVIVOR ADVOCATE ENGAGEMENT CHECKLIST

Engagements with survivor advocates can take many forms, from one off events, workshops and focus groups to longer term co-production projects. Consider the time and resourcing you have available to determine the level of engagement and degree of influence you can offer. No matter the size or type of engagement, there are steps you can take to ensure it is a positive and meaningful experience.

Before the engagement

Explain the engagement opportunity

Introduce yourself – your name, role, pronouns and organisation.

Role – Outline the role of the advocate – facilitator, participant, speaker, panel member, consultant.

Time commitment – Number of anticipated hours, including preparation.

Remuneration – Payment amount and method. Will additional costs such as childcare or travel be covered?

Privacy and confidentiality – Share any limitations to privacy and confidentiality up front.

Audience – Describe who else will be involved or attending. E.g internal stakeholders, external stakeholders, other survivor advocates. Provide information on their role in family violence work and family violence literacy and awareness.

Topics and themes – Explain the topics that will be covered and the input you are seeking.

Influence and outcomes – Explain how their input will influence outcomes, the process for providing feedback and approval before outcomes are shared.

Recording – Outline if the engagement will be recorded, how it will be shared and who with.

Feedback – Outline how the survivor advocate can provide feedback about their engagement experience, and the processes that are in place to support this.

Questions – Invite the survivor advocate to ask questions or offer their suggestions.

Project brief – Confirm this information in a written project brief provided to the survivor advocate. Refer to the *Project Brief Template*.

Discuss the survivor advocate's engagement needs and expectations.

Use the *My Engagement Needs and Expectations Form*, developed by the Safe and Equal Expert Advisory Panel, to record this information.

Experience – What kind of advocacy experience and professional development have they had prior to this engagement?

Introductions – How would they like to be introduced (e.g. as a survivor advocate, as a speaker with lived experience of family violence)? Would they like to introduce themselves and their role? Are they acting as an independent advocate, or representing a group or network?

Access requirements – Explore access or support requirements E.g Auslan interpreter, interpreter, accessibility, breaks, how do they prefer to receive information, reminders or prompts, sending slides and questions in advance, technology requirements.

Safety – Are there any legal, physical, emotional or cultural safety considerations? If so, what support or protection can your organisation put in place to support engagement?

Privacy and confidentiality – How would they like their privacy and confidentiality to be maintained (use of first or full name, use of pseudonym, visibility of email address, use of image or recordings)? Develop a privacy and confidentiality agreement, including for what purpose their information will be used and for how long.

Environment – Explore what is needed to create a safe space, whether in person or online. This could include knowing who else will be in and have power in the space, how the space is set up, where the exits are located and having an agreed way to communicate if the person is uncomfortable.

Boundaries – Explore ways to uphold the survivor advocate's personal and professional boundaries and whether there are topics or themes they are not comfortable speaking about.

Support – What type of support would the advocate find useful? Pre-briefing and debriefing, support from your organisation, from other survivor advocates or their own support person.

Pre-briefing

Written information – Confirm the purpose, participants or audience and any agreed actions to support safe engagement and when you will be in touch after the event at least seven days before the engagement. This could include a run sheet, agenda or Terms of Reference.

Pre-meeting - Depending on the nature and scope of the engagement, explore the option of meeting beforehand to collaborate on planning and meet other contributors.

During the engagement

Welcome – Welcome the survivor advocate and introduce them the way you have agreed. Acknowledge them when they first enter the room, whether it is online or in-person.

Ways of working – Whether through a Terms of Reference or group agreement, set agreed ways of working and give permission to take a break or step out of the session if needed. Remain flexible and open. Be mindful that you might need to adapt your timelines or approach to support participation.

Language - Where possible, minimise jargon, acronyms and overt displays of hierarchy.

Power dynamics – Address power and hierarchy, for example the physical set up of the space or use of titles. Check out the Experts by Experience Framework video on addressing power imbalances when working with people with lived experience of family violence.

Audience engagement –Consider how much direct contact other event attendees or meeting participants will have with the advocate during the session, and whether additional supports need to be put in place. For example, if an audience has low level family violence awareness or literacy, it may be useful to have an extra colleague available to ensure the survivor advocate is not left unsupported at any point.

Discussions - In group discussions, be intentional in asking survivor advocates to contribute. Give permission to pass or come back to a question.

Disclosures – Ensure you have a plan to respond to disclosures of family violence and communicate what supports available for all participants. It should never be the responsibility of a survivor advocate to manage disclosures when engaging with a family violence service.

Respect – Respect the survivor advocate's time and start and finish engagements on time.

Thank you – Have a clear process for what the conclusion of the engagement looks like. Thank them for their contributions and the value they brought.

After the engagement

Debrief – Check in with the survivor after the engagement. Did anything occur during the engagement that impacted them? Did anything come up that could affect their legal, physical, emotional, and cultural safety? Ensure they are comfortable with what they shared, for example, was anything disclosed that they would like edited from a recording or submission? Ensure the time for debrief or time to decompress following an engagement is remunerated.

Invite Feedback – check in how they felt it went, ask if they have feedback about the session. Could anything have been done differently or better? You might consider multiple ways to provide feedback, with the option of anonymity.

Offer feedback – share your reflections on how the engagement went, what the survivor advocate did well, the value they contributed and constructive feedback.

Next steps – Confirm next steps, including how any outcomes from the engagement will be collated and shared. Confirm the process for remuneration including when they will receive payment.

DOMESTIC
VIOLENCE
VICTORIA

THE FAMILY VIOLENCE
EXPERTS BY EXPERIENCE FRAMEWORK

Research Report and Framework 2020

THE UNIVERSITY OF
MELBOURNE

PROJECT AIM

—

THE FAMILY VIOLENCE EXPERTS BY EXPERIENCE FRAMEWORK AIMS TO ENHANCE THE ABILITY OF SPECIALIST FAMILY VIOLENCE SERVICES TO PROVIDE OPPORTUNITIES FOR SURVIVOR ADVOCATES TO INFLUENCE POLICY DEVELOPMENT, SERVICE PLANNING AND PRACTICE.

CONTENTS

PROJECT BACKGROUND

—

Ensuring the centrality of victim survivor voices and responding to the needs and experiences of clients from different communities and client groups was a key message delivered by the Victorian Royal Commission into Family Violence (Recommendation 201).

Following the Victorian Royal Commission, the Family Violence Philanthropy Collaboration Project (FVPCP) was established by Domestic Violence Victoria to bring together representatives from the specialist family violence sector, philanthropic and government sectors to support a coordinated response to the implementation of the Royal Commission's Recommendations.

This group worked with the family violence sector to identify a range of strategic areas for philanthropic investment to address some of the emerging needs of the specialist family violence sector. One of the projects funded was the development of a Lived Experience Framework for specialist family violence services.

The project was supported by Domestic Violence Victoria as part of the Family Violence Sector Capacity Building Program and generously funded by Gandel Philanthropy, the William Buckland Foundation, Give Where You Live Foundation, State Trustees Australia Foundation, the Victorian Women's Benevolent Trust and the Johnstone Gumption Fund and the Jump Start Fund, sub-funds of Australian Communities Foundation.

OUR TEAM

The University of Melbourne, supported by Domestic Violence Victoria, developed the Framework. Key Safer Families Centre researchers on the project were Professor Kelsey Hegarty, Dr Katie Lamb and Dr Rhian Parker supported by Kitty Novy.

The research was co-produced with Amanda, Cina and Fiona who are survivor advocates from the University's WEAVERS (Women and children who have Experienced Abuse and Violence: Advisors and Researchers) lived experience group.

An Advisory group oversaw the development of the framework and included representatives from a range of services supporting people experiencing family violence as well as a number of survivors.

The project team would like to acknowledge the victim survivors and practitioners who gave up their time to contribute to the framework's development. The feedback you gave us about your experiences started some fantastic conversations and has significantly influenced the Framework's design and focus.

PURPOSE

The Family Violence Experts by Experience Framework aims to enhance the ability of specialist family violence services to provide opportunities for survivor advocates[1] to influence policy development, service planning and practice by:

- Encouraging sharing knowledge and experience gained from services and survivor advocates who have been engaged in collaborative work

- Providing guidelines around best practice for engaging survivor advocates of family violence in collaborative work

- Providing resources to support survivor advocates and organisations become ready to engage in collaborative work

This framework complements the Domestic Violence Victoria (2020) Code of Practice: *Principles and Standards for Specialist Family Violence Services for Victim-Survivors*.

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[1]The term *survivor advocate* has been used throughout this document to refer to victim survivors of family violence who are engaged in formal co-production activities and mechanisms to influence policy development, service planning and practice.

OUR APPROACH

—

The development of the Framework was informed by:

- A Literature review

- Mapping existing initiatives

- Consultation with key stakeholders

LITERATURE REVIEW

In order to provide context for the development of a lived experience framework for the specialist family violence sector, a literature review was undertaken.

The research question guiding the literature review was:

What are the elements that underpin models and frameworks for co-production and participatory decision-making models on sensitive issues?

Literature for this review was sought through searches of academic databases and the internet. Key search terms used included 'participatory decision-making', 'community advisory', 'co-production', 'lived experience', 'consumer engagement' and 'service user engagement'. When literature was located that was relevant to this review, the reference lists of these documents was used to locate additional relevant references.

For the purposes of the review, co-production was defined as mechanisms which allow services and those with lived experience to come together to design policies and services that achieve better outcomes.

A summary of the key findings of this review are provided below and a full version of the literature review is provided as Appendix 1.

- There is little consistency in the way in which co-production, co-design and consultation are defined (Loeffler & Bovaird, 2016).

- It is common for the involvement of people with lived experience to be described as occurring across a continuum ranging from relatively low levels of engagement, to work that is consumer-led (Werner-Seidler & Shaw, 2019).

- Co-production is differentiated from consultation because it 'changes people from being "voices" to being agents in the design and delivery of public services' (Boyle, Coote & Sherwood, 2013, p.9)

- The underlying justification for the use of co-production is that needs are better met when people with lived experience are involved in designing and evaluating policies and services (Boyle, Coote, Sherwood, & Slay, 2013).

- Research has also found that the experience of being involved in a co-production activity can have significant positive impacts for the individual (Roper, Grey, & Cadogan, 2018).

- The review found that co-production has been occurring in some areas such as primary healthcare, mental health and Aboriginal service planning for some time.

- In contrast, other areas of social support have only recently begun to engage consumers in the design and evaluation of research, services and policy (Breault et al., 2018).

As the literature about engaging survivor advocates with lived experience of family violence was found to be quite underdeveloped, the Family Violence Experts by Experience Framework has drawn heavily from the literature which has emerged from the mental health sector. This literature was most useful given some of similarities around the sensitivities and stigma that surrounds disclosure of mental health or family violence lived experience.

It should be noted that there are some significant differences between the sectors such as the legislative powers of the mental health system and the additional safety considerations that overlay the work of the family violence sector. Regardless, we can draw upon the literature from the mental health sector to give us a sense of the key barriers and enablers to ensure more effective engagement of consumers in policy, planning and practice.

A summary of the literature is provided arranged under the key themes identified:

GENUINE RELATIONSHIP BUILDING

Regardless of the sector, the literature sugggests that the foundations for successful collaboration are strong and genuine relationships between participants which leads to richer dialogue (Clayson, Webb, & Cox, 2018). This point is particularly emphasised in work with Aboriginal communities (Hunt, 2013). The literature suggests that these relationships can take some time to build and to become comfortable and that structures built to facilitate co-production need to have adequate timelines and longevity to be most effective (Werner-Seidler & Shaw, 2019).

CLARITY ABOUT DEGREE OF INFLUENCE

It has also been suggested that some people with lived experience report feeling frustrated about the limited degree of influence they are able to exercise in co-production processes (Werner-Seidler & Shaw, 2019). The literature suggests that these concerns can be overcome if both parties are clear from the outset about the boundaries and constraints of the process.

REGULAR PROVISION OF FEEDBACK

Evidence suggests that a desire to make a difference is a key driver for why people with lived experience decide to engage in a co-production activity (Werner-Seidler & Shaw, 2019). Therefore the literature suggests that it is important participants are given regular and timely information about how their feedback has led to change.

ADDRESSING POWER IMBALANCES

A key factor to effective co-production has been described as the reduction of traditional boundaries between 'professionals' and 'service users' to allow for a more equal exchange of knowledge (Clayson et al., 2018). The litertaure suggests that for some professionals this can be challenging and experienced as an uncomfortable loss of status (Loeffler & Bovaird, 2016). It is also suggested that power and privilege can still play a role even when barriers between professionals and those with lived experience are broken down. With class, race and sexuality still acting as barriers to effective engagement and levelling of the playing field (Champeau & Shaw, 2002).

EMPOWERMENT

Research has found that some service users feel that practitioners are resistant to co-production as they have a perception that consumers are vulnerable and needing protection or don't have adequate skills to participate (Phillips & Kuyini, 2017). Service users describe providers concerns about their vulnerability as 'excessive, misplaced and patronising' (Happell et al., 2019, p. 53). Evidence suggests that the experience of being involved in co-production activities as someone from a marginalised group can have significant impacts in terms of improved self-esteem (Mayer & McKenzie, 2017).

ORGANISATIONAL SUPPORT FOR THE VALUE OF LIVED EXPERIENCE

Evidence suggests that prominent support from organisational leaders is a critical factor in promoting the status and value of co-production efforts with those with lived experience (Bennetts, 2009). The literature notes that one of the key reasons co-production is avoided by some organisations is that it is still seen as highly risky by many who fear a loss of control and the unpredictability about what a co-production process will produce or how it will land (Loeffler & Bovaird, 2016).

ESTABLISHING HEALTHY GROUP DYNAMICS

Research doccumenting feedback from participants who have participated in co-production activities often report that the social dynamics at play in the group can have a significant impact on the outcomes achieved. In particular, the need for 'respectful' engagement is a key theme and is characterised by ensuring that each person with lived experience is given an opportunity to speak and be heard (Werner-Seidler & Shaw, 2019). Several studies mentioned that 'clashes' had occurred between lived experience group members who are coming from different backgrounds and experiences. (Lazarus et al., 2014) One study described disagreement as inevitable and suggested that this became a valued and valuable part of the process leading to more discussion and debate than otherwise would have happened (Clayson et al., 2018).

COMPENSATION FOR PARTICIPATION

There are mixed views in the literature about whether those with lived experience should be provided with financial compensation for their contributions. While it is fairly common for research which is undertaken with vulnerable populations to compensate participants for their time (Head, 2009) there are no guidelines regarding co-production. Several studies with people with lived experience of mental illness found that financial compensation was not a motivating factor for involvement but a symbolic gesture of valuing and recognising contributions (Bennetts, 2009). It has been suggested that this issue is an important one in the context of the family violence sector, given we know that perpetrators of family violence often tell their victims that they are 'worthless' and actively attempt to reduce their partner's self-esteem (O'Leary & Maiuro, 2001). The literature also suggested that offering experts by experience an option for the method of payment (such as cash or vouchers) was useful for those for whom payment may impact other entitlements.

PROVIDING SUPPORT

Consultation within the mental health sector has found that providing support for people with lived experience during or after an engagement activity is important to ensure people who may have been emotionally distressed or who feel stressed by the experience, are able to discuss this (Victorian Government, 2019b).

The literature about barriers and factors which enable effective co-production in the mental health sector have been influential in the development of the Experts by Experience 'best practice principles' as has the 'Turning Pain into Power: A Charter for Organisations Engaging Abuse Survivors in Projects, Research and Service Development' developed in the United Kingdom (Survivor Voices 2018).

MAPPING CO-PRODUCTION INITIATIVES IN THE FAMILY VIOLENCE SECTOR

In Australia, as in the United Kingdom and the United States, the specialist family violence service system was built upon the foundations established by the refuge movement in the 1970s, where activists disseminated new knowledge about family violence based on their experience learning from women residents (Theobald, 2009). At this time, the issue of family violence was not a named social issue or a crime and these early activists worked alongside those who had experienced family violence to develop organisations built with collective structures. Women with personal experience of family violence played a key role in establishing services which had a focus on self-help and collective activity (Hague & Mullender, 2006). In addition, a significant number of professionals in this sector also have lived experience of violence (whether they chose to disclose this or not) (Hague & Mullender, 2006).

Internationally it has been noted that due to the success of activists, organisations and peak bodies bringing attention to the issue of family violence, the number of people seeking help and breadth of services offering support to survivors of family violence grew considerably and funding was stretched (Hague & Mullender, 2006). In Victoria over the past decade, both demand and funding levels have increased resulting in a range of changes to the way in which family violence specialist services are structured and operate (Theobald, 2011). Likewise, in the United Kingdom research has found that the demand from funders for family violence services to professionalise has conflicted with the sector's commitment to organisational collective approaches to participation (Hague & Mullender, 2006).

When exploring the degree to which survivor advocates can influence service delivery, research in the United Kingdom has found that there are 'two contrasting situations at play' (Hague & Mullender, 2006, p. 573). The first describes statutory agencies who engage in tokenistic or superficial consultation with users of services. The second situation is driven by the activist movement (Hague & Mullender, 2006) who have consistently opposed the positioning of service users as 'passive and powerless' and have used a range of approaches to document and project victim survivor voices (Holder & Putt, 2019, p. 909). However, research suggests that the resources to do this work have been difficult to secure and sustain (McCarry et al.2018). The international literature has commented that with the increase in funding, greater efficiencies and professionalisation of the response to family violence has also come with a trend for survivor advocates to be less likely to be involved in management committees, decision-making or employed as workers than in the past (Hague & Mullender, 2006). Despite this, the literature suggests that the specialist family violence sector is more focused on service user engagement than many other sectors.

Some examples of co-production initiatives in the area of family violence both nationally and internationally include lived experience advisory groups and committees, media training and advocacy programs, and peer workers. As part of the development of this framework, work was undertaken to map family violence co-production activities across Victoria. The initiatives which were identified and where available documentation was accessible are listed in **Appendix 2b and include**:

- Women's Health East – Eastern Media Advocacy 'Speaking Out Program'

- Victorian Government – Victim Survivor's Advisory Council (VSAC)

- Drummond St – iHeal Family Recovery Support Service Peer Work Model

- Safe Steps – Survivor Advocate Program

- University of Melbourne – WEAVERS lived experience group

- In Touch Multicultural Centre Against Violence – Inspire for Change: Multicultural Voices of Lived Experience

It should be noted that a significant number of these initiatives are currently inactive due to discontinuation of funding. A key challenge described by the organisations was securing long term and/or ongoing funding.

CONSULTATION

The development of the Framework was overseen by an Advisory Group which included practitioners, survivor advocates and Victorian government representatives.

A consultation process ran from **September–December 2019** with victim survivors of family violence and a broad range of services who work with clients experiencing family violence. The consultation included:

- Advisory Group meetings (22 people attended including victim survivors and practitioners)

- Online survey of victim survivors (192 responses received)

- Online survey of practitioners (26 responses received)

- Focus groups with existing survivor advocacy groups (3 groups–17 survivors)

- Interviews with key family violence services (5 individual interviews)

- Zoom focus groups with victim survivors (2 meetings with 14 survivors)

- Focus groups with practitioners (3 focus groups with 33 practitioners)

- Presentation to the Domestic Violence Victoria, Specialist Family Violence Leadership Group (15 participants)

Several consultation methods were used to increase access and participation of both victim survivors and practitioners. The consultation process was approved by a University of Melbourne Human Research Ethics Committee (Ethics ID Number: 1955355.1).

CONSULTATION WITH VICTIM SURVIVORS

Victim survivors were invited to participate in an online survey and 192 responses were received in a two-month period. Of those who responded 93% identified as female, 3% as male, 1% transgender, 1% non-binary and 2% unknown. The majority of respondents were aged 26–45 years (56%) or 46–65 years (39%) with 2% aged over 65 and 2% aged 18–25 years.

In terms of diversity, 11% of respondents indicated that English was their second language, 10% identified as LGBTIQ and 10% as having a disability and 2 respondents identified as Aboriginal and Torres Strait Islander.

At the end of the survey respondents were asked to indicate if they would like to be involved in a focus group or interview. A total of 30 respondents from the survey expressed interest and were contacted to arrange interviews and focus groups. A total of two online Zoom focus groups were run (14 victim survivors) and 3 individual telephone interviews were undertaken as not all respondents were able to attend the focus groups.

In addition, three face to face focus groups were also held with existing victim survivor groups to discuss their experiences and involvement with family violence services (17 victim survivors).

In the survey, focus groups and interviews, victim survivors were asked a range of questions about the degree of influence they believe survivor advocates currently have to influence service and policy development, their experiences of being involved in formal advisory processes as well as the kinds of activities they would like to be involved in.

We have summarised and grouped the comments from victim survivors by key theme:

OPPORTUNITIES FOR ENGAGEMENT

Victim survivors hoped that the Framework would encourage family violence (and other) services to look for greater opportunities and more innovative ways of engaging survivor advocates so that they can have an impact on service and policy planning.

Some survivors had already been engaged in providing advice and feedback and had positive experiences:

"I found it affirming and empowering to have my voice heard and to use my experience to help others. I felt that at least all the trauma I went through could be used to help others and that made it more bearable."

"Gives meaning to my experience and pain, that I am helping others. Helps healing and recovery to feel you are impacting on the bigger picture."

While a significant number of victim survivors had positive experiences as survivor advocates, others described their experiences less positively, and felt that some organisations might need a mindset shift to see the strengths rather than the deficits or vulnerabilities of survivors.

"I don't feel valued by the organisations but I hope I made a difference to other women."

"I felt that my feedback was received well and appreciated but I felt that it did not make a difference to the services."

"Quite a few assumptions are made about survivors of domestic violence, particularly around their capacity. Quite often capacity is understood as competency and the two are very different things. ...quite often there is a stigma attached to people who have experienced and survived domestic violence."

Some survivors described being involved in advisory groups where survivors were from similar backgrounds and saw a need for more diverse voices to be both sought and heard.

"I do feel that I come from a position of privilege—white, middle class, I can't speak for all survivors who don't have the resources that I do. With that privilege comes responsibility to speak out and be as vocal as I can. I am aware I don't speak for everyone."

"Minority groups don't get invited to the table and this is a failing in the system."

A number of victim survivors described a desire to make a difference as a key driver for their choice to engage in providing advice. As a result, there was a strong desire for clarity and transparency about how their advice and feedback had influenced systemic change.

"Survivors should be heard. We have valuable contributions to make... we should be reimbursed for our contribution but also get feedback on how we have helped shape practice."

COMPENSATION AND CONDITIONS

While some survivor advocates were happy to volunteer their time for one-off media engagements or advocacy, there was a general view that survivor advocates should be compensated for their time when they are engaged in consultation, advisory, project, research or ongoing advocacy work. There were a range of views about what form remuneration should take and agreement that survivor advocates should be asked what suited their individual circumstances.

"To not compensate survivors for their lived experience and expertise is not just extortionist, but it compounds their trauma (often we're unable to work 'regular' jobs due to trauma, and having no income obviously exacerbates that; especially if we're asked for our lived experience to inform the work that OTHERS get paid to do/deliver)."

It was suggested that standards be developed to ensure consistency in how survivor advocates are remunerated and reimbursed for out pocket costs (such as travel, child care and parking).

A number of survivor advocates wanted to join the family violence workforce and were interested in opportunities for skill development that could support them to move into this work in an ongoing way.

"I built confidence within myself up enough to return to work. I gained this confidence by being involved with an amazing and empowering group of women. The only negative is I wish I could do this work as my full-time job!!"

"I've had some casual positions in the sector. I wanted more of a foundation and more financial security. Being a single mum magnified all that stuff for me. The insecure nature of advocacy. Lot of us re-building from scratch and I started in the red."

THERAPEUTIC BENEFITS AND IMPORTANCE OF ADEQUATE SUPPORT

Survivors felt that being engaged in strategic planning around service responses to family violence could be both therapeutic and empowering. They welcomed opportunities to meet and support other survivors.

"I can identify with the women and I've learnt a lot, and they've got my back and I've got theirs. There's real belonging in this group. A lot of women don't have that."

"Being with people who had similar experiences. Given agency by staff who believe in us and don't mollycoddle us. Believe we have something to contribute. Even though it's a journey with no map. Women are very committed to making a difference."

It was also suggested that survivor advocates should be engaged in pairs rather than as the one person with lived experience on a panel or a governance group, to ensure a feeling of greater comfort, support and security.

Victim survivors agreed that a process of ensuring a survivor advocate is currently in a good place to participate was important. However, they thought that these discussions should focus less on 'readiness' at one point in time but on regular checking in, recognising that recovery is not a linear process. They felt that some services had a fear of engaging survivor advocates for fear of re-traumatisation but felt that if a range of support options were in place, survivors can often navigate this terrain well.

Survivors were very clear that they needed to be provided with the right level of support to ensure their participation experience was a positive one:

"People need to be very, very patient. We've been muted and we don't know how to be un-muted. Give us time and believe in us."

CONSULTATION WITH PRACTITIONERS

Practitioners who work with people experiencing family violence were also consulted in a range of ways. Three focus groups were held in late 2019 with a total of 33 practitioners. Interviews were also undertaken with five key family violence stakeholders. A workshop was run with specialist family violence services in early 2020.

An online survey was also disseminated to practitioners. A total of 26 responses were received. Of those practitioners who completed the survey 73% also had lived experience of family violence.

Across focus groups, interviews and the survey, practitioners were asked about the degree to which victim survivors are involved in service or policy design in their organisation, barriers or challenges preventing services engaging survivors in more systematic and coordinated ways as well as any examples of good practice they had seen or been involved in.

The comments made by practitioners are outlined below:

IDENTIFYING POSITIVE OPPORTUNITIES

Practitioners were supportive of engaging survivor advocates in service and policy design and generally agreed that it would improve service quality and service user experiences.

"It's incredibly important to ensure victim survivors are held at the centre of everything we do. I'm excited to hear their voices are being brought to the forefront."

While some practitioners described being involved in formal processes to engage survivor advocates in policy and service design for some time, a considerable number of practitioners suggested that current engagement with survivors of family violence around high level service planning and policy development is often ad hoc and short term.

Some practitioners saw a need for the engagement of survivor advocates in their organisation in a more systematic way.

"Experts by experience should have more influence then they currently do. They have much to offer"

CURRENT BARRIERS

Across the board, a lack of resources was described as the major barrier to doing more of this work in an ethically appropriate way:

"not having adequate funding means that women are being asked for feedback, there can be triggers… how do you manage to support them if things go on… being mindful of some of that trauma-related stuff that sits in the background"

While some practitioners believed that their organisational culture highly values the contribution of those with lived experience of family violence, there were concerns that this was not universal:

"our view of people with lived experience is they are the heart and soul of our organisation. But not all organisations do."

Several practitioners echoed the comments made by survivors that the biggest barrier to engagement of survivor advocates was:

"Cultural attitudes which elevate the opinions of university educated professionals over the lived experience of survivors."

Some organisations had considerable experience establishing and maintaining formal advisory structures and gave detailed insights into their experiences. Practitioners suggested that the initial stages of establishing these mechanisms and the process of engaging with an individual survivor advocates to discuss risks and mitigation strategies were seen as a crucial stage of the process.

Examples were given of positive engagement of survivor advocates that was genuine, supported with training and supervision, and well resourced:

"an important aspect of that was that the peer support workers were employed…from the get go, from the ground up, was an acknowledgement that this experience is worth something, it's worth something to the organisation, it's worth something to the program and its worth an incredible amount to the victim survivors accessing that program."

IMPORTANCE OF ESTABLISHING SUPPORTS, STANDARDS AND PATHWAYS

Practitioners also described being aware of engagement processes which were tokenistic, and emphasised the need to follow engagement with action even when difficult issues are raised:

"Ensuring their voices and time are valued… and acting on what they say, even if it's uncomfortable."

A number of examples were given where survivor advocates were engaged in advisory work that was not as well thought through as it could have been. Practitioners suggested that some well meaning services are inadvertently setting victim survivors up to fail by placing them in roles they are not prepared for:

"they are not given the training and support and the education or even just additional clinical supervision to deal with the triggers of that, so they end up leaving, burnt out... they get destroyed. It is endemic across the family violence sector."

A number of practitioners wanted to see clear educational pathways supported for survivor advocates so that they are equipped to do the work they are being asked to do:

"what happens with people with lived experience educational pathways...there is an expectation of government that people have a certain qualification. But they will allow people with lived experience to have a certificate."

Some practitioners gave examples where survivor advocates had not been given the support they needed to undertake the roles they had been given. One area that was focused on was the importance of establishing boundaries. A lack of role clarity was described as having the potential to lead to resentment and conflict in the workplace.

"My concern is lived experience roles are blurry and go into social worker roles. It's dangerous... and lived experience representatives can't be challenged—it is considered bullying or being mean."

CHALLENGES FOR PRACTITIONERS WITH LIVED EXPERIENCE

As anticipated, a significant number of practitioners identified as victim survivors themselves and described the challenges they faced when deciding whether to disclose their lived experience in their workplaces. A number of these practitioners expressed concerns about the impact that disclosure would have on their careers and relationships with colleagues, as a barrier to disclosing:

"I feel I have a unique perspective in contrasting my experience as both a professional as well as someone who has personally experienced family violence. I feel constrained by both family court and professional perceptions in sharing my personal story."

"I don't talk about my lived experience that often, because there is so much stigma attached."

Practitioners agreed that the development of guidelines and practical tools to support organisations who want to engage survivor advocates in policy development, service planning and improvement was an important step towards ensuring consistency and quality standards.

WORKSHOP WITH SPECIALIST FAMILY VIOLENCE SERVICES

In February 2020 a workshop was run with the Domestic Violence Victoria, Specialist Family Violence Leadership Group. The group discussed the above literature review findings, existing Victorian models, consultation findings, and draft best practice principles.

The group also participated in an interactive activity where they were asked in table groups to 'plot' a number of different engagement activities with survivor advocates on the chart below.

Some of these activities included:

- Asking clients for informal feedback about the service they had received

- Sending a survey to those using their service

- Supporting survivor advocates prepare a submission to an inquiry

- Inviting survivor advocates to sit on an advisory group

- Inviting survivor advocates to sit a governance group or board

- Engaging survivor advocates to do paid project/policy work

- Engaging survivor advocates to do unpaid project/policy work

- Paid Peer Workers

- Engaging survivor advocates to do unpaid advocacy work

- Engaging survivor advocates to do paid advocacy work

- Training victim survivors to become paid media advocates

- Training victim survivors to become unpaid media advocates

This activity resulted in a very rich discussion about the degree of survivor advocate agency and influence in current initiatives and how that might be increased. There was also acknowledgement that some activities might require additional resources to be carried out in an ethical and empowering way. These discussions have heavily informed the development of the 'models' section of the Experts by Experience Framework.

ENGAGEMENT CHART
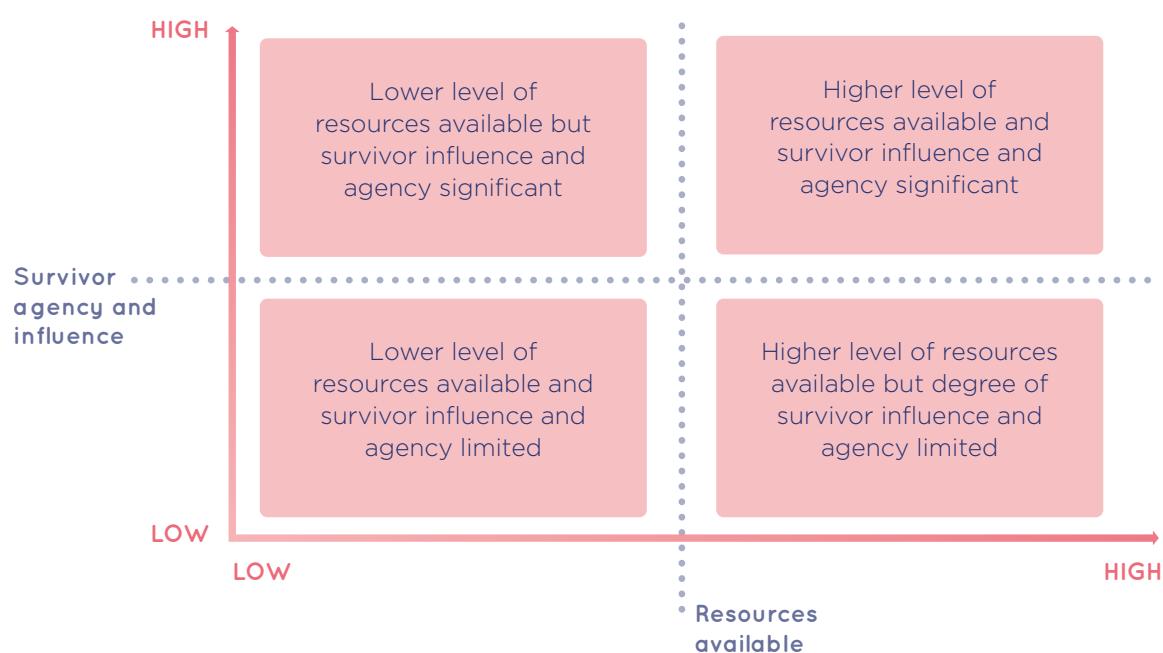
Figure 1: Engagement Activity from the Domestic Violence Victoria Specialist Family Violence Leadership Group workshop, February 2020.

THE FRAMEWORK
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The development of the Family Violence Experts by Experience Framework has been informed by the existing evidence and the considerable insights gained from both victim survivor and practitioners through the stakeholder consultation process. The Framework has been designed as an online resource where information can be updated and resources added over time. The Framework can be found at **dvvic.org.au/members/experts-by-experience**

FAMILY VIOLENCE EXPERTS BY EXPERIENCE FRAMEWORK

What does the literature tell us about effective ways to work with survivor advocates in service planning, improvement and policy development?

What did victim survivors of family violence and practitioners tell us about their experiences and expectations?

PRINCIPLES FOR BEST PRACTICE

EVIDENCE BASE

CONSULTATION

PURPOSE

To enhance the ability of specialist family violence services to provide opportunities for survivor advocates to influence policy development, service planning and practice.

MODELS

RESOURCES

What are some of the ways in which my organisation could work with victim survivor advocates to influence policy, planning and practice?

What resources are available to support my organisation work with survivor advocates in policy, planning and practice?

Figure 2: The Experts by Experience Framework

The Framework includes:

- A set of best practice principles

- Information about the evidence base on which the Framework has been built (see Appendix 1)

- Consultation summary (as outlined in section above)

- Examples of models and initiatives (Appendix 2a and 2b)

- A set of useful resources including

  - An organisational readiness checklist (Appendix 3a)

  - Victim Survivor self-reflection questions (Appendix 3b)

  - A remuneration rates template (Appendix 3c)

  - Strategies for reducing power imbalances video (Appendix 3d)

PRINCIPLES FOR BEST PRACTICE

The Experts by Experience Framework is based on the belief that responses to family violence will be most effective and safe if they are informed and developed in partnership with victim survivors. The following principles have been developed to guide collaborative processes for engaging survivor advocates by specialist family violence services. They have been developed based on consultation with victim survivors and key organisations as part of the development of the Framework and are consistent with the *Domestic Violence Victoria Code of Practice (2020)*.

RECOGNISE

Victim survivors are acknowledged as holding valuable knowledge and expertise about family violence which is reflected in organisational policies and governance structures.

SAFETY

Issues relating to legal, physical, emotional and cultural safety of survivor advocates are carefully considered but not used as a mechanism for exclusion.

VALUE

In addition to being provided with recognition for their expertise, survivor advocates will be financially remunerated for their time, contributions and expenses when they provide significant input into policy and practice.

TRANSPARENCY

There is clarity of purpose and information to support survivor advocates make participation decisions, including the degree of influence, nature of engagement and time commitments. Feedback will be given to survivor advocates about how their contribution influenced change.

ACCOUNTABILITY

Engagement with survivor advocates is subject to regular review, evaluation and accompanied by clear complaints and feedback mechanisms.

SUPPORT

Options for trauma-informed support and appropriate supervision are made available to enable survivor advocates to participate in collaboration.

TRUST

Relationships between services and survivor advocates will be collaborative and built on trust. Power imbalances are addressed by reducing traditional barriers and by genuinely involving survivor advocates in decision-making.

RECIPROCITY

Engagement with survivor advocates will promote mutuality and will be governed by shared information exchange and learning.

INCLUSION

In order to gain insight into family violence from a broad range of perspectives, efforts will be made to look for and engage diverse victim survivor voices that might not usually be heard.

SUSTAINABILITY

Formal engagement with survivor advocates is adequately resourced to allow longer term work, for partnerships to be built and key learnings to be shared across the family violence sector.

RECOMMENDATIONS

The following recommendations have been developed based on a review of the literature, consultations with victim survivors and practitioners across Victoria and with input from the project advisory group. It is also important to reiterate that these recommendations should be viewed in the context of acknowledging that the Victorian specialist family violence sector has developed and been underpinned by the lived experiences of victim-survivors of family violence since its inception. These principles support the adoption of a more formalised approach to the engagement of survivor advocates into the future.

PRIORITISE CO-PRODUCTION

There is general agreement in the literature and amongst key stakeholders that there is scope and support for greater priority to be given to engaging survivor advocates at the strategic level across the specialist family violence sector. The literature suggests that this can be most effectively achieved when organisations are adequately resourced to do this work, and embed the value of lived experience in strategic planning processes and documents.

SECURE SUSTAINABLE FUNDING

Specialist family violence services report increasingly being expected to engage survivor advocates by government and other funders. Consultations with key organisations and practitioners suggested that while there is support for this approach, these requests are not being accompanied by the additional funding needed. With resources stretched meeting serviced demand, this is described as a key barrier to the establishment or sustainability of initiatives longer term. A number of the co-production initiatives engaging survivor advocates identified in the literature and consultation which were rated highly by those in our stakeholder discussions, were only funded as short term pilots and were inactive at the time of the study due to a lack of continuous funding.

MORE CONSISTENT APPROACH

Throughout the development of this framework, mechanisms being used by the specialist family violence sector to engage survivor advocates were found but were not supported by a statewide framework or standards. The lack of a unified approach has led to a degree of inconsistency in terms of the support, remuneration and conditions survivor advocates are receiving across the sector. There is a need to learn from the specialist family violence services who have been engaging survivor advocates for some time to build our knowledge base and better support innovation and sustainable engagement of survivor advocates more broadly.

ACKNOWLEDGE SPECIALIST FAMILY VIOLENCE PRACTITIONER'S OWN SURVIVOR EXPERIENCE

It is known that a significant number of specialist family violence workers have experienced family violence. Some practitioners who were consulted for this framework development described feeling reluctant to disclose their own lived experience of family violence to their workplace for fear of negative consequences for their career. Further discussion about how to value and harness the strengths and insights of the workforce's lived experience is an area identified for future discussion and exploration.

VALUE ALL FORMS OF EXPERTISE

There is more work to be done to establish an authorising environment that supports and values different forms of experience, expertise and perspectives. This includes workplace discussions about how different forms of expertise on family violence can come together to improve outcomes. Implementing this framework re-iterates and builds on the principles and standards of the DV Vic code of practice and origins of the family violence sector valuing the lived experience voice.

ESTABLISH A SURVIVOR ADVOCATE INDUSTRY OR REPRESENTATIVE BODY

One of the key recommendations to emerge from this project is the need for a unified approach to how survivor advocates are supported, engaged and remunerated when they are engaging in contributing to service, policy and practice. It is therefore recommended that a Victim Survivor Industry or Representative Body be established.

It is recommended that this body be led and run by survivors and should:

- Act as the peak organisation for survivor advocates

- Set minimum standards around payment and conditions

- Provide learning and development opportunities

- Provide emotional support

- Connect programs and services to survivor advocates who are interested in being involved

- Play a role in advocacy

- Represent a broad range of survivor advocates of family violence and look for opportunities to better engage survivor advocates with diverse backgrounds and experience

- Support the development of a Peer Support workforce

- Coordinate responses to submissions and inquiries

- Establish a consulting model of fee for service

- Act as a point of dissemination for examples of best practice

APPENDIX 1: EVIDENCE BASE

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In order to provide context for the development of a lived experience framework for the specialist family violence sector, a literature review was undertaken to explore best practice in co-production and participatory decision-making models with service users around sensitive issues. Some of the key findings of this review are summarised below.

TYPES OF CO-PRODUCTION

The review found that there is little consistency in the way in which co-production, co-design and consultation are defined (Loeffler & Bovaird, 2016). For the purposes of the review of the literature undertaken, co-production was defined as mechanisms which allow services and those with lived experience to come together to design policies and services that achieve better outcomes.

The literature suggests that the involvement of people with lived experience can occur across a continuum ranging from relatively low levels of engagement, to work that is consumer-led (Werner-Seidler & Shaw, 2019). Co-production differs from consultation because it 'changes people from being "voices" to being agents in the design and delivery of public services' (Boyle et al. 2013). There is a considerable body of literature about participatory engagement and a number of ways of depicting and defining each level of the continuum. The diagram below is a simplified summary.

INFORM → **CONSULT** → **INVOLVE** → **COLLABORATE** → **EMPOWER**

Diagram 1: Continuum of engagement

IMPORTANCE OF CO-PRODUCTION

The underlying justification for the use of co-production is that the needs of service users are better met when people with lived experience are involved in designing and evaluating policies and services (Boyle et al., 2013). The literature suggests that existing services supporting vulnerable groups have a tendency to disempower those people who are supposed to benefit from services, which may actually entrench and perpetuate a culture of dependency (Boyle et al., 2013). Research has also found that the experience of being involved in a co-production activity as someone from a marginalised group can also have significant positive impacts for the individual (Roper et al., 2018).

SECTORS USING CO-PRODUCTION

The review found that co-production has been occurring in some areas such as primary healthcare, mental health and Aboriginal service planning for some time. In contrast, other areas of social support have only recently begun to engage consumers in the design and evaluation of research, services and policy (Breault et al., 2018).

When looking at the evidence base supporting co-production, the vast majority of work has originated in the United Kingdom (UK) health system where service user involvement and collaborations have become embedded into policy development since the 1990s. While the health context is useful in providing guidance, it is also a very different area from family violence where the issues being tackled are often more sensitive and complex (Wilson, Smith, Tolmie, & de Haan, 2015). The Australian mental health sector and Aboriginal service planning areas have seen concerted efforts to increase engagement of people with lived experience in service planning and evaluation where there are sensitivities.

Since the 1990s the mental health system has been engaging people with experience of using mental health services in a range of ways. There are many examples of co-production in mental healthcare and a growing body of knowledge which explores methods and challenges (Clayson et al., 2018). The focus on engagement of people with lived experience in the mental health system is associated with the concept of recovery, with practitioners moving from focusing on the treatment of the disease and client clinical recovery to the promotion of wellbeing and personal recovery, with consumer engagement seen as one way of furthering this goal (Foglieni, Segato, Sangiorgi, & Carrera, 2019). One significant way in which people with lived experience are engaged in the mental health service system is as paid peer support workers, with over 300 of these roles currently funded across Victoria.

The literature (Byrne, Roennfeldt, & O'Shea, 2017) suggests that some of the biggest challenges that faced the introduction of lived experience work in the mental health sector have been:

- professional defensiveness

- attitudes of mental health practitioners

- scepticism regarding the value of lived experience workers

- challenges in gathering formal evidence of efficacy to secure ongoing funding

For some years Australian state and federal governments have recognised that policy and service planning for Aboriginal people is complex due to factors such as colonisation, politics, geography and socio-economic marginalisation (Dreise & Mazurski, 2018). In response they have recognised that more effective outcomes can be achieved if the Aboriginal community is involved in problem solving and self-determination (Victorian Government, 2019a). While efforts to engage the Aboriginal community have occurred, the literature suggests that early efforts were tokenistic consultations which have little impact on service design or responses (Corrigan & Burton, 2014).

More recently it has been acknowledged that consultation alone is not adequate and we can see examples of co-production where Aboriginal people are engaged in designing services, such as the Victorian Aboriginal Maternal Child Health Initiative (Victorian Government, 2017) and antenatal services (Beaumont, 2019).

When looking at the literature about effective co-production across a range of settings including the mental health sector, some key principles emerge and are summarised below:

GENUINE COMMITMENT

The literature suggests that any co-production activity needs to be supported by organisational leaders who promote the view that people with lived experience have a range of valuable skills and knowledge (Boyle, Coote, Sherwood, & Slay, 2013). A lack of organisational commitment has been described as a key challenge or barrier to effective engagement (Byrne et al., 2017).

TRANSPARENCY

It is well-documented that a key driver for why people with lived experience decide to engage in a co-production activity is a desire to make a difference (Werner-Seidler & Shaw, 2019). It is therefore important that participants are given information about the scope, constraints and degree of influence their views are likely to have and also how their feedback has led to change.

RELATIONSHIP BUILDING

Regardless of the sector in which the co-production is occurring, the foundations for successful collaboration appear to be built upon strong and genuine relationships (Clayson et al., 2018). The literature emphasises these relationships can take some time to build and that structures to facilitate co-production need to have adequate timelines and longevity to be most effective (Werner-Seidler & Shaw, 2019, p. 1637). Another key factor underpinning successful co-production is the ability to reduce traditional boundaries between 'professionals' and 'service users' (Boyle et al., 2013). This allows for power differentials to be reduced and a more equal exchange of knowledge (Clayson et al., 2018).

COMPENSATION FOR PARTICIPATION

There is a considerable body of literature about whether people with lived experience should be paid financial compensation for their involvement in co-production activities and there are multiple views. Several studies have found that financial compensation is not a motivating factor for involvement for those with lived experience, but rather something that was appreciated as symbolic of being valued and recognised (Bennetts, 2009). The literature suggests that offering recompense to participants for their time, input and costs incurred can be effective in contributing to reducing power imbalances.

PROVIDING SUPPORT

The provision of support for people with lived experience is described as particularly important when the issues being discussed and addressed are of a sensitive nature or emotionally distressing. The literature suggests that debriefing for both those with lived experience and those working with these groups is important to ensure the maintenance of boundaries, promote self-care, prevent burnout and ensure the experience is a positive one.

APPENDIX 2A: MODELS OF ENGAGEMENT

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There are a range of ways in which survivor advocates of family violence can be engaged to influence policy development, service planning and practice. In the following section, examples are given about how each activity could be carried out in a way that align with the Framework best practice principles. This list of activities is designed to be illustrative but not exhaustive. It is important to consider that each of the activities listed below provide survivor advocates with a varied degree of agency and influence and require a different level of resourcing.

Activity	Degree of survivor advocate agency and influence	Some examples of how to ensure engagement activities align with the best practice principles
Employ survivor advocates as peer workers Survivor advocates are paid and employed by family violence services to provide support to other victims of family violence navigating the service system.	High	Organisational and strategic planning documents will acknowledge the valuable knowledge and expertise that survivor advocates have, with an emphasis on the benefits of their engagement in terms of mutual information exchange and learning. **(Recognise + Reciprocity)** Survivor advocates will be provided with clear position descriptions and understanding of their role and its limitations, and support to develop the key skills to perform their role. **(Transparency + Reciprocity)** A diverse range of survivor advocates are sought to bring an intersectional lens to peer worker roles. **(Inclusion)** Careful consideration is given to how to reduce power imbalances between survivor advocates and other employees. **(Trust)**
Allocated victim survivor positions on governance groups and boards Positions on the boards of family violence services and peak bodies are designated for 2 or more victim survivors who are paid and who contribute to organisational strategic planning.	High	Reservation of positions for victim survivors on governance groups and boards are established in organisational policies and procedures so that the initiative is sustained regardless of leadership changes. **(Sustainability)** Victim survivors who express interest in joining governance groups or boards will be provided with clarity about how they will be remunerated, tenure, time commitments and scope of their involvement. **(Transparency + Value)** Victim survivors will be provided with the emotional support and opportunities for skill development they need to prepare for and participate in governance structures and understand their legal responsibilities. **(Support + Reciprocity)** A diverse range of voices is sought to participate on boards and other governance groups to ensure an intersectional lens on lived experience can be obtained. **(Inclusion)** Careful consideration is given to how to reduce power imbalances between victim survivors and other members of the group (such as ensuring there is more than one survivor representative). **(Trust)** Survivor advocates will be involved in regular reviews and evaluations of their experience being a member of the board or other governance group. **(Accountability)**

Activity	Degree of survivor advocate agency and influence	Some examples of how to ensure engagement activities align with the best practice principles
Involve Survivor Advocate in organisational strategic planning Family violence services formally engage victim survivors to contribute to and shape organisational policies, procedures and practice.	High	Organisational and strategic planning documents will acknowledge the valuable knowledge and expertise that survivor advocates have, with an emphasis on the benefits of their engagement in strategic planning in terms of mutual information exchange and learning. **(Recognise + Reciprocity)** Survivor advocates will be provided with the emotional support and opportunities they need to prepare for and perform their role and understand their legal responsibilities. **(Support + Reciprocity)** Survivor advocates who are engaged in strategic planning processes will have genuine influence and opportunities to influence decision making. **(Trust)**
Include survivor advocates in advisory or working groups Survivor advocates are invited to become involved in advisory and working groups established to support organisational policy and service development or to support specific projects.	Medium	Victim survivors who are invited to participate in advisory groups will be provided with clarity about how they will be remunerated, tenure, time commitments and scope of their involvement. **(Transparency + Value)** Victim survivors will be provided with the emotional support and opportunities for skill development they need to prepare for and participate in these groups. **(Support + Reciprocity)** A diverse range of voices are sought to participate on advisory and working groups to ensure an intersectional lens on lived experience can be obtained. **(Inclusion)** Survivor advocates who are engaged in advisory and working groups will have genuine influence and opportunities to influence decision making. They will also be involved in regular reviews and evaluations of their experience being engaged in the advisory or working group **(Trust + Accountability)**
Involve survivor advocates in project/ policy work Survivor advocates are invited to become involved in policy and project work to support organisational policy and service development or to support specific projects.	Medium	Organisational and strategic planning documents will acknowledge the valuable knowledge and expertise that survivor advocates have with an emphasis on the benefits of their engagement in terms of mutual information exchange and learning. **(Recognise + Reciprocity)** Survivor advocates will be provided with clarity around their role in project or policy work. They will also be provided with the emotional support and opportunities to develop the key skills needed to perform their role. **(Transparency + Support + Reciprocity)** Careful consideration is given to how to reduce power imbalances between survivor advocates and other employees they will interact with. **(Trust)**

Activity	Degree of survivor advocate agency and influence	Some examples of how to ensure engagement activities align with the best practice principles
Media advocates Survivor advocates are supported to safely and effectively share their personal stories and raise awareness of family violence with a range of media audiences.	Medium	Survivors who express interest in becoming media advocates will be provided with clarity about how they will be remunerated, tenure, time commitments and scope of their involvement. **(Transparency + Value)** Survivor advocates will be provided with the emotional support and opportunities for skill development they need to prepare for and become media advocates. **(Support + Reciprocity)** Considerations relating to the legal, physical, emotional and cultural safety of victim survivors are carefully considered and survivor-led, with guidance available via the **self-reflection questions (Safety)** A diverse range of voices are sought to participate as media advocates to ensure an intersectional perspective on lived experience is gained. **(Inclusion)** Processes that involve the engagement of survivor advocates will be regularly reviewed and evaluated. **(Accountability)**
General advocacy Survivor advocates are supported to safely and effectively share their personal stories with a range of community audiences to raise awareness and to advocate for the service they are engaged with, or for improved responses to family violence.	Low/Medium	Survivor advocates will be remunerated and will be provided with clarity about the time commitments required, costs that will be covered and scope of their involvement. **(Value + Transparency)** Survivor advocates will be provided with the emotional support and opportunities for skill development they need to prepare for their advocacy role. **(Support)** Considerations relating to the legal, physical, emotional and cultural safety of victim survivors are carefully considered and survivor-led, with guidance available via the **self-reflection questions**. **(Safety)** A diverse range of voices are sought to participate as advocates to ensure an intersectional perspective on lived experience is gained. **(Inclusion)**
Support survivor advocates prepare a submission to an inquiry At times an organisation may be preparing a submission to a government inquiry or review and will seek survivor stories, experiences and input to develop that submission.	High	Victim survivors are provided with remuneration for their time and the legal, emotional and cultural support they need to participate. **(Support + Value)** A diverse range of survivor voices are sought and engaged. **(Inclusion)** The necessary resources are provided to assist the survivor advocates prepare the submission while ensuring the shape and focus of the submission is heavily informed by the survivors' voices. **(Recognise + Trust)**

Activity	Degree of survivor advocate agency and influence	Some examples of how to ensure engagement activities align with the best practice principles
Formal feedback about the service All clients who have accessed a service will be asked for their feedback on the service they have attended. This may be via an online survey or phone interview.	Low	Victim survivors will be involved in designing feedback questions and surveys and will receive feedback about the issues raised and how this feedback has influenced practice. **(Transparency)**
Informal feedback about the service Family violence organisations regularly ask clients for feedback about how they feel their needs are being met and suggestions for how the service offering could be improved. Sometimes this will be done face to face or via anonymous suggestion box.	Low	Clients will receive feedback about how their suggestions influenced practice. **(Transparency)**

APPENDIX 2B: EXAMPLES OF INITIATIVES
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University of Melbourne, WEAVERs

WEAVERs is an initiative of the University of Melbourne's Research Alliance to End Violence against women and their children (MAEVe) and was established in 2016. The WEAVERs initiative was developed to ensure that the voices of women and children who have experienced family violence could influence the research agenda. The role of the WEAVERs is to advise MAEVe on areas of research and research design, which may include co-design and input into methodologies and undertake research in collaboration with MAEVEs Academic team.

WEAVERs also develop and carry out research on topics they determine and are provided with support to develop the skills they need to develop research questions, carry out data collection, undertake data analysis and write up findings. WEAVERs regularly present at research events, forums, and conferences.

Victorian Government, Victim Survivors' Advisory Council

Following the Royal Commission into Family Violence in Victoria, a **Victim Survivors' Advisory Council (VSAC)** was developed and supported by the Victorian government to ensure victim survivors of family violence are engaged in the implementation of recommendations. VSAC's role is to:

- Place people with lived experience at the centre of family violence reform.

- Include people who have experienced family violence in service design of family violence reforms.

- Advise on how family violence reform initiatives will impact on people who use services.

- Ensure the government's response to the recommendations of the Royal Commission into Family Violence meets the expectations of people with lived experience.

- Ensure advice to the government reflects the diversity of the family violence experience.

- Provide advice on specific issues requested by the Family Violence Committee of Cabinet and/or the Family Violence Steering Committee.

VSAC members are appointed for two years and are supported by members of the Secretariat who are situated in Family Safety Victoria. The first term of operation of VSAC has recently been evaluated.

Safe Steps Survivor Advocates

Safe Steps is the Victorian statewide response service for women, children and young people experiencing family violence. It provides a 24 hour response line, undertakes risk assessments, arranges access to emergency accommodation, provides emotional support and advocacy. Since 2007 Safe Steps has been running a **Survivor Advocate Program**. This was designed to empower women who have a lived experience of family violence to safely and effectively share their personal stories, and raise awareness of family violence and specialist family violence services with a range of community and media audiences. Safe Steps provides up to three days of training and ongoing support to women, equipping them with skills to effectively engage with the media and present at other events. Safe Steps regularly connects with advocates to offer debriefing and also to seek feedback about their experience of being involved in the program.

Women's Health East, Speaking Out Program

In 2011 Women's Health East initiated the Eastern Media Advocacy Program (EMAP), 'Voices for Change' (which became the **Speaking out Program**) in recognition that women who are directly impacted by violence have important insight into what needs to change in order to end violence against women. The initiative aims to ensure that the voices of women who have experienced family violence and sexual assault are heard in a range of contexts including in advocacy, consultation, submissions to inquiries, the media and at public events. The program supports women to gain the skills necessary to do this work. This project was evaluated and it was found that it had a positive impact on the self-confidence, knowledge and skills of survivor advocates as well as increasing the quality of media reports about family violence and sexual assault. The project produced an implementation guide which is a useful resource for anyone wanting to introduce a media advocacy program for those with lived experience of family violence.

inTouch, Inspire for Change

inTouch, the Multicultural Centre Against Family Violence established an advisory group **Inspire for Change: Multicultural Voices of Lived Experience** in 2018. It comprises past clients to inform the current family violence reforms and advise various stakeholders on different issues relating to family violence. The group informs inTouch projects and programs as well as advocating for systemic changes. The group members provide expert advice based on their lived experiences in the prevention and response of violence against women and children, and are appointed for 12 months.

Drummond St, iHeal Family Violence Recovery

The **iHeal Family Violence Recovery Support service** was a recovery peer work model informed by findings from the Royal Commission into Family Violence that survivors needed longer-term recovery support after leaving family violence situations. The iHeal model was developed and trialled for people from diverse communities, namely Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) communities, CALD communities, and people living with a disability. People from these diverse communities who had a lived experience of family violence were recruited and employed as Recovery Support Workers (RSWs). They provide case work and advocacy to other survivors to provide support around the things that survivors identified as barriers to recovery. These include help navigating complex systems such as court, child protection, mental health, housing, alcohol and other drugs (AOD) services, education and employment and assistance with a range of other diverse needs.

APPENDIX 3A: ORGANISATIONAL READINESS CHECKLIST

The following checklist provides guidance for organisations who are considering engaging people with lived experience of family violence (experts by experience) in the co-design of services and policies. The checklist is designed to be appropriate for a broad range of activities including introducing people with lived experience on boards and other governance groups, or establishing advisory groups.

	Yes	No	Working towards
Governance and Leadership			
Does your organisation have a clear commitment to engaging survivor advocates in the organisation's strategic plan?			
Does your organisation have values and a culture that is consistent with the principles of the **Experts by Experience Framework?**			
Does your organisation have a commitment to making changes to your policies and practice based on input from survivor advocates?			
Has your organisation explored a range of models to ensure you can maximise the degree of influence and engagement of survivor advocates?			
Resourcing & Training			
Do you have funding for a coordinator role to work with the experts by experience?			
Is your organisation able and willing to value the contribution of experts by experience and provide them with remuneration and/ or cover out of pocket expenses?			
Will paid training or induction be provided to experts by experience to develop the necessary skills to carry out the work?			
Workplace Safety & Inclusion			
Do organisational strategies to ensure a healthy and safe workplace extend to and protect experts by experience?			
Does the organisation operate in a trauma-informed way?			
Does the organisation demonstrate diversity and inclusive practice, including ensuring the engagement of experts by experience is resourced for and accessible to people who need interpreters, translators and/or who have a disability?			

	Yes	No	Working towards
Recruitment			
Is your organisation equipped to support victim survivors to weigh up the benefits and challenges of participating? Read **self-reflection questions.**			
Has the organisation thought about how experts by experience will be recruited, to ensure a range of diverse perspectives will be included (including ensuring the process is resourced for and accessible to people who need interpreters, translators and/or those who have a disability)?			
Has the organisation given consideration to what type of induction process might be provided to survivor advocates to ensure they are clear about their rates of pay, conditions, tenure and legal liabilities?			
Procedures			
Has the organisation put in place appropriate supervision, support and ongoing professional development for the safety and wellbeing of the survivor advocates?			
Has your organisation thought through how you will put in place protections around confidentiality, privacy and safety and how you will work with survivor advocates to regularly review arrangements put in place?			
Has the organisation put in place appropriate training, supervision, support and professional development for *workers* supporting the experts by experience?			
Has advice been sought to determine whether survivor advocates are covered by your organisation's insurance policies and legal service?			
Accountability			
Has your organisation established formal feedback mechanisms so that experts by experience are clear about how their engagement with the organisation has influenced change?			
Are there clear formal processes for victim survivors to provide their perspective on how the engagement is working as well as express complaints or concerns?			
Has your organisation established a process for regularly evaluating the initiative?			
Other Considerations			
If your organisation does not have conditions in place and resources to engage experts by experience, have you considered partnering or developing formal memorandums of understanding with other organisations who do?			

APPENDIX 3B: EXPERTS BY EXPERIENCE SELF-REFLECTION QUESTIONS

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This series of questions has been developed to support family violence victim survivors decide whether they would like to be formally engaged as a survivor advocate. These questions might provide useful guidance for discussions between an organisation and a survivor during the recruitment process. **A checklist to determine organisational readiness is also available.**

READINESS TO UNDERTAKE THE WORK

- What are my reasons for wanting to participate as a survivor advocate?

- Do I really want to participate or am I feeling that I should?

- Am I ready to talk about my own personal experiences if required?

RESOURCES NEEDED

- Do I have enough resources in place both personally and professionally to do the work required as an expert by experience?

- What support will I need to ensure my health and wellbeing is not negatively impacted by participation?

- How will I manage the emotions associated with talking about family violence?

- What strategies will I use if someone reacts negatively or judgmentally to my expertise?

SAFETY CONSIDERATIONS

- Is it safe for me to participate?

- Are there any ongoing risks posed by the person who abused me?

- Are there protections that can be put in place to increase my safety?

- Do I know if this organisation has procedures in place to record and remember the safety protections I want to put in place?

BOUNDARIES

- How will I ensure my personal and professional boundaries are upheld?

- What are my personal limits regarding what I am happy to contribute as a survivor advocate?

- Am I clear about the limitations of this role and who I am able to represent when I speak publicly?

LEGAL CONSIDERATIONS

- Am I involved in any ongoing legal proceedings that may be jeopardised by participating as an expert by experience?

- Are there any potential legal consequences of being an expert by experience?

- Am I clear about how I would make complaints or provide feedback about my involvement with this organisation?

PRIVACY

- What information am I ready to share and what information do I want to keep private?

- How do I feel about colleagues or family members finding out about my experiences?

- Do I want to participate in this work anonymously?

- Am I able to use my own name or do I want to develop a synonym?

- Is it ok for photos to be used of me in promotional materials or online?

OTHER CONSIDERATIONS

- Are there people in my life who need to be aware of my decision to be an expert by experience?

- How might my children or family feel about my decision to participate? What might the impacts of this decision be for them?

- How might my community feel about and react to my decision to participate? How might their responses impact me?

APPENDIX 3C: REMUNERATION RATES

One of the Best Practice Principles of the *Family Violence Experts by Experience Framework* focuses on the importance of valuing the contributions and expertise of survivor advocates. One of the other principles emphasises the importance of being transparent when providing information about participation opportunities.

One way in which transparency can be achieved is by ensuring that your organisation provides remuneration in a way that is clear and consistent. An example of the type of document you might like to develop for your organisation is outlined below.

Level of engagement	Remuneration	Mechanisms of engagement	Rate	Specify costs covered (travel, child care, taxi, meals etc)
Co-production	Sitting fee	• Positions on boards and/or other governance structures		
Co-production	Salary	• Paid Peer Support Workers		
Co-production	Hourly rate	• Contribute to organisational strategic planning		
Collaborate	Hourly rate	• Represent the experts by experience perspective on Steering Committees, Advisory Committees, Working Groups • Program and project involvement • Invited Speaker at an event		
Involving	Hourly rate	• Reviewing or contributing to research or project work • Promoting a service publicly • Media advocates • General advocacy work		
Consulting	Hourly rate	• Participation in consultation activities such as focus groups, consultative workshops and interviews (in person or via phone)		
Informing	None	• Attend an event as an audience member • Formal client feedback (eg. complete survey) • Informal client feedback		

Before you set your payment rates, it might be useful to look at the consumer participation rates set by other organisations, for example:

The Consumer Cost Model – Victorian Comprehensive Cancer Centre
https://www.viccompcancerctr.org/about-vccc/consumer-engagement/resources/consumer-cost-model

The National Mental Health Commission - Paid Participation Policy
https://www.mentalhealthcommission.gov.au/getmedia/affffd63-8100-4457-90c7-8617f2d3c6d6/Paid-Participation-Policy-revised-March-2019

Social, Community, Home Care and Disability Services Industry Award 2010
https://www.fairwork.gov.au/pay/minimum-wages/social-and-community-services-industry-pay-rates

More information about legal considerations of engaging consumer representatives can be found at the **Not for Profit Law – Justice Connect website**
https://www.nfplaw.org.au/sites/default/files/media/Payments_to_consumer_representatives_Cth.pdf

APPENDIX 3D: ADDRESSING POWER IMBALANCES
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We asked the University of Melbourne WEAVER survivor advocates for their ideas about how to address power imbalances when working with people with lived experience of family violence.

The video can be accessed online at dvvic.org.au/members/experts-by-experience.

REFERENCES

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Beaumont, T. (2019). Co-designing an antenatal physiotherapy education session with Aboriginal consumers: a pilot study. *Australian Indigenous Health Bulletin, 19*(3).

Bennetts, W. (2009). *Developing good practice guidelines for a sustaimable consumer workforce in the mental health sector, through participatory research*. Retrieved from Victoria:

Boyle, D., Coote, A., Sherwood, C., & Slay, J. (2013). *Right Here Right Now: Taking Coproduction into the mainstream*, . Retrieved from United Kingdom:

Breault, L., Rittenbach, K., Hartle, K., Babins-Wagner, R., Beaudrap, C., Jassaui, Y., . . . Mason-Lai, P. (2018). People with lived experience (PWLE) of depression: describing and reflecting on an exaplicit patient engagement process within depression research priority setting in Alberta, Canda. *Research Involvement and Engagement*, 4.

Byrne, L., Roennfeldt, H., & O'Shea, P. (2017). *Identifying barriers to change: the lived experience worker as a valued membver of the mental health team*. Retrieved from Queensland:

Champeau, D., & Shaw, S. (2002). Power, Empowerment, and Critical Consciousness in Community Collaboration: Lessons from an Advisory Panel for an HIV Awareness Media Campaign for Women. . *Women & Health*, 36(3), 31–50.

Clayson, A., Webb, L., & Cox, N. (2018). When two worlds collide: critical reflection on co-production. *Drugs and Alcohol Today*, 18(1), 51–60.

Corrigan, N., & Burton, J. (2014). *Partnership Training Manual: Creating Change Through Partnerships*. Retrieved from SNAICC: **https://www.snaicc.org.au/wp-content/uploads/2015/12/03346.pdf**

Domestic Violence Victoria (2020). *Code of Practice: Principles and Standards for Specialist Family Violence Services for Victim-Survivors*. 2nd Edition. Melbourne: DV Vic.

Dreise, T., & Mazurski, E. (2018). *Weaving Knowledges: Knowledge exchange, co-design and community-based participatory research and evaluation in Aboriginal communities*. Retrieved from New South Wales:

Foglieni, F., Segato, F., Sangiorgi, D., & Carrera, M. (2019). Evaluating Co-production in Mental Health Services as a Support for Co-design Activities. In M. Pfannstiel & C. Rasche (Eds.), *Service Design and Service Thinking in Healthcare and Hospital Management*. Switzerland: Springer.

Hague, G., & Mullender, A. (2006). Who Listens? The Voices of Domestic Violence Survivors in Service Provision in the United Kingdom. *Violence Against Women, 12*(6), 568–587.

Happell, B., Gordon, S., Bocking, J., Ellis, P., Roper, C., Liggins, J., . . . Platania-Phung, C. (2019). "Chipping away": non-consumer researcher perspectives on barriers to collaborating with consumers in mental health research. *Journal of Mental Health*, 28(1), 49–55.

Head, E. (2009). The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology, 12*(4), 335–344.

Holder, R., & Putt, J. (2019). Research collaborations between women's specialist services Aboriginal women and researchers. *Qualitative Social Work, 18*, 908–925.

Hunt, J. (2013). *Engaging with Indigenous Australia—exploring the conditions for effective relationships with Aboriginal and Torres Strait Islander communities*: Australian Institute of Health and Welfare.

Lazarus, L., Shaw, A., LeBlanc, S., Martin, A., Marshall, Z., Weersink, K., . . . Tyndall, M. (2014). Establishing a community-based participatory research partnership among people who use drugs in Ottawa: the PROUD cohort study. *Harm Reduction Journal, 11*(26).

Loeffler E, & Bovaird, T. (2016). User and Community Co-Production of Public Services: What Does the Evidence Tell us? . *International Journal of Public Administration, 39*, 1006–1019.

Mayer, C., & McKenzie, K. (2017). '. . .it shows that there's no limits': the psychological impact of co-production for experts by experience working in youth mental health. *Health and Social Care in the Community, 25*(3), 1181–1189.

McCarry, M., Larkins, C., Beerry, V., Radford, L., & Stanley, N. (2018). The Potential for Co-production in Developing Violence against Women Services in Wales. *Social Policy & Society*, 17(2), 193–208.

O'Leary, K., & Maiuro, R. (2001). Psychological Abuse in Violent Domestic Relations. In. New York: Springer.

Phillips, D., & Kuyini, A. (2017). Consumer participation at Specialist Homelessness Services: Do the homeless have a say in the services they receive? *International Social Work, 61*(6), 1095–1115.

Roper, C., Grey, F., & Cadogan, E. (2018). Co-production- Putting principles into practice in Mental health contexts. **https://healthsciences.unimelb. edu.au/__dat/assets/pdf_ file/0007/3392215/Coproduction_ putting-principles-into-practice.pdf**

Turning Pain into Power: A Charter for Organisations Engaging Abuse Survivors in Projects, Research & Service Development'. United Kingdom. **https://survivorsvoices.org/charter/**

Theobald, J. (2009). Contructing a Feminist Issue: Domestic Violence and the Victorian Refuge Movement. *Parity, 22*(10), 12–14.

Theobald, J. (2011). *A history of the Victorian Women's Domestic Violence Services Movement: 1974–2005*. (Doctor of Philosophy). RMIT University, Australia.

Victorian Government. (2017). Aboriginal Maternal and Child Health Initiative. Retrieved from **https://www.education. vic.gov.au/childhood/providers/ funding/Pages/amchigrants.aspx**

Victorian Government. (2019a). Victorian Government Aboriginal Affairs Report. Retrieved from **https://www. aboriginalvictoria.vic.gov.au/victorian- government-aboriginal-affairs- report-2019**

Victorian Government. (2019b). Mental Health Lived Experience Engagement Framework. Retrieved from **https://www. dhhs.vic.gov.au/publications/mental- health-lived-experience-engagement- framework**

Werner-Seidler, A., & Shaw, F. (2019). The Social and Emotional Impact of Involving Individuals with Mental lllness in the Research Process. *Qualitative Health Research, 29*(11), 1634–1640.

Wilson, D., Smith, R. T., J, & de Haan, I. (2015). Becoming Better Helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence. Policy Quarterly, 11(1).

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