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Breaking the silence

The prevention of
gendered violence in
healthcare settings

Evaluation report
May 2025



Authors: Gosia Mikołajczak, Annabelle Cleary, Yuan-Hsi Liao, Natalie Barr, Michelle Ryan and Becca Shepard.

We are grateful to Marian Baird for her valuable contributions to this report.

This report was prepared for the Health and Community Services Union.

The *Breaking the Silence* project is supported by WorkSafe Victoria's WorkWell Respect Fund, which supports initiatives that integrate policies, training, and educational resources to reduce harm caused by work-related gendered violence.

The project's academic research partners are The Global Institute for Women's Leadership (GIWL) at the Australian National University, and the University of Sydney.

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Executive summary

This report evaluates the effectiveness of the training delivered within the Healthcare and Community Services Union (HACSU) 'Breaking the Silence' project, supported by WorkSafe Victoria's WorkWell Respect Fund.

The evidence summarised in this report indicates that the training improves workers' knowledge and skills in identifying and responding to work-related gendered violence and that most respondents view the training positively.

While the pilot training modules were generally well received, several areas for improvement were identified to enhance their overall effectiveness:

- **Tailor the training content** to more closely reflect the specific experiences and challenges faced by staff in the healthcare sector.
- **Integrate evaluation into the training process** to collect more comprehensive data, enabling a better assessment of the training's impact across different employee groups and the measurement of intermediate outcomes, such as employees' sense of safety.
- **Adopt a holistic approach** to addressing work-related gendered violence by embedding the training within broader organisational changes, including updated policies and reporting procedures.

Based on these findings, we provide recommendations for minimum training standards and broader measures to address gendered violence in the Victorian healthcare sector.

Background



As 78% of the Victorian health sector workforce are women, gendered violence—in particular sexual harassment—is a crucial point for study”

The Health and Community Services Union (HACSU) project, *Breaking the Silence: Prevention of Gendered Violence in Healthcare Settings*, is a pioneering initiative aimed at addressing gendered violence in the disability and mental health sectors.

This project was launched in response to the growing concerns about the safety of healthcare workers in Victoria. WorkSafe Victoria’s *Mental Health Strategy 2021–2024* identified the healthcare sector as high-risk for psychosocial hazards such as excessive workload and pressure, workplace violence and bullying, and fatigue.

As 78% of the Victorian health sector workforce are women (Victorian Government Department of Health, 2021), gendered violence—in particular sexual harassment—is a crucial point for study.

The following definitions of gendered violence and sexual harassment have been adopted in the project:

Work-related gendered violence can be defined as “any behaviour, directed at any person, or that affects a person because of their sex, gender, sexual orientation or because they do not adhere to socially prescribed gender roles, that creates a risk to their health and safety” (WorkSafe Victoria, 2022)

Workplace sexual harassment “is a common form of work-related gendered violence where a person makes an unwelcome sexual advance, or an unwelcome request for sexual favours, to the other person, or engages in any other unwelcome conduct of a sexual nature in relation to the other person” (WorkSafe Victoria, 2022).

A broader review of the available evidence (Mikołajczak et al., 2024) found that work-related gendered violence is widespread in the Victorian healthcare sector, with serious impacts on employees' physical and mental well-being, financial stability, job performance, and the overall quality of care. As Victoria's largest workforce — employing one in ten working Victorians — the healthcare sector is under increasing pressure to expand in response to rising demand for mental health and disability services. However, high employee turnover rates pose a major challenge to meeting this demand. Addressing gendered violence is therefore not only a critical workplace safety issue — ensuring workers are safe, respected, and supported — but also a broader economic and social imperative.

Existing research highlights staff training as a critical strategy for the prevention and management of work-related gendered violence (Abbott & Whitley, 2023; Boyle et al., 2007; De Cieri et al., 2023; Koritsas et al., 2009; Liu et al., 2019; Newbury-Birch et al., 2017; Sheppard et al., 2022; Still, 2022). There is growing evidence that sexual harassment training can effectively improve healthcare workers' knowledge and awareness of the issue (e.g., Tallutondok et al., 2023).

An important caveat, however, is that staff training should not be viewed as a standalone solution. While valuable, it is only effective when implemented as part of a broader organisational strategy that includes clear policies, robust complaint management processes and responses, and a supportive workplace culture (e.g., Gruber & Smith, 1995). When embedded within a comprehensive prevention framework, staff training becomes a vital link between gendered violence policies and positive workplace outcomes (Reese & Lendenburg, 2003).

This report evaluates the effectiveness of the training delivered through the project and offers recommendations for future training, and for policy and practice aimed at preventing and addressing work-related gendered violence in the healthcare sector.

Training overview

The training delivered through the project aims to equip workers in the mental health and disability services sectors with best-practice approaches to responding to gendered violence.

The training was facilitated by two external providers: Women's Health Victoria and Phoenix Australia.

Women's Health Victoria (WHV) delivered two training modules: *Active Bystander*, which focuses on empowering training participants to safely intervene when witnessing inappropriate behaviour; and *Responding to Disclosures: Safe and Supported in the Workplace (SSW)*, which provides guidance on how to appropriately and sensitively respond to disclosures of gendered violence within the workplace.

Phoenix Australia delivered a tailored online module on Vicarious Trauma, specifically designed to meet the needs of mental health and disability workers. This module was informed by input from HACSU and a workforce steering committee, comprising five mental health workers and six disability workers.

The sections below provide more details about the delivery format and learning objectives of each training.

The training was promoted to workers through a range of channels, including workforce meetings, posters with QR codes on noticeboards, and internal communications to HACSU members. It was also highlighted at key events such as the HACSU Delegates Conference (23-25 October 2024), the HACSU Women's Conference (8 March 2024/5 March 2025), and HACSU Disability Staff Events (13 March 2025).

Additionally, HACSU have showcased the training to workers from the broader health and community sector, supplying information and attending conferences, including VAADA (13-14 February 2025), the peak body for the alcohol and other drugs sector.

To date, 28 sessions of the Active Bystander and SSW workshops (8 in-person and 20 online) have been delivered through the project. The sessions were attended by over 240 workers from the mental health and disability sectors. Over 250 workers across both sectors have completed the Vicarious Trauma training, out of the 1,800 training spots available through the project.

28

sessions of the Active Bystander & SSW workshops have been delivered

240+

workers from the mental health and disability sectors attended

250+

workers across both sectors have completed the Vicarious Trauma training

1,800

training spots are available for the Vicarious Trauma training

A major challenge in delivering training has been the widespread understaffing across both sectors. Gaining commitment from partner employers has proven difficult, as they must balance ongoing service delivery with the need to release staff for training. This is especially demanding in predominantly face-to-face roles, where releasing employees for more than four hours places significant strain on operations.

Active Bystander

The Active Bystander workshop is delivered either as a 4-hour interactive in-person session or a 3.5-hour interactive online session and is designed to deepen training participants' understanding of everyday sexism and the underlying attitudes that contribute to violence against women. It also equips training participants with practical tools to intervene safely and effectively as active bystanders.

According to Women's Health Victoria (<https://whvtraining.com.au/active-bystander/>), being an active bystander means "demonstrating to those around you that violence against women is everyone's business and that everyone has a role to play in eliminating it."

The workshop explores the causes and impacts of violence against women and aims to build training participants' confidence to engage in conversations about this issue, and to challenge or speak out against attitudes and behaviours that perpetuate gender-based violence.

The learning objectives of Active Bystander training are to:

- **Increase understanding and confidence** to discuss gender-based violence with colleagues, friends and family
- **Build skills to challenge attitudes** and behaviours that support gender-based violence.
- **Provide practical tools** to be an active bystander

Safe and Supported in the Workplace (SSW) training

The SSW workshop is delivered either as a 3.5-hour interactive in-person session or a 3-hour interactive online session and is designed to equip training participants with the knowledge and skills needed to respond appropriately to initial disclosures of family violence or sexual harassment in the workplace (<https://whvtraining.com.au/safe-and-supported/>).

The workshop focuses on building training participants' understanding of family violence and sexual harassment, highlighting why these are critical workplace issues, and providing practical guidance on how to respond to disclosures in a safe, supportive, and respectful manner. It aims to foster a workplace culture where individuals feel confident and empowered to support colleagues experiencing these forms of harm.

The learning objectives of the SSW training are to:

- **Increase knowledge** of family violence and sexual harassment as a workplace issue
- **Increase the ability to provide an initial response** to a disclosure in the workplace

Vicarious Trauma training

The Vicarious Trauma training is a 2-hour online course designed to help training participants understand the causes and impacts of vicarious trauma, and how to reduce its risks in the workplace. Indirect exposure to others' trauma – common in healthcare settings –

can have serious mental health consequences, especially for those repeatedly exposed through their professional roles (<https://education.phoenixaustralia.org/product?catalog=Vicarious-Trauma>).

This course deepens training participants' understanding of vicarious trauma and provides practical strategies to mitigate its impact. It introduces a Prepare, Respond, Recover framework that can be applied in the workplace, along with guidance on developing a personalised self-care plan within their organisational context.

The learning objectives of the Vicarious Trauma training are to:

- **Increase knowledge of what constitutes trauma**, its key signs and symptoms, how it affects mental health and wellbeing, and personal and organisational factors that contribute to mental health difficulties after exposure to trauma in the workplace
- **Increase knowledge of resilience** and ability to identify personal and organisational strategies that help build and maintain it
- **Create an individualised self-care plan**

The training content has been tailored to the healthcare context by incorporating sector-specific case studies. The six modules were developed in collaboration with the Workforce Steering Committee, using real case studies from the mental health and disability sectors. They draw on the experiences of a range of disciplines, including disability support workers, mental health workers, lived experience workers, and occupational therapists.

Training evaluation

The GIWL team has been asked to evaluate the training. The training evaluation presented below has been structured around the primary factors influencing the effectiveness of sexual harassment training (Roehling & Huang, 2018):

- **Training objectives**
- **Training design and delivery** (including time in training, delivery method, and active learning component)
- **Trainee characteristics** (including gender, race, and proclivity/tolerance for sexual harassment)
- **Organisational context** (including “aligned” policies/practices, leadership support, climate and culture, and organisational tolerance for sexual harassment)

In the current analyses, we focus on individual (proximal) outcomes such as participants’ subjective evaluations of training’s usefulness and change in knowledge and skills to identify and respond to work-related gendered violence and sexual harassment.

Beyond the scope of the current evaluation are organisational-level intermediate outcomes (such as incidence of sexual harassment, change in the hostility of the work environments, responses to sexual harassment and internal reporting) and distal outcomes such as the total SH-related litigation, productivity, staff turnover and return on investment).

To conduct the evaluation, the team drew on a range of qualitative and quantitative sources, including pre- and post-training survey responses, interviews and focus groups, and feedback from the project steering committee.

The responses outlined in this report are based on the following data:

- **Responses to the post-training surveys**, including a series of closed- and open-ended questions administered at the end of the training sessions for Active Bystander (n = 59 survey responses) and Safe and Supported in the Workplace (SSW) workshops (n = 43 survey responses). Of the N = 102 respondents who completed the survey, n = 30 (29%) were asked to indicate the sector they worked in and their gender.¹ Among this group, the majority (73%, n = 22) worked in mental health, n = 3 worked in disability, n = 4 worked in other sectors, and n = 1 preferred not to disclose their sector. Similarly, the majority of this group 70%, n = 21 identified as women, n = 6 as men, n = 2 as non-binary, and n = 1 preferred not to reveal their gender identity;
- **Responses to the pre-training and post-training surveys** administered to the Vicarious Trauma training participants (n = 18 pre-training survey; n = 3 post-training survey responses);
- **Individual interviews and a focus group** with training participants from those who attended Active Bystander and Safe and Supported in the Workplace workshops (n = 5) or completed Vicarious Trauma modules (n = 3);
- **Feedback shared by workforce steering committee members** and responses to the additional post-training survey distributed by HACSU after the Active Bystander and SSW workshops (n = 5);
- **Responses to the general survey** distributed by HACSU (n = 38), assessing the prevalence and adequacy of measures addressing gendered violence in both sectors. Among this group, the majority (71%; n = 27) worked in mental health, and 29% (n = 11) worked in the disability sector.

¹ Due to a clerical error, both questions were added to the survey late in the project.

Similarly, the majority (68%; n = 26 identified as female) and 26% (n = 12) identified as male (2.6%, n = 1 identified as non-binary).

- **Responses to the WorkWell Survey** collected by WorkSafe Victoria (n = 22, including n = 21 responses from workers, n = 1 response from a leader), assessing conditions, culture and psychological safety of workplaces participating in the project.

Active Bystander & Safe and Supported in the Workplace (SSW) training

Active Bystander and SSW training aim to equip employees with the skills and confidence to appropriately respond to sexist behaviour in the workplace, as well as to disclosures of family violence or sexual harassment. Below is a summary of the quantitative and qualitative feedback collected from training participants.

Knowledge and skills

Overall, the available survey data indicates that both trainings have met their objectives by increasing respondents' knowledge and skills in the targeted areas.

Respondents were asked a series of closed-ended questions measuring their perceived knowledge and skills before and after completing the training, using a five-point Likert scale from 1- 'not at all confident', to 5- 'very confident'. The following graphs demonstrate the percentage of training participants who indicated they felt confident or very confident about their knowledge and skills before and after the training. An asterisk (*) next to the training name indicates that, on average, training participants assessed their confidence to be significantly higher after the training.

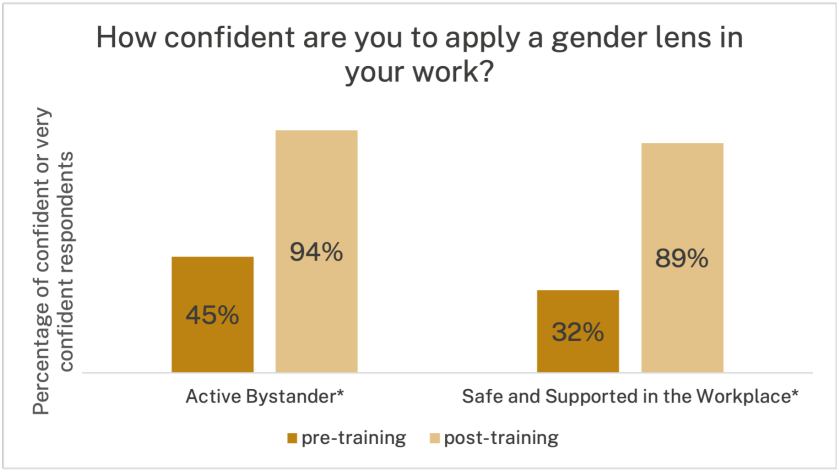


Figure 1. Training participants' confidence to apply a gender lens in their work

Around 9 in 10 training participants felt confident or very confident about applying a gender lens in their work after completing the training (see Figure 1). This was a significant increase compared to their pre-training confidence, with fewer than 1 in 2 Active Bystander training participants and fewer than 1 in 3 SSW training participants indicating that they felt confident to do so.

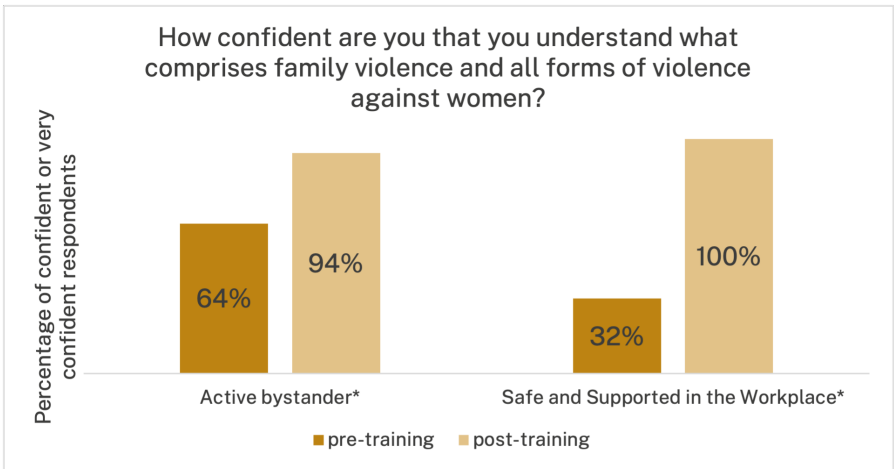


Figure 2. Training participants' understanding of family violence and violence against women

More than 90% of training participants reported feeling confident or very confident in their understanding of family violence and violence against women after completing their training (see Figure 2). This increase in awareness was especially significant among SSW training participants, with only 1 in 3 feeling confident in their understanding before the training. In comparison, around 2 in 3 participants in the Active Bystander training reported confidence in their knowledge before the session.



Figure 3. Training participants' confidence to engage in the primary prevention of violence against women in their work

Training significantly boosted participants' confidence to engage in the primary prevention of violence against women in their work (see Figure 3). Before the training, only 1 in 3 Active Bystander participants felt confident in this area. Following the training, this jumped to nearly 9 in 10 participants reporting they felt confident or very confident. Similarly, fewer than 1 in 3 SSW participants felt confident before the training. Afterwards, more than 8 in 10 reported feeling confident or very confident in their ability to undertake primary prevention in their professional roles.

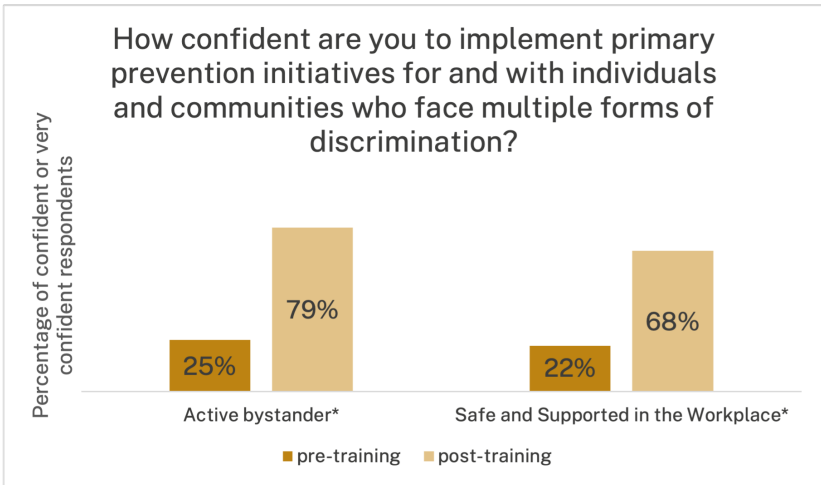


Figure 4. Training participants' confidence in implementing primary prevention for those from minoritised backgrounds

While participants felt less confident implementing primary prevention initiatives for individuals and communities facing multiple forms of discrimination compared to violence against women, there was still a significant increase in confidence following the training (see Figure 4).



Figure 5. Training participants' confidence to safely challenge sexism, sexual harassment, and gender discrimination at work

Only 1 in 4 Active Bystander participants reported feeling confident in this area before training. Afterwards, nearly 4 in 5 felt confident or very confident. Among SSW participants, around 1 in 5 felt confident before the training, increasing to nearly 7 in 10 post-training.



Figure 6. Training participants' understanding of violence against women from minoritised backgrounds

Around 8 in 10 training participants felt confident or very confident in their ability to safely challenge sexism, sexual harassment, gender inequality, and other forms of discrimination in the workplace after completing the training (see Figure 5). This marked a significant increase from pre-training levels, with only 1 in 3 Active Bystander participants and 1 in 4 SSW participants reporting confidence beforehand.

More than 9 in 10 Active Bystander participants and nearly 9 in 10 SSW participants reported feeling confident or very confident in their understanding that women facing multiple layers of disadvantage and discrimination experience higher rates of violence after completing the training (see Figure 6). This reflects a substantial increase of around 30 percentage points

from pre-training levels, where only 2 in 3 participants reported feeling confident in this understanding.



Figure 7. Training participants' understanding of gender factors leading to family violence

More than 9 in 10 training participants felt confident or very confident in their understanding of gender factors that lead to family violence after completing the training (see Figure 7). This is a significant increase from only 1 in 2 participants reporting confidence before completing the training.

The qualitative data collected through the project provided additional nuance to the quantitative findings:

- Overall, respondents reported that **the training helped them build confidence** in advocating against all forms of gendered harassment and violence (HACSU survey)
- Respondents reported that the Active Bystander training allowed them to gain an understanding of the different types of violence and was particularly insightful, **raising awareness of issues they might not have encountered otherwise**. For instance, the dramatisations of sexual harassment highlighted common forms of harassment that

some respondents admitted they had not previously recognised or fully understood (mental health sector worker interview, 18/03).

- Respondents found the **5Ds framework of bystander intervention (Distract, Delegate, Document, Delay, and Direct)** both useful and practical, noting that they could apply it in their workplaces as an alternative to confrontation (Disability Sector, email 16/8/24; open-ended survey response; disability sector worker interview, 18/03; focus group, 20/03).
- Respondents reported that the SSW training provided practical and useful approaches to responding to disclosures (open-ended survey response; HACSU survey). In particular, the training helped them understand the **importance of creating space for individuals**, rather than focusing solely on actions and solutions and gave them knowledge about the available external support services.
- Respondents indicated that the national survey results, case studies, and interactive activities offered **valuable background knowledge and practical insights** (open-ended survey responses).
- **The case studies used across both courses were generally considered relevant and useful** by participants (HACSU survey). One respondent noted that the scenarios helped them challenge the situation by making it more complex and realistic.
- Two respondents from the mental health sector specifically noted that the SSW training was highly applicable to their sector (mental health sector worker interviews, 17/03 and 18/03).
- Overall, respondents highlighted that the training was instrumental in enhancing their understanding of **how to listen without judgment and the proper reporting actions to take** if a colleague confides in them (focus group, 20/03; open-ended survey response).

“ Fabulous training! I really enjoyed the experience that was brought into the training, it would be great to have more examples of first-hand experience”

“ I think every disability worker should get to do these workshops and very grateful I had the opportunity”

“ I just want to say thank you for this amazing session that touched on such important topics”

Areas for improvement

Generally, respondents felt that each training would have benefited from a **broader focus on sector-specific workplace challenges**. Key issues that were perceived as lacking from the training included:

- Considering a **broader spectrum of often less violent but recurrent inappropriate behaviours** that the staff in both sectors are more likely to experience in their work.
- Strategies for handling situations where staff **cannot avoid problematic colleagues, participants or consumers** (mental health worker interview, 18/03; disability worker interview, 18/03; workforce steering committee feedback, 16/08/24).
- **De-identified case studies** of harassment perpetrated by participants and consumers, and guidance on how to work with challenging individuals.
- Dealing with inappropriate behaviour perpetrated by **different perpetrators**, including women, supervisees, and men in non-heteronormative contexts (mental health worker interview, 18/03).

- **Intersectional considerations** within work-related gendered violence, including consideration of race (disability sector worker interview, 13/03).
- Managing these situations in the **absence of proper management structures** or when they occur in a participant's or consumer's home (focus group, 20/03; disability worker interview, 13/03; workforce steering committee feedback, 16/8/24).
- Some respondents expressed concerns that the concept of **resilience was overemphasised** in both the Active Bystander and SSW training.
- Several respondents also expressed concern that while the Active Bystander training provided useful tools for handling backlash from individuals expressing sexist views, it may not be effective in changing the behaviour of **those who need to alter their attitudes most** (workforce steering committee feedback, 16/8/24; open-ended survey responses).
- One respondent felt that the training was a bit vague around how to best handle disclosures of violence or harassment that have **happened at work between employees** (HACSU survey).

Training design and delivery

- Respondents reported that the training was **high quality, engaging and well-structured** (mental health sector worker interviews, 17/03 and 18/03).
- Generally, respondents reported that attending **in-person sessions gave them the best experience**, but that the online sessions were both well-run and necessary for the sessions to be accessible (Mental health sector worker

interviews, 17/03 and 18/03; focus group, 20/03; disability sector worker email 6/8/24).

- Respondents across both programs identified the most valuable aspects as the **opportunities for open, in-depth discussions** facilitated by the presenters, and the **ability to contribute ideas anonymously** through a shared document (open-ended survey response; disability sector worker interview, 18/03; focus group, 20/03).

This anonymous format helped overcome barriers related to public speaking, enabling broader participation and a greater diversity of perspectives to be shared (workforce steering committee feedback, 6/8/24). The shared document exercise in the Active Bystander training provided training participants with access to coping strategies, as well as new perspectives and insights into abuse and trauma that they might not have encountered otherwise (disability sector worker interview, 18/03; focus group, 20/03).

- An important factor contributing to the perceived effectiveness of the workshops was **having enough training participants to support in-depth discussion**. Respondents reported that a group size of 5 to 8 people was ideal for online sessions, while groups of around 10 worked well for in-person delivery. They also noted that a diverse mix of age groups and a balanced gender representation enhanced the collaborative and interactive aspects of the training (focus group, 20/3).
- An Active Bystander training participant mentioned that the training presented practical skills *“in a way that makes them easy to remember in the moment”* (open-ended survey response).

- Respondents reported that **facilitators of the sessions were knowledgeable and created a safe space** for training participants (mental health sector worker interview, 18/03; disability sector worker interviews 17/03 and 18/03).



The presenters were very knowledgeable and provided a comfortable environment”



Enjoyable and interesting”



It was great-really well presented”

Areas for improvement:

As indicated above, a key aspect of both training programs provided by Women’s Health Victoria was the opportunity to **share knowledge and experiences with other participants**. Consequently, the effectiveness of the sessions relies on having an adequate number of engaged participants (mental health sector worker interviews, 17/07 and 18/03). One suggestion for improving accessibility would be to divide the Active Bystander training into 60-90 minute sessions, which could accommodate more participants and help ensure that sessions do not run with too few attendees (mental health sector worker interview, 18/03).

While respondents liked the online format overall, some felt that the discussions in smaller groups in the breakout rooms were **not as robust as they could have been** in the presence of a facilitator (focus group, 20/03). Additionally, there was some **overlap in content between the two courses**. Running the sessions concurrently might help minimise this overlap, while also allowing more time for the discussions that participants found most valuable (focus group, 20/03; open-ended survey response).

Trainee characteristics

Due to **limited data on participants' gender and sector**, we were unable to assess the effectiveness of the training across these specific groups. Additionally, we could not evaluate how training outcomes vary based on participants' roles, tenure, or seniority within their organisations. Similarly, the current evaluation **does not capture information on respondents' race or ethnicity**, limiting our ability to explore the training's impact across diverse demographic groups.

The limited qualitative data indicates that the **training might currently be less effective for men**. One of the male respondents found the discussions of male privilege in the training eye-opening (focus group, 20/03). However, he also noted that the course could have been **more sensitive in the discussion of men's role as perpetrators and victim-survivors of gendered violence**, and provided more support for men. This was seen as a key barrier to the training's efficacy among men (focus group, 20/03). Respondents suggested introducing more 'sandwich-type of feedback' for men and allowing everyone to reflect on instances when they acted as allies or active bystanders could have made everyone more included and motivated to continue their efforts (focus group, 20/03).

A possible limitation of the current training is its **voluntary nature and self-selection bias**. For example, one respondent suggested that the training should be made mandatory for managers, whose awareness of gendered violence is often low (focus group, 20/03). Respondents also noted that the SSW training content was structured more as an **introductory overview** of workplace sexual harassment, rather than a session focused on providing practical strategies for addressing these issues in the workplace (focus group, 20/03; open-ended survey response). As a result, respondents felt that the course primarily "spoke to

the converted,” offering less in terms of actionable support or a deeper explanation of how to change behaviour (focus group, 20/03).

Vicarious Trauma training

Vicarious Trauma Training is designed to enhance participants’ understanding of the causes and impacts of vicarious trauma and to provide strategies for reducing the risk of exposure in the workplace. Below is a summary of the limited available training feedback.

Knowledge and skills

Both before and after completing the training, respondents were asked a series of closed-ended questions measuring their perceived knowledge and skills, using a five-point Likert scale from 1 - ‘not at all confident’, to 5 - ‘very high confidence’. Due to the low numbers (n=18 pre-training survey responses; n=3 post-training survey responses), it was not possible to conduct statistical tests to assess the program’s effectiveness in increasing knowledge and skills. Instead, our analysis focuses on identifying overall patterns observed in the survey responses and qualitative feedback:

- Training elements respondents liked included: the **practical and somatic theory approaches** to dealing with vicarious trauma (disability sector worker interview, 13/03), the introduction of **moral trauma** as a concept (mental health sector worker interview, 18/03), and the **self-care exercises** (open-ended survey response).



The self-care exercises at the end of some modules were fantastic. More of these are not only useful in the moment but terrific skills to take away along with the information”

- All 3 respondents to the post-training survey felt **confident in their understanding of the trauma**, compared to 41% (n=7) respondents in the pre-training survey.
- All 3 respondents to the post-training survey felt confident in recognising personal factors that **contribute to the development of mental health difficulties after trauma**, compared to 24% (n=4) respondents in the pre-training survey. However, **only 1 respondent felt confident in recognising organisational factors** post-training.
- All 3 respondents to the post-training survey felt **confident in their understanding of resilience** and identifying personal strategies to boost and maintain their resilience, compared to 18% (n = 3) and 41% (n = 7) before the training, respectively.
- **2 out of 3 respondents to the post-training survey felt confident in identifying organisational strategies** that boost and maintain employee resistance, compared to 29% (n = 5) before the training.
- Generally, respondents indicated they were **satisfied with the training** (post-training survey) and found it to be **high quality, current, and accessible** (open-ended survey responses).

Areas for improvement:

- Overall, respondents found the training only **moderately relevant for their role** (post-training survey responses). It was also suggested that, particularly for the mental health sector, the course would have been more relevant if it included a **broader definition of trauma** that encompasses PTSD (mental health sector worker interview, 18/03), and if it covered consumer trauma (open-ended survey response).



I experienced vicarious trauma with a consumer and discovered the impacts were fourfold-the distressing story, having to consider the trauma experienced by the interpreter, the idea that my colleagues threw me under the bus and having to process the inadequate experience with the EAP counsellor”

- Respondents noted that the training could have been more effective with a **stronger emphasis on developing a self-management plan** (mental health sector worker interview, 18/03).
- Respondents also wanted to see **more case studies** (open-ended survey responses).

Training design and delivery

- Respondents liked the **overall flow and structure of the training** (post-training survey responses, mental health sector worker interview, 18/03).
- Respondents felt that having the option to complete the online training section by section helped to break down heavy content, and the **flexibility made completing the online training more achievable** (disability sector worker interview, 13/03).
- Two respondents from the disability sector found the written content, activities and downloadable resources effective; all of these elements were rated as less effective by a respondent from the mental health sector (post-training survey).

Areas for improvement

- Respondents suggested that the training would have been more effective if it included **more practical tools to apply in the workplace**. Additionally, they recommended providing a takeaway resource pack with relevant information and services that training participants could use

in their workplace (workforce steering committee feedback, 4/7/2024).

- Respondents also felt that the training could have been **more interactive**. Given the abundance of online wellbeing courses already available in the mental health sector, the course's self-directed format, which relied heavily on individual motivation, was seen as a limitation (mental health sector worker interview, 17/03).

Trainee characteristics

Due to **limited data**, we were unable to assess the effectiveness of the training for respondents based on their gender and other demographic and work-related characteristics. The only comment relevant to trainee characteristics came from a respondent from the mental health sector who suggested that **the training could be useful for all junior workers** (mental health sector worker interview, 17/03).

Organisational context

Adequacy of measures addressing gendered violence in the mental health and disability sectors

Generally, respondents were concerned about their psychological and physical safety at work. Half of the respondents to the HACSU survey (50%; n = 19) indicated that they had felt mentally or physically unsafe due to the risk of gendered violence or sexual harassment in their workplace at least sometimes (including n = 7 who stated that they felt this way often). These concerns were also reflected in the WorkWell Survey, which indicated that workers in organisations participating in the project were more exposed to aggression, violence, traumatic events, and sexual harassment, and had worse systems in place to manage these factors than the available industry benchmarks. 37% of respondents to the HACSU

survey (n = 14) indicated that they had experienced gendered violence or sexual harassment from a participant, consumer or patient; 50% (n = 18) indicated they had witnessed a situation where it affected a colleague. 34% of respondents to the HACSU survey (n = 13) indicated that they had witnessed a situation where gendered violence or sexual harassment was perpetuated by a visitor, family member or carer.

When asked about the adequacy of current safety measures and policies to prevent and address gendered violence and sexual harassment, the opinions were mixed, with half of respondents (50%; n = 19) seeing them as adequate, one in six seeing them as inadequate (16%; n = 6), and one in three (34%; n = 13) being unsure (HACSU survey). Respondents also noted that, while workplaces may have the right policies in place, staff are often unaware of them and unprepared to engage with the appropriate processes when an issue arises, either for themselves or a colleague (mental health sector worker interview, 17/03). This was also reflected in the responses to the HACSU survey, with 32% (n = 12) of workers not knowing whether their workplace has procedures in place for reporting incidents of gendered violence and sexual harassment.

A key challenge mentioned by respondents was the normalisation of violence perpetuated by patients, participants and consumers and the corresponding lack of policies and procedures protecting staff (focus group, 20/03; mental health sector worker interview, 18/03). Another common challenge mentioned was uncertainty around escalating an issue if a manager or HR is not supportive (focus group, 20/03).

Experiences with reporting work-related gendered violence

Overall, respondents expressed confidence in knowing the appropriate actions to take, with 62% of HACSU survey participants (n = 23) indicating they felt equipped to respond to work-related gendered violence, whether affecting themselves or someone they knew. However, one in four respondents (24%; n = 9) reported that while they felt adequately informed, they would choose not to act due to fears of repercussions, such as disciplinary action, reduced work hours, or being reassigned to a different location (HACSU survey).

One respondent also highlighted a fear of victimisation and noted that many colleagues did not feel as confident as they did to navigate the current reporting procedures (HACSU survey). Close to one in three (32%, n = 12) HACSU survey respondents indicated they reported an incident of gendered violence or sexual harassment in their workplace (either involving them, a colleague, a manager, a consumer or a participant). Only in 7 out of 12 cases did employers take any action in response. The discretionary responses of individual managers to complaints remain a significant barrier to staff taking action (disability sector worker interview, 13/03; HACSU survey). For instance, respondents reported that their complaints often receive less attention when they involve inappropriate behaviour, rather than physical risks (disability sector worker interview, 18/03).



As HSR, I feel quite equipped in navigating and finding these processes however do fear victimisation or retribution at times. I know that many of my colleagues do not feel as equipped as me”

The limited available data from the WorkWell Survey – including only one response from a leader – suggest a potential disconnect between how managers and workers perceive the severity of aggression, violence, and bullying, as well as the adequacy of current measures to address them in their workplaces. One of the respondents also noted that the supervisors in their current workplace had a limited understanding of what constitutes trauma (disability sector worker interview, 13/03).



I don't trust my managers to respond appropriately if they don't feel like they are being monitored by the union"

Prevention and support measures beyond training

Respondents from both sectors emphasised the urgent need for stronger measures to address violence perpetrated by patients, participants and consumers as well as the urgent need for more support. Respondents suggested that workplaces should establish clear definitions of acceptable behaviour, especially given the common perception that patients, participants and consumers cannot be held accountable for inappropriate actions (mental health sector worker interview, 18/03; disability sector worker interview, 13/03; HACSU Survey).

The WorkWell survey revealed that participating workplaces had a high-risk psychosocial safety climate (28 out of 100, compared to the current industry benchmark of 38), indicating employees felt management did not adequately prioritise or address psychological health and safety of workers. Addressing this issue effectively may require not

only better policies but also additional training at different management levels, ensuring that managers are equipped with concrete examples of inadequate responses and strategies to avoid them (disability sector worker interview, 18/03; HACSU survey). This is particularly important in the mental health and disability sectors, where zero tolerance approaches might not be adequate as inappropriate behaviour may not be entirely preventable due to behaviours associated with mental illness and cognitive impairment. One respondent emphasised that access to specialist psychological support services and counselling is essential so that staff feel confident they will be supported if an incident of this nature occurs (HACSU Survey).

One respondent also shared the sentiment that current incidence reports are catered towards consumers, not the staff. These reports centre on the action itself, rather than the effect of the inappropriate behaviours on the staff (disability sector worker interview, 13/03). Respondents highlighted the need for a space where staff can reflect on their experiences and receive support, without the immediate pressure of escalating the issue to a manager, particularly for nursing staff (mental health sector worker interview, 17/03). Similarly, having a dedicated physical space and someone to talk to in person, rather than relying on phone interactions to discuss incidents after they occur, would enhance staff members' sense of safety and encourage them to speak up (disability sector worker interview, 13/03).



We are never going to eradicate this [violence] from our services due behaviours that might be present due to mental illness. It's about escalation, early awareness, intervention, skills and capabilities prior to entering the sector”

To mitigate the risk of unsupportive reactions from supervisors, respondents suggested that additional trauma-informed training for supervisors, along with a platform for junior staff to voice their concerns, would be beneficial (disability worker interview, 13/03). Respondents generally expressed the need not only for clear and safe reporting mechanisms but also for the need to foster a culture of talking openly about violence and harassment in their organisations (HACSU survey).

Fragmentation of the disability sector and physical isolation, with staff performing their work across independent living houses and in-home care, were seen as major risk factors for work-related gendered violence. A possible solution to this issue could be providing additional personnel for in-home care visits, however, our respondents doubted whether that solution would be financially feasible given the financial constraints faced by the sector (disability sector worker interview, 13/03). A respondent from the mental health sector noted that the appropriate solution is not just to have more staff but to have the right mix of staff with more experience on the ground so that the junior staff feel adequately supported (mental health disability sector worker interview, 17/03).

Respondents emphasised the importance of further investment in the physical environment, particularly in mental health wards, as a key strategy to reduce the risk of gendered violence and sexual harassment. A significant concern is the overcrowding of wards, where vulnerable individuals may be placed alongside individuals exhibiting unsafe or predatory behaviours. The development of new facilities, including gender-specific spaces, would play a critical role in mitigating these risks from the outset (HACSU Survey).

Feedback also highlighted the need for clearer and more coherent policies to ensure a shared understanding of the roles and responsibilities of various institutions, such as workplaces, HACSU, and WorkSafe. Clarifying these roles is essential so that employees know where to seek prevention support and how to access appropriate services.

“ We need more investment in the physical environment of our mental health wards, where too many unwell people are packed in together, especially people who are vulnerable (female, young, with intellectual disability) being in the same spaces as people with unsafe or predatory behaviours”

Recommendations for future training

Based on the evaluation data summarised in this report and a broader review of the literature (Mikołajczak et al., 2024), we propose the following recommendations for future training:

1. **Training content should align more closely with healthcare-specific experiences and challenges.** Those in direct care roles should receive targeted training on how to identify, manage, and respond to gendered violence perpetrated by patients, participants, consumers, and visitors (Still, 2022). Staff who work with cognitively impaired individuals and older patients in long-term care settings should also receive specialised training focused on promoting positive behaviours, recognising and minimising the use of restrictive practices to prevent harm to both the individual and others in the environment (Still, 2022), and on managing intimate and sexual needs and addressing unintentional sexual behaviours among these populations (Thys et al., 2019).
2. To maximise its impact, staff **training should be universally accessible**, reaching as many employees as possible, while being tailored to the specific contexts of individual organisations and teams. To ensure greater accessibility, training could be delivered both in person and online. Regardless of the mode of delivery, training should be interactive, allowing staff to share and learn from each other's experiences.
3. **Training should be tailored differently for managers and staff.** Managers need to understand their legal responsibility to ensure the safety of their staff, including protection from gendered violence. They should receive additional training to deepen their understanding of the legal consequences of failing to uphold this

responsibility, the evidence of gendered violence within the organisation and their teams, and the measures currently available or implemented to address it (Wang et al., 2008). Training should also provide them with the specific skills needed to prevent and respond to gendered violence as part of their legal obligations (Hunt et al., 2010). To be effective, it should cover areas such as conflict management, communication, and emotional intelligence (McDonald et al., 2015).

4. **Effective training must be gender sensitive.** This means recognising that men are more likely to be perpetrators or bystanders of gendered violence and are often less sensitive to assessing gendered violence, while also acknowledging that men who experience gendered violence may face greater stigma, shame, or reluctance to report their experiences.
5. **Training should be culturally sensitive** and informed by research that highlights the unique structural factors influencing the experiences of culturally and racially marginalised (CARM) employees with gendered violence (Kennedy et al., 2024).
6. **Using behavioural definitions of gendered violence**, rather than relying solely on legal definitions, can be particularly effective in helping individuals, especially those from linguistically diverse backgrounds, better understand what constitutes inappropriate conduct (Respect@Work, n.d.). Focusing on the identification of specific behaviours, rather than exclusively framing them within the broader concept of work-related gendered violence, may also improve prevention and reporting, particularly for staff working with cognitively impaired patients, participants, and consumers (Nielsen et al., 2017).
7. It is also important to **educate healthcare staff on cultural biases and stereotypes** related to the sexuality of older adults, cognitively impaired

individuals, and people from sexually minoritised groups (Thys et al., 2019) to improve staff knowledge, attitudes, and inclusive practices (Morris et al., 2019; Yu et al., 2023).

8. **Training should be ongoing**, with regular, shorter refresher sessions to reinforce learning and adapt content to evolving workplace environments (Ilkiw & Lavalley et al., 2002).
9. **Training evaluation should be integrated into the training process** to collect more comprehensive data, enabling a better assessment of the training's impact across different employee groups and the measurement of intermediate outcomes, such as employees' sense of safety in their workplace, responses to gendered violence and sexual harassment, and internal reporting
10. **Training should be embedded within broader organisational policies** and reporting procedures, which may influence how the knowledge and skills acquired in training transfer to and are sustained in the workplace (e.g., Taylor, 2019).

Recommendations for addressing gender-based violence in the healthcare sector

1. In response to the significant rates of gendered violence experienced by healthcare workers in Victoria, as highlighted by survey responses in this report and supported by a broader review of the available evidence (Mikołajczak et al., 2024), we recommend that the Victorian Government adopt a **whole-of-sector approach to addressing this issue**. This should include adequate and sustained funding for healthcare and community organisations to implement effective prevention and response strategies.
2. Effective prevention and management of gendered violence in the healthcare sector should include the following key components:
 - **Ongoing training** for both managers and staff;
 - Regular review and improvement of **gendered violence policies**;
 - **Transparent, fair, and accessible** complaint processes; and
 - The promotion of **safe, respectful, and inclusive workplace environments**.
3. These measures should be **embedded within a broader gender equity strategy** that proactively addresses the **systemic and structural drivers**

of gendered violence, including poor working conditions, understaffing, and entrenched gender norms.

4. Given the current lack of legislative oversight regarding gendered violence against health sector workers, it is essential to introduce **regulatory guidelines that specifically protect practitioners from violence perpetrated by patients, consumers, and participants.**
5. To address the under-reporting of work-related gendered violence, **organisations must tackle the structural barriers that discourage reporting.** These include the absence of clear standards for appropriate behaviour, workplace cultures that downplay the seriousness of gendered violence; fear of personal, professional, or economic repercussions; and the lack of efficient, transparent, safe, and trauma-informed reporting mechanisms.
6. **Ongoing evaluation, data collection, and stakeholder consultation are needed across the sector** to identify high-risk groups and ensure that policies, reporting mechanisms, and training programs are effective and fit for purpose. Particular attention should be given to mental health and disability sector workers from minoritised groups who remain under-represented in existing data.
7. Informal feedback collected during the project highlights also a growing **need to legally recognise and address work-related gendered violence facilitated through technology.** Technology-facilitated workplace sexual harassment, such as sending explicit messages or engaging in stalking, is often minimised or not taken seriously.

Contributing factors include its occurrence outside the physical workplace, the ability to alter or delete digital evidence, limited training on identifying technology-facilitated harassment, and the tendency to dismiss social media interactions as private matters. In caring professions, the boundaries between personal and professional interactions are further blurred.

This makes it challenging to respond to inappropriate communication, especially when it is perceived as occurring “outside of work.” Relationships that appear collegial or friendly can mask inappropriate behaviour, and patients, consumers or participants may use personal communication channels to bypass professional boundaries.

Additionally, many healthcare professionals rely on personal phones for work-related communication. This practice, combined with on-call responsibilities, creates a heightened expectation of availability, further complicating the separation between work and personal life.

The ‘Preventing Tech-based Abuse’ project, funded by eSafety Commissioner and conducted by the GIWL team, highlights several key recommendations to more effectively address this form of gendered violence in the healthcare sector:

a. Integrate Technology in Policies and Training
Workplace policies and training on appropriate behaviour should explicitly address technology use. Including clear examples of technology-facilitated harassment can help formalise responses through existing complaints processes and empower employees to recognise and call out inappropriate behaviour.

b. Recognise Digital Communication as an Organisational Purview

Organisations should acknowledge that communication between colleagues outside the immediate work context, such as on social media, may, in certain cases, fall under the scope of workplace policy. Similarly, contact from patients, consumers, participants, or their families via personal phones or social media platforms should also be treated as an organisational concern, particularly when such interactions cross professional boundaries.

c. Balance Staff Visibility with Safety

While staff profiles on organisational websites can support professional visibility and patient, consumer and participant engagement, they also carry risks, particularly for women and racially marginalised employees who may be more vulnerable to stereotyping and online abuse. Organisations must consider these risks and implement protective measures where necessary.

d. Proactively Implement Right to Disconnect Legislation

Organisations should take a proactive approach to the Right to Disconnect legislation by clearly defining what constitutes 'reasonable' work contact outside of regular hours, helping to establish healthier boundaries for employees.

e. Provide Training on Workplace Technologies

Employers should offer comprehensive training on workplace technologies, particularly targeting support for employees with lower levels of digital literacy. This is especially important for minoritised groups who may otherwise be more vulnerable to technology-facilitated harm.

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@GIWLANU
giwl.anu.edu.au
giwl@anu.edu.au