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CURRENT NSW HEALTH DOMESTIC VIOLENCE POLICY

Prevalence and health effects of domestic violence
NSW Health defines domestic violence as “violent, abusive, or intimidating behaviour carried out by an adult against a partner or former partner to control and dominate that person. Domestic violence causes fear, physical and/or psychological harm. It is most often violent, abusive, or intimidating behaviour by a man against a woman”.

Globally, 30% of women who have been in a relationship have experienced physical and or sexual violence by their partner. Due to the effect of domestic violence on the physical, psychological and social health of many women and children in New South Wales, it is a significant public health issue. Many negative, long term mental health impacts on victims of domestic violence have been reported including depression, anxiety, post-traumatic stress, substance abuse and suicide. Victims of domestic violence report higher rates of a range of health issues than non-victims.

Victims of domestic violence are high users of health services but often are not identified. This limits the capacity of health services to intervene and provide appropriate and effective health care. It can also lead to victims remaining isolated, being inappropriately diagnosed and missed opportunities to prevent further injury or death and social costs.

NSW Health’s Domestic Violence Routine Screening program
It has been shown that women tend not to disclose their experience of domestic violence unless they are directly asked about it. Evidence suggests that routine screening can support the disclosure of domestic violence in the absence of other presenting symptoms.

Since 2001, NSW Health services have undertaken routine screening of female clients for domestic violence as an early identification and intervention strategy. The purpose of Domestic Violence Routine Screening is to promote awareness of the health impact of domestic violence, ask questions about patients’ safety in relationships, and to provide information on health services to help victims and abusers.

The NSW Health Domestic Violence Policy formalised this strategy. It requires the screening of all women presenting to the following four target programs:

- Antenatal services;
- Child and family health services;
- Mental health services (for women aged 16 years and over) and;
- Drug and alcohol services (for women aged 16 years and over).

In addition, women’s health and other programs can undertake DVRS on an opt-in basis.
The Domestic Violence Routine Screening program identifies domestic violence by asking two direct questions to elicit yes/no answers:

Q1. Within the last year have you been hit, slapped or hurt in other ways by your partner or ex-partner?
Q2. Are you frightened of your partner or ex-partner?

If domestic violence is identified, two further questions are then asked, one to ascertain safety and the other offering assistance.

Q3. Are you safe to go home when you leave here?
Q4. Would you like some assistance with this?

Health workers offer the z-card, *Domestic Violence Hurts Your Health*, to all women screened, regardless of whether or not they are experiencing domestic violence. The card provides information on what domestic violence is, how it affects health and wellbeing, and what steps can be taken, including where to find help.

The Domestic Violence Routine Screening Program complies with the World Health Organisation clinical and policy guidelines, which recommend:

- Procedures are in place,
- Staff are trained,
- A minimum response is required,
- There is a private setting,
- Confidentiality is ensured, and
- A system for referral is in place. 8

NSW Health is working to improve each of these components, through a review of the current NSW Health policy.

**NSW Health Domestic Violence Policy**

The current NSW Health Domestic Violence Policy has been in place since 2003, with minor amendments in 2006. This document assumes the format of a conventional policy statement outlining the responsibilities of the NSW Health services and workers regarding victims and perpetrators of domestic violence.

The *NSW Health Policy and Procedures for Identifying and Responding to Domestic Violence (PD2003 amended 2006)* 1 (the ‘DV Policy’) aims to:

- Reduce the incidence of domestic violence through primary and secondary prevention approaches
- Minimise the trauma that people living with domestic violence experience, through tertiary prevention approaches, including ongoing treatment and follow up counselling.

Guided by the DV Policy, NSW Health currently provides a response to domestic violence through the Domestic Violence Routine Screening program (DVRS), Social Work services, Emergency Departments, specialist Mental Health, Drug and Alcohol services, Aboriginal Family Health services and one domestic violence specialist counselling service (St George Domestic Violence Service).

Living with domestic violence has a profound effect upon children and young people and constitutes a form of child abuse. In the 2006, the DV Policy was amended to include additional questions about child victims of domestic violence. 1

As mandatory reporters, in situations where NSW Health workers have reasonable grounds to suspect a child is at risk of significant harm, a report to Community Services is required. 9

In accordance with NSW Health policy and guided by the privacy principles outlined in Schedule 1 of the *Health Records and Information Privacy Act (HRIPA) 2002* (NSW), police may be notified if the woman wishes and/or where there are concerns for the safety of the woman and/or her children. 10
In all other cases where domestic violence is identified, the referral pathway is guided by the woman’s preferences and needs. Health workers will refer women to relevant health services or to services outside the health system.

The NSW Health DV policy is available online, however, there are no other resources available on the NSW Health website for staff or victims.

Local Health Districts develop their own policies and resources for implementation at a local level. Some LHDs have developed a variety of resources to support the implementation of the NSW Health domestic violence policy.

Domestic Violence Routine Screening has its own protocol which directs the implementation of this program.

**Domestic Violence Policy review**
The DV Policy is currently under review to reflect the changes to the environment since 2003. The new policy will be driven by the needs of victims, clearly define the role of NSW Health workers, and provide direction to LHDs in the response to domestic violence in NSW.

**The objectives of the DV Policy review are:**
- To ensure the Policy takes account of changes to legislation, interagency policies and priorities, and ties in with whole of government initiatives wherever possible,
- To capture areas of best practice,
- To deliver a revised policy that is accessible, meaningful and evidenced based,
- To develop key performance indicators.

The review of NSW Health’s DV Policy is underpinned by a targeted consultation strategy, of which this workforce survey is a critical element. The current policy has been in place for 10 years without major review, during which time significant legislative, policy and service changes have taken place at both a state and Commonwealth level.

**PURPOSE OF THIS REPORT**
The NSW Health workforce domestic violence survey was undertaken to capture the views of those implementing the policy at a service level in order to identify policy, implementation and service delivery issues to inform the revised DV policy.
SURVEY DESIGN AND METHODOLOGY

The domestic violence workforce survey was developed with input from the Domestic Violence Policy Review Reference Group (which includes representatives from Local Health Districts (LHD), Women’s Health NSW, Education Centre Against Violence and the Mental Health and Drug and Alcohol Office), consultation with academics with experience in the area, and liaison with internal Ministry of Health staff (see Appendix 1 for the survey).

The survey was tested by members of the Domestic Violence Policy Review Reference Group and staff from the Violence Prevention and Child Protection Unit of NSW Kids and Families.

In February 2013, the LHD and Speciality Network’s Chief Executives were asked to distribute the workforce survey to all staff to identify policy, implementation and service delivery issues to inform the revised DV policy. The survey remained open for four weeks. The aim was that all LHD and Speciality Network staff would be invited to complete the survey, to capture a spectrum of knowledge and experience with regards to domestic violence.

The survey was distributed via an ‘all staff’ email outlining the rationale for the survey and providing a link to the survey website (www.surveymonkey.com). In the LHDs this email was sent by the chief executive, with the exception of South Western Sydney LHD, where the program lead of Ambulatory Care distributed the email. In Far West LHD the all staff email was not sent until the second half of February 2013.

Data management and analysis

The survey responses were retrieved in a Microsoft Excel format and all analysis was undertaken using SAS Enterprise Guide 5.1 (SAS Institute Inc., Cary, NC, USA).

All duplicate responses, based on identical response patterns and identical commencement of survey times, were removed. All incomplete responses were removed. Incomplete responses were those that did not answer any questions other than the initial workforce questions (questions 1 to 3 only).

Response rate calculation

Workforce numbers (specifically “Incidents of payroll”) for each LHD and service were obtained from the State Health Information Exchange for February 2013 when the survey was carried out. “Incidents on payroll”:
- include all active employees who received a payment for the February 2013
- exclude Ministry of Health and NSW Health pillars
- may include duplicate records due to multiple assignments carried out by employees.

The best available figures for St Vincent’s Hospital were based on “full time equivalent” figures for March 2013.

Analysis of open ended responses

In order to analyse the open ended responses an inductive content approach was used; that is, the categories emerged from the data rather than being decided upon before the analysis. The categories for each recoded question is detailed in Appendix 2.
RESULTS

A total of 4783 responses to the survey were received from NSW Health staff. Of these, 19 entries were identified as duplicate responses and were removed. A further 106 responses were incomplete and were also removed. Therefore a total of 4658 responses were included in the subsequent analysis.

Characteristics of respondents

Local Health District or Specialty Network

The majority of NSW Health staff who responded to the survey worked in metropolitan LHDs (59%); these are Central Coast, Illawarra Shoalhaven, Nepean Blue Mountains, Northern Sydney, South Eastern Sydney, South Western Sydney, Sydney and Western Sydney LHDs.

Almost a quarter of responses came from regional and rural LHDs (24%); Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW and Western NSW LHDs. Reflecting that some people may work across LHD boundaries, 18 staff reported working across regional and metropolitan LHDs.

The remaining responses were received from Specialty Health Networks (Sydney Children’s Hospital Network, St Vincent’s Hospital and Justice and Forensic Mental Health; 8% of responses) and the Ambulance Service of NSW (9% of responses; figure 1).

Figure 1: Area of NSW Health in which respondents work

Response rates for each LHD/Specialty Health Network

The estimated response rate for the survey was calculated using “incident of payroll” in February 2013 (and “full time equivalent” for St Vincent’s Hospital staff in March 2013) of which there were a total of 120,257. The estimated response rate based on these figures was 3.9% of NSW Health staff. Metropolitan LHDs had estimated response rate of 4.0% and Rural and Regional LHDs had an estimated response rate of 3.3%.
The highest estimated response rates were for Far West LHD (10.7%), followed by the Ambulance Service of NSW (9.3%) and Central Coast LHD (6.6%). The lowest estimated response rate was from Hunter New England LHD (1.1%; figure 2).

Current role in NSW Health
Respondents were asked two questions related to their work role with NSW Health. One question related to the broader work role (question 2, n=4647) with the possible options being:

- Administrative
- Managerial
- Clinical
- Other (please specify)

The majority of respondents to the survey reported that they were in a clinical role within NSW Health (65%; Figure 3). The remaining respondents reported an administrative (20%) or managerial role (15%).
In addition, staff were asked an open-ended question about the main focus of their current role with NSW Health (Question 1, n=4658).

Based on the responses by NSW Health staff to questions 1 and 2 regarding current role and occupation, work roles were further classified into function within NSW Health and the service type within which that respondent worked.

**Specific work function**

Sufficient information was provided by 1560 NSW Health staff to enable work role to be classified into a specific function. Of the remaining responses, 3020 were categorised based on the response to the broader work role question (Question 2; Administrative, Managerial or Clinical role). A further 78 (1.7%) responses were not able to be categorised. For specific function, 494 (10.6%) respondents reported a nursing function within NSW Health and 420 (9%) respondents reported a counselling, social work, psychology or case management role (Figure 4).
Figure 4: Function in NSW Health

Notes: “Counselling/Social work” includes psychology services and case management. “Corporate and clinical governance” also includes quality assurance and risk management.

Service type
A total of 1946 (41.8%) respondents provided sufficient information to classify them into a service type within NSW Health. Of these, 19% worked in Child, Adolescent and Family Health, 17.5% in the NSW Ambulance Service and 16.6% in Mental Health. A further 7.6% worked in Child Protection, Domestic Violence or Sexual Assault services (Figure 5).

Figure 5: Service type within which respondents work
**Time in current role**
Just over half of NSW Health staff (52%) who responded to the survey reported working in their current role for 5 years or more, with a further 16% reporting being in their role for 12 months or less (Figure 6).

**Figure 6: Time in current role**

**Domestic Violence knowledge and training**
Less than one-third of respondents reported a good or very good knowledge of domestic violence policy, domestic violence legislation and domestic violence service and referral options (29%, 23% and 31% respectively).

Respondents employed in a clinical role were slightly more likely to report good or very good knowledge (domestic violence policy, 34%; domestic violence legislation, 27%; domestic violence service and referral options, 36%; figure 7).
Training in current role
The majority of NSW Health workers who completed the survey responded that they had received no training in their current role. Further, the results demonstrate that across the NSW Health workforce levels of domestic violence training are more likely to fall within the none to minimal range.

Only 7% of NSW Health staff who completed the survey reported that they had received a moderate or significant level of training in current role (table 5). Those who worked in clinical roles reported slightly higher moderate to significant training levels (10% of respondents; figure 8).

Table 5: Level of DV training

<table>
<thead>
<tr>
<th>Level of training</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2704 (63%)</td>
</tr>
<tr>
<td>Minimal</td>
<td>1313 (30%)</td>
</tr>
<tr>
<td>Moderate</td>
<td>269 (6%)</td>
</tr>
<tr>
<td>Significant</td>
<td>48 (1%)</td>
</tr>
</tbody>
</table>
Higher levels of DV training (moderate or significant) were reported in NSW Health staff who worked in a drug and alcohol service (21%) or in a social work/counselling role (24.6%). This is consistent with contact with victims of DV, 64% of those working in a drug and alcohol service and 81% currently in a counselling or social work role had contact with at least one known domestic violence victim in the month before the survey (see below).

Those respondents who reported working longer in their current role also reported higher levels of domestic violence training (2% in those in their current role for 12 months or less reported moderate to significant levels of training compared to 8.9% in those >3 years).

**Injury documentation policy in specific LHD/Specialty Network**
One third (33%) of respondents reported that there was an injury documentation policy in their service (question 14; n=3971). Sixty per cent of respondents were not sure if there was such a policy in their service.

**Contact with victims of domestic violence**

**Victim contact in the last month**
Thirty nine per cent of respondents reported contact with a victim of domestic violence in the last month (question 5, n=4658; Figure 9).
Where was the domestic violence victim referred?
The survey asked respondents where they referred domestic violence victims both within NSW Health (question 12) and to other agencies or services (question 13). Responses were categorised into specific service areas (figures 10 and 11). In responding to the question regarding NSW Health referrals, a large number of responses noted referrals to external services, these numbers (191 responses including referrals to FACS, NSW Police, external DV services and women’s refuges) were not included in figure 10.

Common across all referral questions, was feedback contained within free text comments emphasising that there was no single approach to best meet the needs of victims and their families, rather usually more than one service or referral is required.
Figure 10: Referral to a NSW Health service

Note: Respondents could give multiple responses.

Figure 11: Referral to an external service

Note: Respondents could give multiple responses.
Domestic violence prevention activity in current role
Domestic violence prevention activity was undertaken by 18% of respondents in their current role (question 10, n=4323).

Likely response to domestic violence victim
Respondents were asked “In your current role, please indicate the actions you are most likely to take when dealing with someone who is a victim of domestic violence”. There were 11 possible options and respondents could choose multiple responses (figure 12). A total of 4012 respondents answered this question.

Figure 12: Most likely response to dealing with a victim of domestic violence

- Treat physical injuries
- Treat emotional injuries
- Case management
- Assessment
- Refer to Police
- Contact the Child Wellbeing Unit
- Make report to Community Services Child Protection Helpline
- Note, no further action required
- Refer to another NSW Health Service
- Refer to another agency or service
- Other

Note: Respondents could give multiple responses.

The most likely responses to a victim of domestic violence was to:
- Make a report to Community Services Child Protection Helpline, 45%
- Refer to Police, 40.9%
- Contact Child Wellbeing Unit, 38.6%

When compared to those with minimal or no domestic violence training, respondents who reported higher levels of domestic violence training were:
- More likely to report “Treat emotional injuries”, “Case management”, “Assessment” or “Child protection wellbeing”.
- Less likely to report “treatment of physical injuries”
as the most likely action with domestic violence victims.
**Clarity of information sharing with other agencies**

NSW Health staff were asked to respond to a multiple choice question regarding information sharing with other agencies (table 6). Forty one per cent of respondents reported that the information was “mostly clear” and they knew who to approach for clarification. A further 30% of staff reported that information sharing was not clear.

**Table 6: Information sharing with other agencies**

<table>
<thead>
<tr>
<th>Are the limits and/or opportunities for information sharing with other agencies sufficiently clear?</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, very clear what information can be shared</td>
<td>524 (14%)</td>
</tr>
<tr>
<td>Mostly clear, but I know who to approach for clarification if required</td>
<td>1564 (41%)</td>
</tr>
<tr>
<td>Mostly clear, but I don’t know who to ask when I’m not sure</td>
<td>575 (15%)</td>
</tr>
<tr>
<td>No, not clear</td>
<td>1157 (30%)</td>
</tr>
</tbody>
</table>

**Difficulties encountered during work with domestic violence victims**

NSW Health staff were asked to outline the difficulties they may encounter when working with victims of domestic violence. There were 2644 free text responses to this question and these were classified into broad categories for comparison (figure 13). Of these responses 393 were incomplete or unable to be classified.

- The highest number of responses was in relation to the victim’s reluctance or fear of disclosing or reporting domestic violence (863, 32.6%).
- The second highest reported difficulty relates to the limited referral or service options for victims of domestic violence (547, 20.7%).
- The third highest response was around the lack of knowledge of NSW Health staff (313, 12.7%).
Figure 13: Difficulties encountered when working with DV victims

- Victim afraid/reluctant to disclose/report
- Limited referral/service options
- Limited/lack of knowledge (staff)
- Privacy/information sharing
- Staff safety concerns/dealing with perpetrator
- Child Protection/Safety
- Time constraints
- Patient unable or unwilling to engage/respond
- Staff attitude
- Cultural and linguistic differences
- Gender bias towards female victims
- Co-morbidity with other clinical issues
- Traumatic impact of working with DV
- Staff DV

Note: Respondents could give multiple responses.

Rural and regional LHDs were more likely to report limited referral and service options and privacy/information sharing issues than respondents from metropolitan LHDs (figure 14).

Staff from the Specialty Health Networks expressed greater concerns about dealing with the perpetrator and families and staff safety than respondents from the LHDs. Concerns regarding safety were frequently cited in responses by the Ambulance Service of NSW (figure 14).
Figure 14: Difficulties encountered when working with DV victims by LHD or service type

Note: Respondents could give multiple responses.

Respondents with high levels of reported domestic violence training and knowledge (policy, legislation and referral knowledge) were consistently more likely to report that they face difficulties with regards to limited referral/service options when dealing with victims of domestic violence.
Domestic violence service and response improvement

Victim support services
In response to the question about the services that best support the victims of domestic violence (question 18; n=3580) the highest responses were in support of counselling for the victim (82%), referral to domestic violence specific services (80%) and after hours, crisis support (74%; figure 15).

Figure 15: Services that would most help DV victims

Policy and procedure guidelines
When asked what resources would be “useful when requiring guidance on the policy and procedures relating to domestic violence?” (Question 17, total responses n=3750), respondents chose:

- "a range of one page fact sheets", 65%
- “referral flow charts”, 52%
- “a website with a range of resources", 48%
- “access to training”, 43%
- “an overarching policy and procedures document", 20%.

Note: Respondents could give multiple responses.
Domestic Violence Routine Screening (DVRS) services

Respondents were asked if they used DVRS in their work (Question 19). Of those who responded (n=3682), 31% reported using DVRS in their work.

The remaining 69% of respondents reported not using DVRS, most stated DVRS was not done in their role or in their service (Figure 16). A further 6 per cent of respondents reported that the DVRS forms were not available to use.

**Figure 16: If you do not use DVRS in your service, why not?**

![Pie chart showing reasons for not using DVRS](image)

- 1603; 64% Not done in my role
- 635; 25% Not done in my service
- 146; 6% Screening forms not available
- 131; 5% Screening questions separate to initial assessment

All responses to the following questions regarding DVRS services were only answered by those who reported using DVRS in their service.

**Characteristics of those who reported using of DVRS in their role**

Domestic Violence Routine Screening (DVRS) is required to be undertaken in antenatal, child and family health and, for women over 16 years of age, mental health and alcohol and other drugs services. Of the 3682 NSW Health staff who completed the DVRS question, 1158 (31%) reported using DVRS.
Table 7: Characteristics of those respondents reporting using DVRS in their work.

<table>
<thead>
<tr>
<th></th>
<th>Reported DVRS use (n=1158)</th>
<th>Did not report DVRS use (n=2524)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current role</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative</td>
<td>4.2%</td>
<td>19%</td>
</tr>
<tr>
<td>Clinical</td>
<td>81.5%</td>
<td>59.5%</td>
</tr>
<tr>
<td>Managerial</td>
<td>11.3%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Other or missing</td>
<td>2.9%</td>
<td>5.2%</td>
</tr>
<tr>
<td><strong>Time in role, 5 years or longer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>56.7%</td>
<td>50.3%</td>
</tr>
<tr>
<td><strong>Training, moderate or significant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>19.8%</td>
<td>3.1%</td>
</tr>
<tr>
<td><strong>DV knowledge</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy, good or very good</td>
<td>60.4%</td>
<td>17.3%</td>
</tr>
<tr>
<td>Legislative, good or very good</td>
<td>47.2%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Referral or service, knowledgeable or very knowledgeable</td>
<td>62.0%</td>
<td>19.1%</td>
</tr>
<tr>
<td><strong>Contact with domestic violence victims</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>60.6%</td>
<td>34.3%</td>
</tr>
</tbody>
</table>

One in five (19.8%) Domestic Violence Routine Screeners reported moderate or significant levels of training in comparison to 3.1% of respondents who did not report DVRS use. Domestic Violence Routine Screeners also reported consistently higher levels of policy, legislative and referral knowledge (Table 7).

Staff who use DVRS were more likely to indicate “case management” and “assessment” as their likely response to victims of domestic violence and less likely to indicate treatment of physical injuries or referral to police or another NSW Health service as a likely response (figure 17).
Domestic violence Routine screening implementation

Those who reported DVRS use in their service were asked what would support the implementation of DVRS in that service. The highest number of responses were for regular DVRS training (58%), clear referral pathways (54%) and awareness and information material for clients about domestic violence (46%; figure 18).
Figure 18: Factors that would support DVRS implementation

Other issues regarding the implementation of DVRS raised in comments included a broadening of domestic violence screening to other groups (e.g. men) and concerns related to being able to appropriately respond when domestic violence was reported (e.g. availability of referral services, interpreters).

**Domestic violence screening questionnaire improvement**

NSW Health staff were asked about potential changes to the DVRS questionnaire. Respondents expressed a clear preference for adding “controlling and/or coercive behaviour” to question one (70.9%). There was also a preference for rewording question 2 of the questionnaire to “Has your partner done anything to make you feel afraid in the last year?” (73.7%; Table 8).
### Table 8: DVRS questionnaire improvement

<table>
<thead>
<tr>
<th>DVRS questionnaire changes</th>
<th>Number of respondents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suggested addition to question 1</strong></td>
<td></td>
</tr>
<tr>
<td>Choking/Strangling</td>
<td>198 (18.3)</td>
</tr>
<tr>
<td>Controlling and/or coercive behaviour</td>
<td>767 (70.9)</td>
</tr>
<tr>
<td>Pushing/shoving</td>
<td>388 (35.9)</td>
</tr>
<tr>
<td>Punching</td>
<td>170 (15.7)</td>
</tr>
<tr>
<td>No change</td>
<td>202 (18.7)</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>233 (21.5)</td>
</tr>
<tr>
<td><strong>Preferred suggested wording of question 2</strong></td>
<td></td>
</tr>
<tr>
<td>Were you frightened of your partner or ex-partner in the last year?</td>
<td>288 (26.3)</td>
</tr>
<tr>
<td>Has your partner done anything to make you feel afraid in the last year?</td>
<td>805 (73.7)</td>
</tr>
</tbody>
</table>

**Emotional and psychological abuse in DVRS**

The survey asked those who used DVRS whether they thought other examples of abuse should be included in screening (question 24, n=1061). Of those respondents who specified “other” the responses could be categorised into “controlling behaviour”, “Actions that create fear”, “Emotional abuse” or “Sexual coercion/abuse”. There was strong support for the inclusion of controlling behaviour (86% of respondents) and actions that create fear (80% of respondents) into the questions asked by routine screening questions. Only 2.4% of respondents wanted “emotional abuse” included in domestic violence screening and 0.7% wanted “Sexual coercion/abuse” included.

**Additional services appropriate for DVRS implementation**

Respondents who currently use DVRS were asked which services would be most appropriate for inclusion if screening was extended (Question 25, n=1060). The services most commonly recommended for an extension of DVRS were emergency departments (83%), women’s health services (78%) and general practice (77%).
Figure 19: Services appropriate for the extension of DVRS

- GP
- Emergency Department
- Sexual health
- Sexual assault services
- Women's health nursing services
- Dental services (public)
- Aged care
- Women's Health
- Other Community Health or Hospital

Note: Respondents could give multiple responses.

Reinforcement of work with victims of domestic violence

The majority of responses to the question asking what would reinforce your use of DVRS (question 26, n=584) related to “resource/service enhancement” (33%) and workforce development (30%) with a further 15% indicating “clear and responsive referral pathways” as an issue (Figure 20).

Figure 20: Factors that would reinforce the use of DVRS

- Workforce development
- Resource/service enhancement
- Professional resources
- Prevention and awareness raising
- Organisational and Management support
- Integrated service response
- Clear and responsive referral pathways
- An appropriate Justice and Legal response
- A victim centred response/securing safety

Note: Respondents could give multiple responses.
KEY FINDINGS

This survey was developed to determine specific DV related knowledge and training of NSW Health staff, as well as their likely responses to and difficulties encountered when dealing with DV cases. The findings from this survey will be used to inform the current DV policy review.

There were 4658 valid responses to the survey received from all 15 Local Health Districts as well as the Ambulance Service of NSW, Sydney Children’s Hospital Network, St Vincent’s Hospital and Justice and Forensic Mental Health.

- There were relatively high response rates from the Ambulance Service of NSW (9.3%) and Far West LHD (10.7%).
- The highest proportion of responses was from those in Child, Adolescent and Family Health (19.1%), Ambulance (17.5%) and Mental Health (16.6%) services.
- Self-reported levels of Domestic Violence training were extremely low with 93% of NSW Health staff reported minimal or no training in their current role.
- Correspondingly, the level of knowledge reported by staff about Domestic Violence was low; ≥70% of respondents had basic or no knowledge of “DV legislation”, “DV policy” or “DV services and referrals”.
- NSW staff indicated that their most likely referral of a DV case would be to social work or counselling within NSW Health (36.9%) or to a women’s refuge or centre outside of NSW Health (18.4%).
- The most commonly reported difficulty when dealing with DV victims was the reluctance of victims to disclose DV (35% of responses).
- In rural/regional LHDs a quarter of respondents expressed concerns about the limited availability of referral services.
- 1 in 5 respondents from Specialty Health Networks (predominantly from the Ambulance Service of NSW) reported concerns about staff safety and having to deal with DV perpetrators.
- There was a expressed preference for brief reference resources to guide DV related work such as one page fact sheets (65%) and referral flow charts (52%).
- Domestic Violence Routine Screening (DVRS) activities could be reinforced by workforce development and clear referral pathways according to 30% and 33% of respondents respectively.
- There was a strong preference for DVRS forms to include questions related to non-physical abuse such as controlling behaviour (86%) and actions that create fear (80%).

The most striking finding from the survey was the low levels of DV training reported by respondents. Moderate or significant training levels were reported by only 7% of respondents. Further, no respondents from the Ambulance Service reported a moderate or significant level of DV training in their current role. This is of particular concern as NSW Ambulance staff frequently attend DV victims at the scene of a DV incident, often with perpetrators and other family members present.

However, the framing of the question around training may have influenced these results as the specific question asked about training received in “your current role”. This does not take into account training received in previous roles. The levels of training reported may therefore be an underestimate of the level of DV training undertaken during a respondent’s career.
As might be expected, reported levels of DV related knowledge were also low. Respondents were asked about their knowledge of DV policy, DV legislation and DV services and referral options. Approximately 70% of staff reported “none” or “basic” levels of knowledge to each of these areas.

The most common referral option within NSW Health, was to “Social work/Counselling services” (35%), while the most common referrals to external services were to “Women’s centres/refuges” (18.4%), “Social work/counselling services” (16.4%) and “Child protection” (14%).

The primary difficulties reported by staff when working with DV victims were the reluctance of victims to disclose DV (35%), limited referrals options/services (22.2%) and limited staff knowledge (12.7%). Specialty health service staff were much more likely to report safety concerns and dealing with the perpetrator (19.5%) than LHD staff (8%). Rural and regional LHDs were more likely to report limited referral and service options than metropolitan LHDs (24.7% and 19.7% of responses respectively).

NSW Health staff were most interested in the availability of brief resources to guide their DV related work. When respondents were asked what would be most useful when they require policy or procedure guidance related to DV, one-page fact sheets and referrals flows charts were considered useful by more than half of respondents (65% and 52% of respondents respectively).

Thirteen one per cent of respondents reported using DVRS in their work. Of the 69% who did not use DVRS in their work, the predominant reasons were that DVRS were not carried out in their service or role. Of concern, 6% of respondents who reported not screening in their work did not do so due to a lack of available screening forms. This might suggest that these individuals would screen for DV if these forms were available to them.

Those currently working in DVRS services are not as likely to be involved in treating physical injuries as other NSW Health staff. Therefore the finding that only 6% of staff using DVRS in their work reported “treatment physical injuries” as their most likely response to DV victims (compared to 36% of staff who did not use DVRS) is not unexpected.
RECOMMENDATIONS

Training and development
Focus on DV training across NSW Health in order to:
1. Increase overall levels of DV training across NSW Health, especially in the Ambulance Service of NSW who are often first line responders.
2. Reinforce continuing professional development for NSW Health staff to update and maintain levels of DV knowledge throughout the careers of NSW Health Staff.
3. Improve the ability of staff to identify and effectively manage victims of DV.

DV resources
4. Provide NSW Health staff with one-page fact sheets and referral flow-charts to guide their management of DV victims.
5. Increase availability of DV related services, especially in rural and regional areas.

DVRS services
6. Broaden the scope of the DVRS questionnaire to include emotional abuse and controlling behaviour.
7. Ensure the availability of DVRS forms for all services that carry out DV screening.

Further evaluation
Additional, more targeted evaluation may be required to validate the findings of this survey and to provide greater detail on the issues related to the management of DV in different areas and services of NSW Health. It is also recommended that focused discussions are undertaken with non-clinical staff and staff in rural and regional NSW to ascertain their specific needs in relation to dealing with victims of DV.

See Appendix 1 for further information pertaining to sampling and survey design.
LIMITATIONS

The limitations of a survey are those characteristics of design or methodology that impact or influence the interpretation of the results of the survey. Survey limitations may affect the generalisability and utility of the findings.

Summary of limitations

Response rate could not be accurately determined as there was no way to assess the number of staff who received the survey.

The estimated response rate was very low (3.9%) which brings into question the generalizability of the survey.

The distribution of the survey meant that assessing:
- the response rates of specific services or work functions was not possible.
- the reasons that staff did not respond to the survey is not possible as non-responders could not be identified.
- whether some staff were more or less likely to respond to the survey depending on their work and personal histories was not possible.

The heavy reliance on open-ended responses made the accurate analysis and interpretation of some questions difficult.

Caution must be exercised when generalising the findings to all NSW health staff. A primary potential limitation of the findings is the estimated survey response rate of 3.9% across all NSW Health staff (ranging from 1.1% to 10.7%). However, as these response rate calculations are an estimate based on “incidents of payroll” for the month that the survey was active, and respondents may have multiple roles within NSW Health so they might be represented by more than one “incident of payroll”, we have likely underestimated the response rate. Even given the likely underestimation the response rate is small.

Chief Executives of LHDs and Specialist Networks were asked to distribute the survey to staff via email (see Appendix 1). Using this method of dissemination means there is no way to assess:
- The number of NSW Health staff who actually received the survey
- Whether specific services were preferentially targeted to complete the survey (did some LHDs or specific areas within an LHD or service receive multiple reminders of the survey?). This may explain disparities in some LHDs where response rates are low but reported DV training levels were relatively high.

Further consideration needs to be made based on who is more or less likely to answer the survey. Staff may be more or less likely to respond to the survey depending on:
- Their previous or recent contact with DV. This could include working in a DV service or recent contact with a DV victim. This may explain the relatively high response rate from the Ambulance Service of NSW.
- A personal or family history of DV.
- The amount of time they spend at a computer in their current role.

The specific services that returned the most responses were Child, Adolescent and Family Health services (19% of responses), the Ambulance Service of NSW (17.5%) and Mental Health services (16.6%). These services would be more likely to have contact with DV victims than other services, and therefore staff in these services may have been more likely to respond to the survey.
Due to the open-ended nature of the answers used to assign respondents to specific work function and service within NSW Health, the accuracy of these classifications is dependent upon the detail given by the respondent. Many responses did not provide enough detail to define a specific work role (e.g. "Clinician" or "Nurse"). Future surveys may consider providing pre-determined multiple responses to work role/service and similar questions in order to improve both clarity and direction for the respondent and interpretation for the survey analysts.

Question 21 of the survey was only answered by those who reported using DVRS. This question asked ‘what would help DVRS roll out in your service?’, when all respondents currently worked in a service that had rolled out DVRS. Unsurprisingly, many responses indicated that nothing would be required, as DVRS was already being used successfully in their service.

Similarly, the same group of respondents were asked which services they would recommend for the extension of DVRS screening. By definition the respondents work in DVRS screening services and therefore do not work in any of the proposed services put forward for screening extension. This group of respondents may not therefore be in a position to know if the proposed services would be appropriate for DVRS extension.

Any of these factors could influence the overall results of the survey. These issues need to be taken into consideration when drawing conclusions and interpreting the findings for the purpose of policy review, and when planning future surveys.
REFERENCES


APPENDICES

Appendix 1: Design and distribution of the NSW Health domestic violence workforce survey

1.1 The domestic violence workforce survey

NSW Kids & Families Workforce Survey

Your role in NSW health

*1. What is the MAIN focus of your current role?*

[Blank space for input]

2. Which of the following best describes your current occupation?

- [ ] Administrative
- [ ] Managerial
- [ ] Clinical
- [ ] Other (please specify)

[Blank space for input]

*3. How long have you worked in your current role?*

- [ ] Less than 6 months
- [ ] 6 – 12 months
- [ ] 1 – 2 years
- [ ] 3 – 5 years
- [ ] 5 years or more
*4. What Local Health District do you work for?

☐ Ambulance Service of NSW
☐ Central Coast
☐ Illawarra Shoalhaven
☐ Nepean Blue Mountains
☐ Northern Sydney
☐ South Eastern Sydney
☐ South Western Sydney
☐ Sydney
☐ Western Sydney
☐ Far West
☐ Hunter New England
☐ Mid North Coast
☐ Murrumbidgee
☐ Northern NSW
☐ Southern NSW
☐ Western NSW
☐ St Vincent’s Hospital
☐ Sydney Children’s Hospital Network
☐ Justice Health

*5. What contact have you had in the LAST MONTH with victims of domestic violence?

☐ None
☐ 1 case
☐ 2 – 5
☐ 6-10
☐ More than 10 cases
Policy, legislation and referral options

6. How would you describe your level of knowledge about the current policy that guides NSW Health’s work on domestic violence?

☐ None
☐ Basic
☐ Good
☐ Very Good

*7. How would you describe your level of knowledge about the legislation that guides NSW Health’s work on domestic violence?

☐ None
☐ Basic
☐ Good
☐ Very Good

*8. How informed do you feel about services and referral options available to victims of domestic violence?

☐ No knowledge
☐ Limited knowledge
☐ Knowledgeable
☐ Very knowledgeable
Training and prevention

9. What training relevant to domestic violence have you received since you began in your CURRENT role?

10. In your current role, do you perform or participate in any Domestic and Family Violence prevention activities?
   [ ] Yes  [ ] No

Actions and referrals

11. In your current role, please indicate the actions you are most likely to take when dealing with someone who is a victim of domestic violence

   [ ] Treat physical injuries
   [ ] Treat emotional injuries
   [ ] Case management
   [ ] Assessment
   [ ] Refer to Police
   [ ] Contact the Child Wellbeing Unit
   [ ] Make report to Community Services Child Protection Helpline
   [ ] Note, no further action required
   [ ] Refer to another NSW Health Service
   [ ] Refer to another agency or service

   Other (please specify)

12. If you referred the case to another NSW Health Service, which one?

13. If you referred to another agency or service, which one?
Documenting domestic violence injuries

*14. Is there a recognised policy in place in your LHD/Service regarding documenting injuries (physical and psychological) incurred as a result of domestic violence?

- Yes
- No
- Not sure

Areas for improvement and information sharing

15. Please comment about the difficulties you might encounter in your work with victims of domestic violence?

*16. Are the limits and/or opportunities for information sharing with other agencies sufficiently clear?

- Yes, very clear what information can be shared
- Mostly clear, but I know who to approach for clarification if required
- Mostly clear, but I don’t know who to ask when I’m not sure
- No, not clear

How best to provide information on domestic violence policy and procedures

17. What would you find most useful when requiring guidance on the policy and procedures relating to domestic violence?

- An overarching policy and procedures document;
- A range of one-page fact sheets to provide a quick reference guide;
- A range of referral flow charts to cover different situations;
- A website with a range of resources;
- Access to training.

Other (please specify)
Services for victims of domestic violence

18. What services best support victims of domestic violence?

☐ Treatment for injuries
☐ Information about rights and options
☐ Information (i.e. leaflets, websites, etc) about the nature and impact of domestic violence
☐ Culturally competent services
☐ Documentation (photographs of injuries, medical notes) to assist Court/Legal matters
☐ Support through the legal process
☐ After hours, crisis support
☐ Counselling for the victim
☐ Counselling for the victim’s children
☐ Referral to Police
☐ Referral to legal advice
☐ Referral to a domestic violence service/hotline/refuge

Other (please specify)

__________________________________________

Domestic violence routine screening

19. Do you currently use Domestic Violence Routine Screening in your work?

☐ Yes
☐ No

*20. If no, what is the reason you do not use Domestic Violence Routine Screening?

☐ Not done in my role
☐ Not done in my service
☐ Screening forms not available
☐ Screening questions separate to initial assessment

Other (please specify)

__________________________________________
21. Please select what would most support the successful implementation of Routine Screening in your area?

- Regular training on Domestic Violence Routine Screening
- Awareness and information material for clients on the impact and nature of domestic violence
- Increased staffing levels
- Greater privacy for client
- Clarify regarding reporting obligations for domestic violence to Community Services
- Management support
- Clear referral pathways
- Make service a target program for Routine Screening
- More time with the client(s)

Are there other things that would support Routine Screening in your area? Please comment...
Domestic violence routine screening

22. The first screening question asks, “...have you been hit, slapped or hurt in other ways by your partner or ex-partner?” Would it be useful to include other examples of physical and non-physical violence? If so, what examples/behaviours?

☐ Choking/Strangling
☐ Controlling and/or coercive behaviour
☐ Pushing/shoving
☐ Punching
☐ Other, please state
☐ No change

Other (please specify)

*23. The second question asked in Routine Screening aims to assess a woman’s level of fear. Please indicate your preferred wording out of the following options:

☐ “Were you frightened of your partner or ex-partner in the last year?”
☐ “Has your partner done anything to make you feel afraid in the last year?”

24. Should examples of emotional/psychological abuse be added to the question posed in routine screening?

☐ Controlling behaviour
☐ Actions that create fear

Other (please specify)
Extending domestic violence routine screening

Routine screening currently operates in four target areas: antenatal, early childhood health services, mental health and drug and alcohol.

25. Domestic Violence Routine Screening (DVRS) currently operates in four target services where the incidence and prevalence of domestic violence is high: Antenatal, Mental Health, Alcohol & Other Drugs, and Early Childhood Health services. Should routine screening for domestic violence be extended to other targeted services (choose all that apply)?

- [ ] GP
- [ ] Emergency Department
- [ ] Sexual health
- [ ] Sexual assault services
- [ ] Women’s health nursing services
- [ ] Dental services (public)
- [ ] Aged care
- [ ] Women’s Health

Other Community Health or Hospital, please specify:

Improving outcomes for victims of domestic violence

26. What things would reinforce your work with victims of domestic violence? Please comment....

Thank you for filling in the survey!

Thank you, you have now finished the survey.

The results of this survey will be sent directly to NSW Kids and Families to be incorporated into the development of a revised domestic violence policy and procedure.

The results will be completely anonymous, and no personal data has been collected by filling in this survey.

If you are a victim of domestic violence and need support or advice, you can:

- Contact the Employee Assistance Program in your Local Health District
- Contact 1800RESPECT, Australia’s national 24/7 sexual assault, domestic and family violence counselling service on 1800 737 732 or www.1800respect.org.au

If you have any questions about this survey, please do not hesitate to contact Tamsin Anderson, Senior Analyst, Violence Prevention and Response Unit, NSW Kids & Families on (02) 9391 9884, or by email tande@sdoh.health.nsw.gov.au
1.2 All staff email

All staff email sent to LHD and Specialty Health Network Chief Executives for distribution of the DV workforce survey:

Dear Chief Executives,

The NSW Kids & Families, NSW Health is currently reviewing the Domestic Violence (DV) policy PD2006_084 Identifying and Responding: Policy and Procedures for Identifying and Responding to Domestic Violence. The review is underpinned by a targeted consultation strategy which includes a workforce survey, a victim survey, and a final consultation on the revised policy with all LHD and Specialty Network’s Chief Executives.

To facilitate the review, I am writing to all LHD and Speciality Network Chief Executives requesting the distribution of the following ‘all staff’ email. The text for the email below invites staff to complete the survey to identify policy, implementation and service delivery issues to inform the revised DV policy. The survey will run from Monday 4th February – 1st March 2013. Accordingly, I would be grateful if you could send the email below on the morning of the 4th February.

So as to encourage a good level of returns, the workforce survey is a simple web-based questionnaire that has been designed to take between 5 – 10 minutes to complete and is totally anonymous. Once the survey results have been analysed you will be fully briefed on the results.

Should you have any questions regarding the survey may I direct you or your staff to Tamsin Anderson, Senior Analyst, Violence Prevention and Response Unit on (02) 93919884, or tande@doh.health.nsw.gov.au.

Yours sincerely

Joanna Holt
Chief Executive, NSW Kids & Families

Draft email for LHD Chief Executives
To: All Staff
From: LHD Chief Executive
Subject: Survey - NSW Health services for victims of domestic violence

Dear Colleague,

About one in three Australian women experience physical violence over their lifetime. Domestic violence impacts on the physical and mental health of victims and their families.

NSW Health provides a number of different services to victims of domestic and family violence including counselling, treatment for physical injuries, violence prevention activity and safety planning.
To help improve the way NSW Health responds to domestic violence, we are inviting all staff to complete a short, state-wide survey. The survey aims to gauge your views on the current NSW Health response to domestic violence, and explores what changes can be made to deliver improved service responses to victims and their families.

It will take you between 5-10 minutes to complete and is totally anonymous. No personal data will be collected through your participation in this survey.

Thank you for helping NSW Health and NSW Kids and Families reduce the prevalence and health impacts of violence and neglect on individuals, families and the communities in which they live.

To complete the survey, simply click on this link: https://www.surveymonkey.com/s/NSWHealthDomesticViolenceSurvey

Kind regards

<insert name> Chief Executive

<insert name>
1.3 Considerations for future NSW Kids and Families surveys

All surveys have limitations but there are ways that different methods can be used to maximise the useability of the results.

Future surveys undertaken by NSW Kids and Families need to be developed in close consultation with health survey experts in addition to content experts for the specific area of the survey.

A balance needs to be reached between capturing as much information as possible and creating a survey tool that provides the required evidence and is straight forward and clear to both individuals completing the survey and the analysis team. Pilot processes should involve testing with the target audience and analysis of findings to ensure that the data can be analysed in line with the analysis plan.

Future surveys of the health Workforce may be more informative if carried out in a targeted manner. One possible model would be to target several specific services within different LHDs and services, and distribute the survey directly to all staff in those services. For example, this may include distributing the survey to:

- DV specific services
- A range of DVRS services
  - An antenatal service
  - A Drug and Alcohol service
  - A mental health service
- A range of non-DVRS services (including those flagged for the potential introduction of DVRS)
  - Women’s health services
  - Emergency Departments
  - Ambulance Service of NSW
  - Community health services

Although this approach would be more time consuming and resource intensive, by targeting specific services there would be accurate numbers on how many staff received the survey and how many of those surveys were completed, resulting in much more reliable response rates. In addition, staff that would never encounter DV victims in their current role, such as administration, finance and support staff would not be asked to complete the survey therefore making the overall results more relevant. This approach would also provide an opportunity to follow up those individuals who did not respond to the survey to ascertain the characteristics of non-responders and the possible reasons for not responding. A targeted survey with a smaller sample using follow up techniques to increase response rates would result in more reliable findings and increased generalisability.
Appendix 2: Recoding of open ended questions

**Role within NSW Health**

Respondents were asked the open ended question (Question 1): “What is the MAIN focus of your current role?”

The survey also contained with the multiple choice question (Question 2): “Which of the following best describes your current occupation? Either:

- Administrative
- Managerial
- Clinical
- Other (please specify)”.

Based on the responses to these questions, work roles were further classified into “Function within NSW Health” and the “Service type within NSW Health”. The categories for these variables were determined in consultation with the Domestic Violence Policy Review Reference Group. Any responses that provided insufficient detail to categorise into specific function were classified based on their answer to question 2 of the survey (Administrative/Managerial/Clinical).

**Training in current role related to Domestic Violence**

Open-ended responses to the question “What training relevant to domestic violence have you received since you began in your current role?” were reclassified into a new variable defined as “Level of training”. The criteria for each level of training were determined in consultation with the Domestic Violence Policy Review Reference Group (table 1).

**Table 1: Categories for the new variable “Level of training in current role”**

<table>
<thead>
<tr>
<th>Level of training category</th>
<th>Examples of responses included</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None; Nil; Not in this role; Don’t know</td>
</tr>
<tr>
<td>Minimal</td>
<td>Induction; Orientation; Mandatory; In-service; Child protection;</td>
</tr>
<tr>
<td></td>
<td>Keep Them Safe (KTS)</td>
</tr>
<tr>
<td>Moderate</td>
<td>1-2 days of training; DVRS unspecified duration; Education Centre</td>
</tr>
<tr>
<td></td>
<td>Against Violence (ECAV)</td>
</tr>
<tr>
<td>Significant</td>
<td>Specified over 2 days training</td>
</tr>
</tbody>
</table>
**Difficulties you might encounter when working with victims of domestic violence.**

Based on a review of the responses to this open-ended question (question 15), a range of categories were generated that covered the range of difficulties reported. These new categories are outlined in table 2.

**Table 2: Categories for difficulties encountered when working with DV victims.**

<table>
<thead>
<tr>
<th>New categories</th>
<th>Examples included</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child protection/safety</strong></td>
<td>Concern for impact and long term effects on children</td>
</tr>
<tr>
<td><strong>Co-morbidity with other clinical issues</strong></td>
<td>Emotional distress; depression; mental health issues</td>
</tr>
<tr>
<td><strong>Cultural and linguistic differences</strong></td>
<td>Language barriers; availability of interpreters; responding appropriately to people from culturally diverse backgrounds</td>
</tr>
<tr>
<td><strong>Gender bias towards female victims</strong></td>
<td>Limited service options for men; policy focus towards female victims</td>
</tr>
<tr>
<td><strong>Limited referral/service options</strong></td>
<td>Limited referral/service options for perpetrator; dealing with issues of past/historical abuse; lack of housing services; difficulties in ensuring adequate and timely Police response</td>
</tr>
<tr>
<td><strong>Limited/lack of knowledge (staff)</strong></td>
<td>Limited/no knowledge on where to refer, what to do; recognising domestic violence; how to encourage women to take action</td>
</tr>
<tr>
<td><strong>Patient unable or unwilling to engage/respond</strong></td>
<td>Patient unable to comply with treatment due to incapacity, illness, age, intoxication, distress etc.</td>
</tr>
<tr>
<td><strong>Privacy/information sharing</strong></td>
<td>Presence of partner; disclosing/not disclosing perpetrator information; confidentiality; safety of victim; rural and regional locations where both victim and perpetrator may be known</td>
</tr>
<tr>
<td><strong>Victim afraid/reluctant to disclose/report</strong></td>
<td>Not realising/accepting in domestic violence situation; fear of escalating violence if reported; child protection concerns; reprisals to victim.</td>
</tr>
<tr>
<td><strong>Staff attitude</strong></td>
<td>Victims do not receive a supportive/appropriate response from NSW Health staff; incorrect assumptions/stereotypes about domestic violence; lack of support or understanding from colleagues</td>
</tr>
<tr>
<td><strong>Staff domestic violence</strong></td>
<td>Colleagues who are domestic violence victims; absenteeism</td>
</tr>
<tr>
<td><strong>Staff safety concerns/dealing with the perpetrator</strong></td>
<td>Issues of home visiting; fear of escalating violence or reprisals to staff or other professionals</td>
</tr>
<tr>
<td><strong>Time constraints</strong></td>
<td>Pre-determined ED targets; emphasis on brief interventions; limited total number of sessions (i.e. counselling)</td>
</tr>
<tr>
<td><strong>Traumatic impact of working with domestic violence</strong></td>
<td>Emotional distress of staff; emotional fatigue</td>
</tr>
</tbody>
</table>
Referral of victims of domestic violence

Responses to questions regarding likely referral decisions when encountering domestic violence victims (questions 12 and 13) were recoded into discrete service areas as outlined in table 3. Any external services reported in referrals to NSW Health services (question 12) were excluded.

Table 3: Services to which respondents referred victims of domestic violence

<table>
<thead>
<tr>
<th>NSW Health referral services</th>
<th>External referral services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal services</td>
<td>Aboriginal services</td>
</tr>
<tr>
<td>Aged care</td>
<td>Aged care</td>
</tr>
<tr>
<td>Ambulance/ED/Hospital</td>
<td>Centrelink</td>
</tr>
<tr>
<td>Case-by-case basis</td>
<td>Child and Family services</td>
</tr>
<tr>
<td>Child and Family health service</td>
<td>Community health</td>
</tr>
<tr>
<td>Child Wellbeing Unit</td>
<td>Cultural and linguistically diverse services</td>
</tr>
<tr>
<td>Domestic Violence Service</td>
<td>Disability services</td>
</tr>
<tr>
<td>Drug and Alcohol</td>
<td>Domestic violence helpline</td>
</tr>
<tr>
<td>Education Centre Against Violence</td>
<td>Domestic violence services</td>
</tr>
<tr>
<td>General Practice</td>
<td>Drug and Alcohol</td>
</tr>
<tr>
<td>Mental health</td>
<td>Family and Community Services/Child protection</td>
</tr>
<tr>
<td>Sexual assault service</td>
<td>Legal services</td>
</tr>
<tr>
<td>Social work/counselling</td>
<td>Mental health service</td>
</tr>
<tr>
<td>Women’s health/Maternity</td>
<td>Non-government organisation</td>
</tr>
<tr>
<td></td>
<td>Sexual assault service</td>
</tr>
<tr>
<td></td>
<td>Social work/counselling</td>
</tr>
<tr>
<td></td>
<td>Women’s centre/refuge</td>
</tr>
</tbody>
</table>
Domestic Violence Routine Screening (DVRS)

Question 19 of the survey asked respondents if they “currently used Domestic Violence Routine Screening in your work”. If the respondent answered no, they were asked the reason they did not use DVRS (Question 20) and this completed the survey. If respondents stated that they used DVRS in their work, they were asked a series of questions on DVRS implementation, potential changes, expansion and improvement of DVRS (Questions 21-26).

Those respondents who reported using DVRS were asked the open-ended question “What things would reinforce your work with victims of domestic violence?” Based on a review of the responses to this question, a number of categories were generated that covered the range of issues reported. The categories are outlined in table 4.

Table 4: Categories for the questions: “What would reinforce your work with victims of DV?”

<table>
<thead>
<tr>
<th>Categories</th>
<th>Examples included</th>
</tr>
</thead>
<tbody>
<tr>
<td>A victim centred response/securing safety</td>
<td>Developing trust with the victim; ensuring victim safety</td>
</tr>
<tr>
<td>An appropriate justice and legal response</td>
<td>Efficient and timely access to legal support; prompt police response</td>
</tr>
<tr>
<td>(Police/Courts)</td>
<td></td>
</tr>
<tr>
<td>Clear and responsive referral pathways</td>
<td>Clear referral pathways; access to support services; improved awareness of available services</td>
</tr>
<tr>
<td>Integrated service response</td>
<td>Effective communication with other services; collaboration between services</td>
</tr>
<tr>
<td>Organisational and management support</td>
<td>Better system support; support from management</td>
</tr>
<tr>
<td>Prevention and awareness raising</td>
<td>More public awareness; community awareness</td>
</tr>
<tr>
<td>Professional resources</td>
<td>Information brochures for clients; posters and flow charts</td>
</tr>
<tr>
<td>Resource/service enhancement</td>
<td>Better staffing; more refuge accommodation; increased social work services</td>
</tr>
<tr>
<td>Workforce development</td>
<td>More education and training; regular updated training</td>
</tr>
</tbody>
</table>