Health Interventions for Family and Domestic Violence: A Literature Review

for NSW Kids and Families

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## Abbreviations and acronyms

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<tbody>
<tr>
<td>AAS</td>
<td>Abuse Assessment Screen</td>
</tr>
<tr>
<td>AVO</td>
<td>Apprehended Violence Order</td>
</tr>
<tr>
<td>AOD</td>
<td>alcohol and other drugs</td>
</tr>
<tr>
<td>ATSI</td>
<td>Aboriginal and Torres Strait Islander people</td>
</tr>
<tr>
<td>CALD</td>
<td>culturally and linguistically diverse</td>
</tr>
<tr>
<td>DA</td>
<td>Danger Assessment</td>
</tr>
<tr>
<td>DA-I</td>
<td>Danger Assessment for Immigrant Women</td>
</tr>
<tr>
<td>DV</td>
<td>domestic violence</td>
</tr>
<tr>
<td>DVSAT</td>
<td>Domestic Violence Safety Assessment Tool</td>
</tr>
<tr>
<td>ED</td>
<td>emergency department</td>
</tr>
<tr>
<td>FACS</td>
<td>Family and Community Services</td>
</tr>
<tr>
<td>GP</td>
<td>general practitioner</td>
</tr>
<tr>
<td>HARK</td>
<td>Humiliation Afraid Rape Kick (tool)</td>
</tr>
<tr>
<td>HITS</td>
<td>Hurts, Insults, Threatens and Screams (tool)</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine (USA)</td>
</tr>
<tr>
<td>IRIS</td>
<td>Internet-based Intervention to Improve Mental Health Outcomes for Abused Women</td>
</tr>
<tr>
<td>LGBTI</td>
<td>lesbian, gay, bisexual, transgender and intersex</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Clinical Medicine (UK)</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>OVAT</td>
<td>Ongoing Violence Assessment Tool</td>
</tr>
<tr>
<td>PTSD</td>
<td>post-traumatic stress disorder</td>
</tr>
<tr>
<td>SARA</td>
<td>Spousal Assault Risk Assessment Guide</td>
</tr>
<tr>
<td>STaT</td>
<td>Slapped, Threatened and Throw tool</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>WAST</td>
<td>Women Abuse Screening Tool</td>
</tr>
<tr>
<td>WEB</td>
<td>Women’s Experience with Battering (tool)</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
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Using this Document

This review describes eleven different areas of intervention for health services responding to domestic violence supported by the research literature. Section 2 of this document briefly outlines the methods used to search the literature, followed by definitions of terms used in Section 3.

A summary table of the eleven areas of intervention and the recommendations for each as well as additional recommendations specific to programs or populations comprises Section 4 of the document.

A full description of each intervention type, the evidence for it, risks and limitations of each and a more expanded version of each recommendation constitutes Section 5 of the document. Sections 6 and 7 then outline additional issues identified in the literature for specific programs and populations, followed by Section 8 which constitutes a list of the 45 recommendations arising from the evidence.
1. INTRODUCTION

1.1 Background

This literature review was conducted by the School of Social Sciences at the University of NSW from July to September 2014 to support the revision of the NSW Health *Policy and Procedures for Identifying and Responding to Domestic Violence* (2006), which is the current statewide health policy guiding responses across hospital and community-based health services in relation to domestic violence. The review was commissioned and funded by NSW Kids and Families.

Abuse by a partner is a major problem in Australia with an estimated 17% of all women and 5% of all men having experienced violence by a partner since the age of 15 (Australian Bureau of Statistics, 2013). Aboriginal people are at particular risk, with Indigenous females and males being estimated to be respectively 35 and 22 times more likely to be hospitalised due to domestic violence-related assaults than other Australian females and males (Al-Yaman et al., 2006). The costs of domestic violence are substantial, estimated in 2009 to cost the Australian economy $13.6 billion annually, $863 million of which is health costs (National Council to Reduce Violence Against Women, 2009).

Domestic violence is now recognised as a significant worldwide public health risk and a major cause of premature death. Research indicates that globally one in seven homicides are committed by an intimate partner, with this proportion being six times higher for female homicides than for male homicides (Stöckl et al., 2013). The issue directly affects the full range of health services in light of the well-documented and extensive effects on women (Tjaden and Thoennes, 2000; Campbell, 2002). The effects of domestic violence include:

- physical and mental health functioning scores lower than the rest of the population, which decrease in inverse proportion to increased physical assault and psychological aggression (Straus et al., 2009)
- levels of mental health functioning that are directly associated with the length of exposure to abuse (Bonomi et al., 2006)
- a threefold increased risk of self-harm compared to the rest of the population (Boyle et al., 2006)
- double the likelihood of being prevented from accessing contraception (Williams et al., 2008)
- increased sexually transmitted diseases and greater likelihood of having low birth-weight infants (Sharps et al., 2007)
- increased rates of pre-term delivery (Rodrigues et al., 2007) and miscarriage (Morland et al., 2008)
- higher rates of chronic pain, gastrointestinal and gynaecological problems, depression and anxiety, and injuries compared to other women (Rivara et al., 2007b)
- health costs 20% higher than for those who have not experienced abuse (Rivara et al., 2007b).
Victims of abuse have frequent encounters with health services and higher rates of health services utilisation (Institute of Medicine, 2011). Australian research has identified that women who report more than two physical symptoms in the past month to their general practitioner are twice as likely to have experienced partner abuse in the past year (Hegarty et al., 2008). Yet they are less likely to receive needed services, more likely to overuse services, and more likely to have a poor relationship with their health-care provider (Plichta, 2007). A synthesis of Australian, British and American studies found that victims of domestic violence continued to experience difficulties when accessing health-care services, including inappropriate responses by health-care professionals, discomfort with the health-care environment, perceived barriers to disclosing domestic violence, and a lack of confidence in the outcomes of disclosure to a health professional (Robinson and Spilsbury, 2008).

Challenges for health policy development are underscored by the need for efforts that address domestic violence to be broadly based, with a recent systematic review establishing its association with gender inequality, gender norms, and social cohesion (Vanderende et al., 2012). This literature review canvasses the peer-reviewed research literature base to support a well-founded, evidence-informed policy.

1.2 Aims of the literature review

This literature review was undertaken with the following aims:

1. Review and analyse academic literature and program evaluations (2005–2014) to identify best-practice health-system responses to domestic violence in Australia and internationally in relation to the program areas of:
   - emergency departments
   - maternity
   - child and family health
   - drug and alcohol
   - mental health.

2. Canvas emerging relevant evidence of health practice around domestic violence in respect of:
   - systemic responses
   - perpetrators of domestic violence
   - home visiting.

3. Recommend evidence-based proposed areas of change to the current NSW Health domestic violence policy, describing the potential risks and benefits of each in relation to their impact on the above services and, where discussed in the literature, in relation to anticipated outcomes for victims, in particular those who:
   - identify as Aboriginal or as Torres Strait Islander
   - identify as lesbian, gay, bisexual, transgender or intersex
   - are from a culturally and linguistically diverse (CALD) background
   - are children or young people
   - are at high risk of further harm (to themselves and their families).
2. METHODOLOGY

This review is theoretical and investigative in nature and covers the published literature from January 2006 to August 2014.

Literature was retrieved through 159 separate searches using the terms ‘domestic violence’ OR ‘intimate partner violence’, in different combinations with: systematic reviews, randomised control trials, health policy, health response, assessment tools, intervention, mental health, drug and alcohol, substance abuse, CALD communities, ethnic groups, cultural diversity, linguistically diverse, homosexuality, LGBTI, emergency department, pregnancy, antenatal, Aboriginal, Indigenous, vulnerable populations, and children. The following databases were searched:

- Medline (Ovid)
- CINAHL
- Psycinfo
- Social work Abstracts
- Informit
- Violence and Abuse Abstracts
- Family Studies Abstracts
- Cochrane library of systematic reviews
- EMBASE

A total of 1647 documents were selectively retrieved from these databases, of which 59 were systematic reviews. The sample of publications selected for this literature review is not definitive but selective. Publications were chosen for relevance to best practice in identifying and responding to domestic violence in the key program areas and with a focus on populations of interest. The majority of publications were from medium- to high-income countries such as the United States, the United Kingdom and Australia. The search was supplemented by citations from identified documents and suggestions from key informants.
3. DEFINITIONS AND TERMINOLOGY

This literature review applies the definition of domestic violence as used in the current NSW Health *Policy and Procedures for Identifying and Responding to Domestic Violence*, as follows:

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. Living with domestic violence has a profound effect upon children and young people and constitutes a form of child abuse. (NSW Ministry of Health, 2006)

Different terminology is used around the world to describe partner abuse. ‘Domestic violence’ is the term commonly used in Australia and the UK to denote abuse between adult partners or former partners, which is the most common form of family violence between adults (Australian Bureau of Statistics, 2013). The term is also used in a range of ways internationally and even locally between agencies, often to include assaults carried out between any members of a household. The phrase ‘intimate partner violence’ is more widely used, particularly in academic literature, and is commonly used in the USA and Europe. The term has some advantages because of its specificity. ‘Family and domestic violence’ is another useful term which reflects the fact that abusive relationships can occur between multiple and varied family members. This term is preferred by some Aboriginal communities and agencies because it reflects the complexity of abuse in Aboriginal families.

This review uses the term ‘domestic violence’ and is concerned with violence between any member of a household, but predominantly abuse by a partner or ex-partner.

Domestic violence is considered a gendered form of violence with the majority of cases perpetrated by a man against a woman (Australian Bureau of Statistics, 2013). In light of its gendered nature this document refers to those who experience abuse as women. This is done both for the sake of simplicity of language and to avoid the more pathologising label of ‘victim.’ In doing so it is also recognised that some men also experience and are negatively affected domestic violence.
## 4. SUMMARY TABLE OF INTERVENTIONS AND RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Section</th>
<th>Relevant programs</th>
<th>Potential risks</th>
<th>Potential benefits</th>
<th>General comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Routine screening for domestic violence</strong></td>
<td>5.1.2.3</td>
<td>Antenatal, Child and Family, Alcohol and Other Drugs, Mental Health services</td>
<td></td>
<td>Improved accuracy, acceptability, interpretation, documentation and responses to screening</td>
<td>Improved identification in at-risk populations</td>
</tr>
<tr>
<td>Rec 1. A fully validated screening tool that includes a scoring system should be piloted as an alternative to the current domestic violence screening questions used in NSW Health services.</td>
<td>5.1.2.1</td>
<td>Sexual health, HIV, gynaecology, women’s health, neurological clinics; couple &amp; family counselling; private antenatal, mental health and AOD services</td>
<td></td>
<td>Screening by a skilled health worker directly asking questions increases identification of abuse, is supported by women who have experienced both abuse and brings benefits particularly when associated with referral to counselling.</td>
<td>Screening increases the likelihood of those in vulnerable populations being identified as experiencing abuse including ATSI, CALD, lesbian, young women and those vulnerable to re-abuse.</td>
</tr>
<tr>
<td>Rec 2. Screening should be extended to additional programs where female patients are at elevated risk of domestic violence.</td>
<td>5.1.2.4</td>
<td>All screening programs</td>
<td>On-site counselling services are unable to respond to the referrals from screening health workers</td>
<td>Sustained screening rates by health providers and improved outcomes for women identified as experiencing DV.</td>
<td>See also separate recommendations for women from vulnerable populations (Reccs 39-46)</td>
</tr>
<tr>
<td>Rec 3. Access to immediate onsite social work response should be incorporated into screening policies.</td>
<td>5.1.2.4 &amp; 5.8.2.1</td>
<td>All screening programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rec 4. Comprehensive and ongoing training should be provided to all new staff in screening programs, and frontline staff tasked with screening, should receive annualised continuing education, which includes practice opportunities along with recent findings from research and training on culturally competent responses.</td>
<td>5.1.2.4 &amp; 5.8.2.1</td>
<td>All screening programs</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### Recommendations

| Rec 5. Health professionals conducting screening should have access to specialist clinical supervision in relation to responding to disclosure. | 5.1.2.4 | All screening programs | | Continuity of care maximises trust and the likelihood of disclosure. Screening at subsequent visits also reduces the likelihood of attendance of partners / other family | Continuity of care is particularly important for vulnerable women |
| Rec 6. Audited systems are required to ensure that all women who are asked screening questions receive appropriate written resources at the time of screening. | 5.1.2.4 & 5.8.2.1 | Sites where multiple visits are typical, particularly antenatal services | | | |
| Rec 7. In services where patients attend for multiple visits, screening should be undertaken at the second visit, with continuity of care of providers across both visits. | 5.1.2.2 | | | | |

#### 2. Risk assessment and safety planning

Rec 8. A structured risk assessment tool should be selected for use by NSW Health frontline staff.

Rec 9. Training should be provided on use of a selected risk assessment tool (See also Section 5.7 Training).

Rec 10. Safety planning should be undertaken with all women identified as currently experiencing domestic violence.

Rec 11. Safety planning should in general be undertaken by social workers.

<table>
<thead>
<tr>
<th></th>
<th>Section</th>
<th>Relevant programs</th>
<th>Potential risks</th>
<th>Potential benefits</th>
<th>General comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S. 5.2 p22-25 5.2.2.1</td>
<td>Antenatal, Child and Family, Alcohol and Other Drugs, Mental Health, Emergency Department hospital wards, community health centres</td>
<td>Practitioners using tools have insufficient training in their use and limitations.</td>
<td>With good training structured risk assessment tools support decisions and planning in responding to DV including high-intensity protection by law enforcement agencies where needed or interagency safety planning processes</td>
<td>Most current risk assessment tools do not yet take into account diverse populations and need to be cross-validated through research with those groups. Systems for identifying those who have experienced abuse and assessing their risk are particularly important in mental health and substance use services.</td>
</tr>
<tr>
<td></td>
<td>5.2.4 &amp; 5.7.1</td>
<td>Social workers attached to all programs</td>
<td></td>
<td>Social workers are most likely to be able to provide specialist knowledge of DV, skilled interviewing, time and privacy not necessarily afforded to other health professionals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.2.2.2</td>
<td>Social workers attached to all programs</td>
<td></td>
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<tr>
<td></td>
<td>5.2.5</td>
<td>Social workers attached to all programs</td>
<td></td>
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</tbody>
</table>

#### 3. First line responses

Rec 12. Supportive advocacy should be a prioritised intervention for community health services.

Rec 13. Resources for distribution and referral pathways for each health unit should be identified and regularly reviewed by a designated senior person attached to that unit/clinic.

<table>
<thead>
<tr>
<th></th>
<th>Section</th>
<th>Relevant programs</th>
<th>Potential risks</th>
<th>Potential benefits</th>
<th>General comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S. 5.3 p26-27 5.3.2</td>
<td>Community Health Centres</td>
<td>Women may not respond to intervention immediately because responses /attitudes to abuse are complex and decision-making about safety is gradual</td>
<td>Supportive advocacy in community settings has been found to reduce the frequency of re-abuse, as well as distress and depression. Repeat opportunities to access services maximise the likelihood of uptake &amp; change.</td>
<td>Supportive first line responses increase the likelihood of vulnerable women accessing support from workers they may be more willing to trust</td>
</tr>
<tr>
<td></td>
<td>5.3.2-5.3.4</td>
<td>All health services providing frontline patient services</td>
<td></td>
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<td></td>
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*Health interventions for family and domestic violence: literature review*
## Recommendations

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Section</th>
<th>Relevant programs</th>
<th>Potential risks</th>
<th>Potential benefits</th>
<th>General comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Counselling with women after domestic violence</strong></td>
<td>S. 5.4</td>
<td>Social workers in hospital clinics, in-patient settings and community health services</td>
<td>Uptake of counselling interventions by those who have experienced DV will vary due to uncertainty, stigma and shame.</td>
<td>Reduced incidence and severity of DV, increased adoption of safety behaviours, reduced depressive symptoms and better outcomes for infants among abused women receiving counselling.</td>
<td>Cultural competence training is required by any social worker providing counselling to populations which may include Aboriginal women.</td>
</tr>
<tr>
<td>Rec 14. Women who are identified in hospital and community health services as experiencing domestic violence either currently or the past 12 months should be provided with 6-8 sessions of counselling to address the impact of the abuse.</td>
<td>5.4.2</td>
<td></td>
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</tr>
<tr>
<td>Rec 15. Antenatal patients should be a priority for this counselling, which should be provided onsite, timed to occur simultaneous to scheduled visits.</td>
<td>5.4.2</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Rec 16. Counselling should be provided by social workers with specialist domestic violence training (see also Section 5.7 Training).</td>
<td>5.4.2 &amp; 5.7.1-2</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Rec 17. Community health services should be supported to provide group work intervention for women affected by domestic violence.</td>
<td>5.4.2</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>5. Mother-child interventions</strong></td>
<td>S. 5.5</td>
<td>Child and family teams, specialist child protection counselling services and community health centres with capacity to respond to children affected by domestic violence</td>
<td>Insufficient resources and specialist training are provided to conduct Mother–child dyad work.</td>
<td>Improved child behaviour and self-esteem, reduced traumatic stress levels among both children and mothers, and reduced PTSD and anxiety in children can occur.</td>
<td>The severe long-term impacts on children of exposure to violence, and the health costs this entails suggest this is likely to be a cost-effective endeavour.</td>
</tr>
<tr>
<td>Rec 18. Mothers and their children who have been exposed to DV should have access to at least eight sessions of mother–child dyad counselling.</td>
<td>5.5.1-5.5.2</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Rec 19. Mother-child interventions after DV should include combined group work programs</td>
<td>5.5.2</td>
<td></td>
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</tr>
<tr>
<td><strong>6. Child protection notification in the context of DV</strong></td>
<td>S. 5.6</td>
<td>Social workers in hospital clinics, in-patient settings and community health services</td>
<td>Child protection notifications alone are insufficient to bring about safety for children and careful assessment is required in order to determine the need and basis for making reports.</td>
<td>Child protection notification allows statutory agencies to take action to protect children who are at risk from exposure to domestic violence, in cases where this is warranted.</td>
<td>The past forced removal of Aboriginal children and their over-representation in out-of-home care give rise to the need for particular care in making notifications. Alignment with the NSW Health Aboriginal Family Health Strategy (2011) is central.</td>
</tr>
<tr>
<td>Rec 20. Child protection notification practice should be supported by specialist training on domestic violence and children at risk conducted in a multi-agency context.</td>
<td>5.6.2</td>
<td></td>
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</tr>
<tr>
<td><strong>7. Training</strong></td>
<td>S. 5.7</td>
<td>LHD Executive</td>
<td>Training alone is insufficient</td>
<td>Training and systemic changes</td>
<td>Training should canvas the</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Section</td>
<td>Relevant programs</td>
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<td>Rec 21. Accompanied by systems changes and monitoring</td>
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<td>and clinic level changes by health services can increase identification and improve the standard of clinical assessment of domestic violence</td>
<td>range of factors that increase domestic violence in Aboriginal communities</td>
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<td>Rec 22. Introduced at the undergraduate level</td>
<td>5.7.2</td>
<td>Tertiary education institutions</td>
<td>to improve identification and referral by health professionals in response to DV without addressing system-wide and individual clinic level barriers</td>
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<td>Rec 23. Tiered as appropriate to the needs of the health professionals, in line with the four-level approach recommended for British health services ie. Level 1 – all frontline staff Level 2 – health workers who screen Level 3 – social workers providing referral responses, risk assessment and safety planning Level 4 – specialist DV / sexual assault service workers</td>
<td>5.7.1</td>
<td>All health services providing frontline patient services</td>
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<td>Rec 24. Delivered where possible by the service providers to whom health workers are expected to refer those experiencing DV</td>
<td>5.7.2</td>
<td>Social workers providing referral responses and specialist DV services</td>
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<td>Rec 25. Updated annually and delivered in such a way that new staff are identified and trained to the required level</td>
<td>5.7.2</td>
<td>LHD Executive</td>
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<td>Rec 26. Provided in conjunction with access to on-call consultation with specialist service providers, which may include hospital/clinic social workers with specialised DV training and skills</td>
<td>5.7.1</td>
<td>Social workers providing referral responses and specialist DV services</td>
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<td>8. System-level responses</td>
<td>5.5.8</td>
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<td>Rec 27. Implementation of a revised policy requires a multi-dimensional approach integrating the four tiers of training, systematic provision of mentoring; ongoing education and consultation; systems for information sharing; auditing and monitoring; documentation tools; and documented referral pathways with immediate response when current DV is identified.</td>
<td>5.5.8 &amp; 5.7.1</td>
<td>LHD Executive</td>
<td>Insufficient resources and attention are directed to bring about and monitor system-level change</td>
<td>Multi-level, system-wide change programs for health responses to DV appear more likely to bring about sustained wholesale change, than single-level interventions</td>
<td>The considerably enhanced outcomes point to the long-term cost-effectiveness of this approach.</td>
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<tr>
<td>Rec 28. Champions of the revised DV policy should be appointed at the unit, professional and program level in each Local Health District. These champions are identified personnel with interest in supporting implementation and who receive as a minimum, Level 3 training.</td>
<td>5.8.2.1</td>
<td>LHD Executive and senior staff</td>
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<td><strong>Rec 29.</strong> Provision should be made in the overarching NSW Health privacy policy for all episodes of care of adults to automatically include time alone with the health provider.</td>
<td>5.8.2.2</td>
<td>NSW Ministry of Health</td>
<td>to include private time with the health provider.</td>
<td>Abuse is reduced through greater opportunities for women to disclose abuse and receive intervention.</td>
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<td><strong>9. Multi-agency collaboration</strong></td>
<td>5.5.9 p39-41</td>
<td>NSW Kids and Families</td>
<td>Multi-agency collaboration is hindered by competing time and resource priorities</td>
<td>Benefits include improved access to services by vulnerable women, enhanced responses to those experiencing multiple problems, strengthened relationships between agencies, increased reporting of incidents, increased charges and reduced retractions of police reports and AVO applications, increased conviction of DV offenders and reduced reported violence by women</td>
<td>Those who are vulnerable because of past abuse, Aboriginality, or being members of groups who experience discrimination are most likely to benefit from combined efforts, however particular care should be taken in seeking consent to share information.</td>
</tr>
<tr>
<td>Rec 30. Multi-agency responses should include combined referral and assessment systems, simplified information sharing, and local inter-agency networks actively maintained through regular contact.</td>
<td>5.9.2</td>
<td>Domestic and Family Violence (DFV) Reforms DFV Reforms Delivery Board</td>
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<td>Rec 31. Multi-agency collaboration requires champions at the senior level of each LHD; robust governance arrangements that operate at multiple levels from the frontline to senior levels of agencies; clearly defined outcomes; and monitoring; and accountability strategies, to successfully address barriers to collaboration</td>
<td>5.9.2</td>
<td>NSW Ministry of Health NSW Kids and Families LHD Executive</td>
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<td><strong>10. Home visiting in the context of DV</strong></td>
<td>S. 5.10 p39-41</td>
<td>NSW Kids and Families</td>
<td>Failure to address evidence and practice-based responses to home visiting denies vulnerable and isolated patients access to needed health services.</td>
<td>Evidence and practice-based protocols for home visiting may allow safe and successful engagement in with women who have experienced abuse enabling those who are isolated to access services that they would not otherwise receive.</td>
<td>It should not be presumed that because a woman has experienced past abuse, that she continues to live with the person who abused her, nor that that person is a threat to others. Vulnerable populations who have either experienced exclusion from health services, are least likely to attend health services and may particularly benefit from home visiting.</td>
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<td>Work should be done to identify:</td>
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<td>NSW Kids and Families funded services</td>
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<td>Rec. 32. health services that currently engage in home visiting, which may include patients who have experienced or demonstrated aggressive behaviour, to determine current risk assessment and safety protocols</td>
<td>5.10.2</td>
<td>NSW Kids and Families</td>
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<td>Rec. 33. a risk assessment and safety protocol based on consultation with agencies and/or research projects where home visiting occurs.</td>
<td>S. 5.11 p43-46</td>
<td>All frontline health services</td>
<td>Risk to health workers is possible but cannot automatically be presumed by those who have been abusive to their partners.</td>
<td>Work with fathers who have exposed their children to domestic violence has the potential to reduce the impact of the abuse on children where</td>
<td>The consensus from large reviews is that there is a lack of consistent evidence on the effectiveness of programs for people who</td>
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<td><strong>11. Responses to perpetrators of DV</strong></td>
<td>S. 5.11 p43-46</td>
<td>All frontline health services</td>
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<td>Rec 34. Based on the evidence, NSW Health services should not provide treatment for the perpetration of domestic violence.</td>
<td>5.11.2. 1</td>
<td>All frontline health services</td>
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<td>Rec 35. Health services accessed by perpetrators that</td>
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<td>do not attempt to treat the perpetration of abuse should continue to be provided unless it there are clear indications of a risk to health workers.</td>
<td>5.11.2. 2</td>
<td>All frontline health services</td>
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<td>safety and suitability criteria can be met.</td>
<td>perpetrate domestic violence</td>
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<tr>
<td>Rec 36. Consideration should be given to inclusion of perpetrators of domestic violence in child protection interventions where no known risk factors preclude this.</td>
<td>5.11.2. 3</td>
<td>Child Protection Counselling services and New Street Adolescent Network NSW Kids and Families funded services</td>
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<td>Emergency departments</td>
<td>S. 6.2 P47 6.2</td>
<td>Emergency departments</td>
<td>Insufficient resourcing is provided to provide an adequate response.</td>
<td>Increased identification of and improved response to abuse among the 12-14% of women presenting to EDs who have experienced abuse in the past 12 months and those attending ED after an incident of abuse, the majority of whom are not identified</td>
<td>DV remains under-identified in emergency departments and responses to disclosures of abuse made in ED have been characterised as unhelpful.</td>
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<td>Rec 37. The development and trial of an integrated strategy to increase identification and documentation, and provide first line responses to those presenting to emergency departments who have experienced recent domestic violence, which could include a trial of targeted screening, is urgently indicated.</td>
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<td>Mental Health and Alcohol and Other Drugs services</td>
<td>S.6.7 p50 6.7-</td>
<td>Mental health services &amp; Alcohol and Other Drug services</td>
<td>Specialised training and support in responding to DV is not provided to health professionals in these services</td>
<td>With training and support to professionals, improved responsiveness to abuse and potentially reduced presentation for substance/mental health care.</td>
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<td>Rec 38. Mental health and substance use services should develop and offer or partner to provide integrated responses to domestic violence, which address both the presenting issue, as well as safety and trauma issues.</td>
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<td>Recommendations for Aboriginal women</td>
<td>S.7.1 p53-54 7.1-7.1.1</td>
<td>Programs providing intervention to Aboriginal women and children including those responding to DV: Aboriginal Maternal and Infant Health Service (AMIHS) Aboriginal Family Health Strategy services</td>
<td>Insufficient resources are provided for cultural competence training and continuity of care. Aboriginal communities are reluctant to consult with mainstream health services</td>
<td>Increased and early appropriate attendance at services responding to abuse and other health issues reduces the need for more complex intervention.</td>
<td>Aboriginal children are 10 times more likely to be in out-of-home care which contributes to Aboriginal people’s unwillingness to seek help for family violence</td>
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<td>Rec 42. Programs need to reflect the range of factors that increase domestic</td>
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<td>violence in Aboriginal communities</td>
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<td>Rec 43. Elements of traditional healing may be important components in</td>
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<td>programs for recovery and prevention of domestic violence in Aboriginal</td>
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<td>families.</td>
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<td><strong>Recommendations for culturally and linguistically diverse women</strong></td>
<td>S.7.2</td>
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<td>Evidence suggests that cultural practices receive a disproportionate level of attention in relation to</td>
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<td>Key suggestions in the literature for improved intervention with women from</td>
<td>p55</td>
<td>intervention to</td>
<td>resources are</td>
<td>accessible,</td>
<td>experiences of domestic violence and that more critical factors for CALD women include poverty,</td>
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<td>CALD communities who have experienced abuse are:</td>
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<td>women from CALD</td>
<td>provided to</td>
<td>including language</td>
<td>inequalities, new articulations of patriarchies, legacies of colonialism and racism</td>
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<td>responding to DV</td>
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<td>consult with</td>
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<td>Rec 44. Language accessibility, and bilingual or ethnic workers providing</td>
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<td>same-language support groups</td>
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<td>Rec 45. Culturally sensitive approaches that take into account women’s</td>
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<td>broader social context including not only culture but also gender, family</td>
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<td>structures, immigration status, trauma experiences, social class and age</td>
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<td>Rec 46. Community engagement, recognising the need to work with community and</td>
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<td>religious leaders.</td>
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*Health interventions for family and domestic violence: literature review*
5. EVIDENCE-BASED INTERVENTIONS FOR HEALTH SERVICE RESPONSES TO DOMESTIC VIOLENCE

5.1 Routine screening

5.1.1 Description

Routinely asking women about current or recent partner abuse using a standardised set of questions regardless of the presenting issue is defined here and in most of the literature as ‘routine screening’. Also referred to as ‘universal screening’, it is distinguished from ‘case finding’, which involves asking patients only in situations where there is a high index of suspicion.

In NSW Health services, screening according to a specified protocol is currently directed under existing policy to occur in all public antenatal, early childhood, mental health, and alcohol and other drugs services, monitored annually through a one-month data snapshot (NSW Ministry of Health, 2012). The policy does not apply to private health services (NSW Ministry of Health, 2006).

Screening programs in general, such as breast or bowel cancer screening, are identified as public health initiatives which must meet agreed conditions for their introduction to be seen as warranted. These vary slightly by jurisdiction but usually include: a sufficiently accurate tool or tools to identify the problem; availability of an effective intervention once the ‘disease’ is identified; low risk to patients; acceptability to patients; and, in the UK, acceptability to health-care providers. Most of the major reviews therefore use these questions to guide their research (Feder et al., 2009; Nelson et al., 2012).

Globally, routine screening has been the most widespread DV intervention to be introduced in health services. Uptake has been strongest in the USA where, since 2004, the Joint Commission on Accreditation in Healthcare Organizations has required hospitals to have criteria to identify patients who may be victims and to train staff in using these criteria (Phelan, 2007). This differs from the UK where screening is not widespread.

Routine screening is a tool to identify abuse and is distinct from the process of risk assessment, which is specifically designed to predict risk of further abuse or death (see 5.2, Risk assessment and safety planning).

Nine systematic reviews have been undertaken in the past five years on the evidence for screening (Trabold, 2007; Feder et al., 2009; Rabin et al., 2009; O’Reilly et al., 2010; Zhang et al., 2010; O’Campo et al., 2011, Todahl and Walters, 2011; Nelson et al., 2012, Taft et al., 2013). In addition, three major statements synthesising the literature and making recommendations have been issued by the World Health Organization (Responding to Domestic Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines), the US Preventive Services Task Force and the UK’s National Institute for Clinical Medicine (NICE). Further, numerous individual studies on a range of issues in relation to the outcomes and implementation of routine screening have been conducted. This section draws on all these sources.
The following discussion on the evidence for screening is based around the positions taken by key bodies, followed by summaries of the evidence on: who should be screened, when screening should occur, which screening tools are most useful, and what other supports are required to sustain screening.

5.1.2 Evidence base

The WHO guidelines conclude there is strong evidence that screening by a skilled health worker directly asking questions increases the identification of women experiencing abuse. The guidelines stop short of recommending universal screening at each health visit, concluding that there is insufficient evidence to support the idea that screening on its own leads to a reduction in DV or improvement in quality of life or health outcomes (World Health Organization, 2013). It should be noted that the WHO definition assumes asking women at every health-care encounter (World Health Organization, 2013: 18). This is different from practice in many settings including under the NSW Health screening protocol, where screening is conducted only at the point of entry to the service (NSW Ministry of Health, 2006). Other literature indicates that many protocols direct rescreening at subsequent specified intervals, often annually, or in antenatal visits at the mid-trimester and in postnatal periods (Family Violence Prevention Fund, 1999; Feder et al., 2009; Hadley, 2009; O’Reilly et al., 2010).

The WHO guidelines draw on the Feder et al. 2009 British review and recent Cochrane review (Taft et al., 2013), concluding that while screening increases the identification of women experiencing abuse, it has not been shown to reduce domestic violence or to improve women’s health outcomes. A key study analysed in all reviews was a large Canadian randomised trial which compared women who were screened for abuse versus not screened in primary care and acute care settings. Results indicated improvements in rates of abuse and quality of life several months later, but there were no significant differences between screened and unscreened women (MacMillan et al., 2009). For ethical reasons, however, women randomised to the unscreened comparison group were also asked questions about abuse, received information about domestic violence, and were offered services if needed, reducing measureable differences between screened and unscreened women.

In addition, a recent trial by Klevens et al. (2012) of a computerised screening for domestic violence appears to reinforce the position of insufficiency of evidence for screening. This study was a three-group trial which compared computerised screening for domestic violence plus provision of a domestic violence written resource list, versus provision of the written resource list only, versus a control group. At one-year follow-up, there were no significant differences in quality of life, physical/mental health, or recurrence of violence (Klevens et al., 2012). A further element taken into account in the Feder et al. (2009) review was acceptability of screening to health professionals, which in the UK ranged from 15% to 95% of health professionals who were asked in studies about their views of screening for DV.

The position taken by the WHO differs from the 2013 US Preventive Services Task Force, which makes a much stronger recommendation in favour of screening, that is, ‘that
clinicians screen women of childbearing age for [DV]’ (Moyer and U. S. Preventive Services Task Force, 2013: 478). This recommendation was based on a systematic review conducted by Nelson et al. (2012), which concluded that screening instruments accurately identify women experiencing DV; that screening women for DV can provide benefits that vary by population; and that adverse effects are minimal.

Of relevance, this review included studies that provided interventions following screening, which were explicitly excluded from the Taft and Feder reviews and therefore from the scope of the WHO guidelines. The Nelson review drew on the findings of four trials of counselling provided after identification of abuse. Key results were reduced incidence of DV and improved birth outcomes for pregnant women (Kiely et al., 2010; El Mohandes et al., 2011), reduced incidence of DV for new mothers (Bair-Merritt et al., 2010; Taft et al., 2011), and reduced pregnancy coercion and unsafe relationships for women in family-planning clinics (Miller et al., 2011).

Apart from these two bodies, policy positions based on reviews of the evidence have also been issued by the Institute of Medicine (IOM), the health arm of the non-profit National Academy of Sciences in the USA, which recommended universal screening for violence as a component of women’s preventive services (Institute of Medicine, 2011). The IOM concluded that asking women and adolescent girls about their interpersonal and domestic violence experiences could identify abuse not otherwise detected, help prevent future abuse, lessen the risk of disability, and improve future functioning and success in life, noting that women may not disclose abuse unless directly questioned under safe and respectful conditions (Institute of Medicine, 2011). The IOM also concluded, similar to other reviews, that most female respondents consider screening for abuse acceptable, though fewer health professionals do, and that most women who have been screened for abuse report no adverse effects from the screening. Additionally, NICE in the UK, which is sponsored by the Department of Health to provide advice to British health and social care services, has issued a guidance statement aimed at helping to identify, prevent and reduce domestic violence and abuse (National Institute for Health and Care Excellence, 2014). These guidelines propose that in selected programs trained staff ask service users whether they have experienced domestic violence and abuse, recommending that this be a routine part of good clinical practice, even where there are no indicators of violence and abuse (National Institute for Health and Care Excellence, 2014:12).

A number of smaller reviews were also conducted, the results of which are incorporated into the following sections.

5.1.2.1 Who should be screened?

A review of 134 global prevalence studies found that average prevalence of lifetime physical violence was higher in every health setting measured than in population-based studies, with the highest rates in psychiatric, obstetrics/gynaecology and emergency departments (Alhabib et al., 2010). Alhabib and colleagues also found particularly high levels of emotional abuse (65-87%) in studies conducted among patients attending emergency departments, of which over 30 were included in the review. In this and other studies, the extent of violence identified, the significant link between domestic violence and poor health (Ellsberg et al., 2008), and costs associated with these health effects (Access Economics, 2004; VicHealth,
2004; Rivara et al., 2007a) point to the need for significant efforts to address DV. Drawing on this picture, the WHO and NICE guidelines propose that the following groups of women be routinely asked about domestic violence:

- women with mental health symptoms or disorders
- women attending for antenatal care
- women experiencing substance abuse problems
- women presenting for sexual health or HIV testing.

In addition the NICE guidelines propose routine asking of adults in:

- postnatal and reproductive health settings
- children’s services.

The WHO additionally recommends screening of women experiencing conditions which may be caused by or exacerbated by DV, including: frequent presentations; intrusive presence of partner; unexplained injury; chronic gastrointestinal, reproductive or genitourinary symptoms or chronic pain; sexual dysfunction; adverse reproductive outcomes (including multiple unintended pregnancies and/or terminations); delayed pregnancy care; adverse birth outcomes; repeated vaginal bleeding; traumatic injury, particularly if repeated and with vague or implausible explanations; or problems with the central nervous system including headaches, cognitive problems or hearing loss.

A separate review recommended that screening be used in couple and family counselling, in light of the risks associated with ignoring DV and evidence in relation to the benefits of screening (Todahl and Walters, 2011).

In most US jurisdictions screening is undertaken in emergency departments. This is not currently the case for NSW Health. See 6.2 Emergency departments for evidence and recommendations in relation to this stream.

No completed studies were identified that specifically addressed the experiences of Aboriginal women and those from culturally diverse backgrounds in relation to screening. However taking the view of screening as an opportunity for women to disclose and access services should timing and circumstances provide safety, and in light of the under-disclosure of abuse by both groups, there is strong argument to include both groups in screening programs with attention to cultural competence in training provided. See also 7.1 Aboriginal and Torres Strait Islander people and 7.2 People from culturally and linguistically diverse backgrounds. Similarly no studies were identified which validated screening tools in populations of young people, however in light of the elevated rates of violence experienced by young women a strong case can be made to exploring extension of screening to programs for young people See also 7.4 Children and young people.

### 5.1.2.2 When should screening occur?

Although some reviews presume that screening occurs at every health encounter (World Health Organization, 2013), in practice screening at entry point and then specified intervals thereafter appears more common.
Rescreening following an initial screen is recommended in a number of studies, for example Bullock et al. (2006), Gerlach et al. (2007), Thackeray et al. (2007), and Soglin et al. (2009), and multiple screening throughout pregnancy has been found to increase disclosure of DV (O’Reilly et al., 2010). This aligns with the views of women who have experienced abuse and been screened who suggest that health workers should persist in asking even if women initially deny there is any problem (Renker and Tonkin, 2006; Sharps et al., 2007; Spangaro et al., 2011b; Malpass et al., 2014). In light of the fact that at least 14% of women who do not disclose abuse when screened have in fact experienced abuse in the 12 months prior (Spangaro et al., 2010b), rescreening is important to build trust and increase opportunities for contact or disclosure by women isolated by abuse. The initial presentation to a service, which is traditionally when screening occurs for the first time, may not be the best point at which to raise the issue of abuse, principally because trust has not yet been established with the health professional (Bacchus et al., 2007; Koziol-McLain et al., 2008; Spangaro et al., 2010b, 2011b). In the case of ongoing care relationships, such as antenatal or drug and alcohol services, the second scheduled clinic visit may provide a more appropriate point at which to raise sensitive issues (Feder et al., 2009). Where the nature of the service requires patients to attend multiple visits, protocols should be amended so that screening questions are asked at the second visit to the health service, particularly in antenatal visits where family and partners often accompany women to the initial visit. Continuity of care in providers at the second visit will also maximise the likelihood of greater trust by the patient and therefore increased chance of disclosure (Spangaro et al., 2010b, 2011b).

5.1.2.3 Which screening tools are most accurate?

Considerable work has been done in the development and validation of tools to assist health workers to ask screening questions since this initiative was introduced in the early 1990s. At that time the Abuse Assessment Screen developed by the American Medical Association was the prevailing tool (Basile et al., 2007). Validation of tools against longer, more comprehensive surveys, such as the Conflict Tactics Scale or Composite Abuse Screen, enables screening tools to be refined to a minimum number of questions, to reduce the time taken and burden on patients of being asked a large number of questions. These longer comprehensive surveys comprise 60–70 questions designed primarily to measure prevalence in research studies, and are considered by many to be the gold-standard DV measures (Sherin et al., 1998; Chen et al., 2005). Validation of screening tools is undertaken to test sensitivity – the capacity of a tool to accurately identify actual cases – and specificity – the capacity of a tool to exclude non-cases. The use of validated tools, as opposed to general questions, achieves four goals:

1. an accurate approach to asking about abuse with the minimum number of questions
2. use of questions which have been tested to maximise their acceptability to and comprehension by patients
3. provision of a system for interpreting women’s responses and so to reach a supportable conclusion as to whether abuse is current for patients
4. clarity of interpretation of answers to reliably inform referrals or provision of care by the health service.
A comprehensive British review that canvassed the evidence for different screening tools being used internationally, identified 18 tools which ranged from single questions to 30-item research inventories (Feder et al., 2009). Most tools in use include scoring systems and/or cut points which assist health workers to interpret the threshold at which responses can be considered clearly indicative of abuse (Basile et al., 2007).

The British reviewers concluded that though several short screening tools are relatively valid and reliable for use in health-care settings, the HITS (Hurts, Insults, Threatens and Screams) scale showed most diagnostic accuracy, concurrent validity and reliability for identifying women who are experiencing current abuse with the best predictive power (sensitivity ranged from 86% to 100%, specificity ranged from 86% to 99%) (Feder et al., 2009). The HITS tool contains four questions. Respondents are verbally asked to estimate the frequency of four behaviours from their partner:

1. Hit or physical hurting
2. Insults
3. Threats
4. Screaming or swearing.

Scores for each item are allocated on a Likert scale (never=1, rarely=2, sometimes=3, fairly often=4, frequently=5) and totalled to derive a possible maximum score of 20. A score of greater than 10.5 has been validated against the Conflict Tactics Scale and Index of Spouse Abuse as identifying women who are currently experiencing DV. A potential limitation of the HITS scale noted by review authors was that it excludes sexual abuse and violence which is no longer current, so would need to be administered with another screening tool if it is considered important to detect these forms of abuse (Feder et al., 2009). Exclusion of those whose abuse experience is past may however be considered advantageous in directing efforts to those currently at risk. Among a sample of 122 women whose responses affirmed experience of DV according to the NSW screening questions, only 54% would have been classified as currently experiencing abuse based on the HITS tool (Spangaro et al., 2010a). Looking at more diverse health-care settings, a Chinese review found the HITS was the most precise diagnostic tool for use in emergency departments (Zhang et al., 2010).

Other tools Feder and colleagues found to have reasonable performance include the Women’s Experience with Battering (WEB) scale, which assesses abuse by characterising women’s perceptions of their vulnerability to physical and psychological danger or loss of control in relationships (Coker et al., 2001). The tool comprises 10 items and uses a six-point Likert-type scale giving a potential range of scores from 10 to 60. A score greater than 20 indicates domestic violence. Ten items may be considered by some health workers to be more burdensome than the current tool which comprises four questions.

The Ongoing Violence Assessment Tool (OVAT) is another instrument that aims to detect current abuse and asks about physical and non-physical violence occurring within the past month. The four questions are concluded to be quick to administer and score (Ernst et al., 2004). Three questions are true/false items:

1. At the present time does your partner threaten you with a weapon?
2. At the present time does your partner beat you up so badly that you must seek medical help?

3. At the present time does your partner act like he/she would like to kill you?

The fourth item is answered on a five-point Likert response: My partner has no respect for my feelings (never/rarely/occasionally/often/always) (Basile et al., 2007). The OVAT was found in the single study included in the British review to have good predictive power and reasonable validity (Ernst et al., 2004; Feder et al., 2009).

The Abuse Assessment Screen (AAS) was singled out as a tool with low combined sensitivity and specificity and was concluded not to be a good candidate for screening programs in clinical settings (Feder et al., 2009). In addition to a body chart for marking up injuries and specific questions about sexual violence and abuse, and abuse during pregnancy, the AAS questions are: Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? and Are you afraid of your partner or anyone you listed above? (Basile et al., 2007). It was also concluded by the Feder review that single questions such as ‘Do you feel safe at home?’ are not suitable for screening, with one study finding that this question had a sensitivity (ability to accurately predict abuse) of only 9%. This underscores the importance of ensuring that health workers tasked with implementing screening do not paraphrase screening questions into a single item. The Feder review did not assess acceptability to women or health-care professionals of each of the tools specifically, but did find that screening overall was acceptable to women who experienced abuse, even where disclosure did not occur, because it helped remove the stigma of abuse and raised their awareness (Feder et al., 2009). There is evidence, however, that health workers support tools which are short and simple to use and interpret (Feder et al., 2009, Spangaro et al., 2011a).

The United States Preventive Services Task Force review of the evidence for DV screening concluded that five instruments with one to eight items demonstrated sensitivity and specificity of greater than 80% for current abuse in clinical populations of asymptomatic women (Nelson et al., 2012). These were the HITS (English and Spanish versions), the OVAT (Ernst et al 2004), the Humiliation Afraid Rape Kick tool (HARK) (Sohal et al., 2007), the Slapped, Threatened and Throw tool (STaT) (Paranjape and Liebschutz, 2003) and Women Abuse Screening Tool (WAST) (MacMillan et al., 2006).

In relation to these tools, the questions asked for each are as follows:

HARK
1. Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner? 2. Within the last year, have you been afraid of your partner or ex-partner? 3. Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? 4. Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner? This is a relatively new tool which has not as yet had wide application. A positive answer to one or more questions is taken as indicating the presence of DV.

OVAT
1. Within the last month my partner has threatened me with a weapon
2. Within the last month my partner has beaten me so badly that I had to seek medical care.
3. Within the last month my partner has no respect for my feelings.
4. Within the last month my partner has acted like he or she would like to kill me.

Responses to Questions 1, 2 and 4 are true/false. Question 3 is a 5 point scale from Never to Very Frequently. A true response to questions 1, 2, or 4, or a response of 3 or higher for question 3 is considered positive for DV.

STaT
1. Have you ever been in a relationship where your partner has pushed or slapped you?
2. Have you ever been in a relationship where your partner has thrown, broken or punched things?
3. Have you ever been in a relationship where your partner has threatened you with violence?

A positive response to each item scores 1 point with scoring assuming that a positive response to any of the questions makes a history of violence likely.

WAST
1) “In general, how would you describe your relationship?”
2) “Do you and your partner work out arguments?”
3) “Do arguments ever result in you feeling down or bad about yourself?”
4) “Do arguments ever result in hitting, kicking or pushing?”
5) “Do you ever feel frightened by what your partner says or does?”
6) “Has your partner ever abused you physically?”
7) “Has your partner ever abused you emotionally?”
8) “Has your partner ever abused you sexually?”

All questions use 3 point scales eg “none” to “a lot”/ “never” to “often” which are then totalled.

The value of validated tools was reinforced in another review from the USA on screening in antenatal care, which found across five studies that identification of DV was significantly higher when a standardised tool was used compared to non-standardised tools or no screening at all (O’Reilly et al., 2010).

In addition to considering tools for asking questions, most studies underscore the importance of providing written information to women. In NSW the policy directs that all women should be provided with a specifically designed, wallet-sized information card (NSW Department of Health, 2001; NSW Ministry of Health 2006). In a study of 10 NSW health services it was found, however, that only half the women who disclosed abuse recalled receiving this card (Spangaro et al., 2010b). Of those who did receive the card, many made use of it, including to initiate discussions with others about abuse (Spangaro et al., 2011b).

5.1.2.4 What conditions are required for screening?

The WHO and NICE guidelines propose the minimum requirements for asking about domestic violence are:

- a protocol / standard operating procedure that is known by staff which includes information about services, policies and procedures of local agencies for people who experience DV
• training on how to ask, minimum response and beyond (see 5.7, Training)
• a private setting
• confidentiality
• formal referral pathways established which include services for children who have been affected by DV.

As part of the protocol there is also a view that effective DV screening programs include a screening tool with sound psychometric properties (Rabin et al., 2009). Brief tools that are embedded into other assessment tools are well accepted by health-care providers who are tasked with screening (Spangaro et al., 2011a).

In a systematic review of mechanisms underpinning screening which analysed 17 different programs, it was found that programs which took a comprehensive approach (i.e. incorporated multiple program components, including monitoring/audits) were successful in increasing DV screening and disclosure/identification rates. The reviewers identified four program components which they determined increased provider efficacy: 1) institutional support; 2) effective screening protocols; 3) thorough initial and ongoing training; and 4) immediate access/referrals to onsite and/or offsite support services (O’Campo et al., 2011).

Others have also emphasised the importance of immediate access to services and other forms of institutional support in sustaining screening, including access by screeners to ongoing supervision and training in relation to DV (Gutmanis et al., 2007; Spangaro et al., 2011a; Todahl and Walters, 2011). A recent British study found that rapid responses to referrals after disclosures of abuse to a general practitioner were pivotal in women’s progress to safety and important to the women involved (Malpass et al., 2014). The same study found that GPs were more likely to ask about abuse and make referrals when they had a pre-existing relationship with a specific person at the domestic violence service through prior training and consultation, and to whom the practitioner would make the referral (Feder et al., 2011). These findings point to the importance of immediate onsite care being incorporated into screening policies wherever possible to sustain screening rates and best outcomes for women identified as having experienced DV.

Screener characteristics and setting can also make a difference. A survey of 140 women who had experienced DV about the characteristics of the screener and screening environment that made them feel more or less comfortable when disclosing a history of DV, found a preference to be screened by a woman, someone of the same race, a provider aged 30–50 years, and without anyone else present (Thackeray et al., 2007). Health-care worker beliefs and attitudes about DV, preparedness and comfort following disclosure have also been found to be critical to sustained screening (Gutmanis et al., 2007; Todahl and Walters, 2011). These findings reiterate the importance of training, including that which addresses attitudinal issues for health workers conducting screening (see also 5.7, Training).

5.1.3 Benefits

There is clear evidence that screening by a skilled health worker directly asking questions increases the identification of women experiencing abuse, has little or no adverse effect on
women, is supported by most women who have experienced both abuse and screening, and can bring about benefits to women particularly when associated with referral to counselling.

Among women who have experienced abuse and screening, both those who did and those who did not disclose report useful outcomes as a result, most commonly re-evaluating their situation and reduced isolation (Spangaro et al., 2010a).

5.1.4 Limitations

Research into screening is acknowledged in the major reviews to be limited by heterogeneity of samples, tools and results; lack of true control groups; high loss to follow-up of study participants, reducing the ability to generalise results; and lack of accepted reference standards (Nelson et al., 2012; World Health Organization, 2013). Undertaking research in this field is typified by challenges to ensuring safety for participants, high drop-out rates and under-disclosure, which mean that quality issues are inevitable (Plichta, 2007). It has been concluded by most researchers in the area that studies combining screening with therapeutic intervention for women’s long-term wellbeing are needed (Koziol-McLain et al., 2010; Nelson et al., 2012; Taft et al., 2013; World Health Organization, 2013).

In terms of limitations of screening per se, evidence from major reviews and large studies of screening suggest the impact of screening is limited and that at a minimum discussion of the issue with the health-care provider, and ideally referral to an onsite counselling service, is required to bring about change to the woman’s situation or wellbeing. In relation to specified validated tools, it should be borne in mind that these have been validated for use with women and are not necessarily suitable for use with male populations should it be decided for some reason that men should also be screened in some settings.

5.1.5 Recommendations

1. A screening tool which has been fully validated and which includes a scoring system to support health workers to interpret, accurately document and act on the results of the screening questions should be piloted as an alternative to the current screening questions used in NSW Health services.

2. Screening in NSW Health services should be extended to women attending sexual health, HIV, gynaecology, women’s health, and neurological clinics; to health services providing couple or family counselling; and to private antenatal, mental health and alcohol and other drugs services which provide care to a significant proportion of at risk women.

3. Access to immediate on-site social work response I should be incorporated into screening policies wherever possible to sustain screening rates and best outcomes for women identified as having experienced DV.

4. Comprehensive and ongoing training should be provided to all new staff in screening programs, and frontline staff tasked with screening, should receive annualised continuing education which includes practice opportunities along with recent findings from research and training on culturally competent responses.
5. Health professionals conducting screening should have access to specialist clinical supervision in relation to responding to disclosure.

6. Audited systems are required to ensure that all women who are asked screening questions receive appropriate written resources at the time of screening.

7. In services where patients attend the health service over multiple visits, clinical guidelines should be developed which direct that screening questions are asked at the second visit to the health service with continuity of care of provider from the first visit.

5.2 Risk assessment and safety planning

5.2.1 Description

Research is beginning to reflect the fact that leaving an abusive partner is not the only way for women to remain safe and, further, to acknowledge that many women are committed to working with their partner towards ending the violence while remaining in the relationship (Nicholls et al., 2013). This recognition has brought about an increase in the use of and interest in both risk assessment and safety planning for women experiencing domestic violence. Risk assessment is undertaken with people who have disclosed that they are the victims of domestic violence with the aim of evaluating their risk of further harm (National Institute for Health and Care Excellence, 2014). It is distinct from processes of identifying DV, in particular through screening, and policy and practice need to address these processes distinctly, recognising the sensitivity of a person’s decision to disclose abuse and the need to proceed at a pace that attends to their vulnerability.

Clinicians have traditionally conducted risk assessments based entirely on their professional judgement; however, the past 10 years has seen risk assessments based on professional judgement in many jurisdictions, by both police and others who respond to DV, being replaced by assessments that rely on empirically validated measures which are based on statistical modelling and recidivism research (Hoyle, 2008), and which draw on advances in violence risk assessment in the past 20 years (Nicholls et al., 2013). A third approach, often referred to as structured professional judgement, recognises the limits of professional judgement and actuarial approaches, and draws on the strengths of both approaches. Although much of the literature has arisen from law enforcement practice, there is also support in Australia from the health sector for more sophisticated risk assessment, particularly in relation to child protection risk in the presence of DV (Laing et al., 2013).

Safety planning is an intervention to help people judge their risk of violence, identify the warning signs and develop plans on what to do when violence is imminent or occurring (National Institute for Health and Care Excellence, 2014). Safety planning often follows risk assessment and is the rationale in many settings for use of risk assessment tools. Safety planning generally constitutes discussions with abuse victims about strategies for protection in the context of an abusive relationship, including strategies such as safe storage of contact details for emergency services, hidden car or house keys, money, copies of key documents and other strategies for exiting in an emergency or signalling for help (Roberts et al., 2006). As a recommended response to domestic violence, safety planning has arisen in large part from recognition by the sector that leaving an abusive relationship may be neither necessary, nor sufficient to eliminate the threat to safety. Safety planning is now regarded
by some practitioners and researchers as the gold standard in responses to DV (Bloom et al., 2014). Such moves are slow to be adopted, however, with one study finding that most women who disclosed abuse to a health-care provider being advised to leave the relationship, and only 31% reporting that safety planning was provided (Morse et al., 2012).

5.2.2 Evidence base

5.2.2.1 Risk assessment

Only one systematic review which specifically considered risk assessment was identified in this review (Nicholls et al., 2013). It concluded that use of risk assessment tools to support professionals assessing the probability of DV significantly increases the accuracy of risk predictions (Nicholls et al., 2013).

The Nicholls review identified and analysed 19 different tools but stopped short of recommending one tool over others, suggesting there was insufficient evidence to support the superiority of any one risk assessment tool for DV. The review noted that the perceptions of women experiencing abuse often contribute valid and potentially unique information to risk assessments. On the other hand, it also reported that the reliability of professionals’ subjective judgement based on their own intuition is limited, particularly in light of the advances in violence risk assessment in the past 20 years (Nicholls et al., 2013). A promising development noted by the review was strong emerging evidence that in combination with increased police resources to respond to an assessment of high risk, recidivism and risk of death or recurrent domestic violence can be reduced (Belfrage et al., 2012).

A limitation of most tools from the perspective of health professionals working with victims of abuse is that many are designed for use with offenders. No attempt is made here to summarise the extensive research on the tools and their predictive capacity (see e.g. Williams, 2012; Storey et al., 2014). However, three tools suitable for use with victims of relevance to health-care professionals are briefly reviewed here along with current developments in their application.

The Domestic Violence Safety Assessment Tool (DVSAT) has been specifically developed for use in the NSW context as part of a new statewide integrated response to domestic and family violence, currently being rolled out. The DVSAT is a structured professional judgement tool which draws on a number of actuarial tools and has been developed over some years by NSW agencies working in collaboration.

The Spousal Assault Risk Assessment Guide (SARA) is a structured professional judgement tool suitable for use by those working with victims and has been evaluated in seven studies (Nicholls et al., 2013). SARA has 20 risk items which are rated No, Possible/partial or Yes – present, and a score which results in a summary judgement indicating the perpetrator is at low, moderate or high risk of committing further violence. This tool was found to produce risk assessments with significant predictive validity with respect to risk management recommendations made by police, as well as with recidivism measured through subsequent contacts with police. This was the tool used in combination with increased police response which resulted in reduced incidence of abuse (Belfrage et al., 2012).
The Danger Assessment (DA) was developed specifically for use by health professionals, originally for nurses in clinical settings as a tool to predict lethality of the situations of women living with domestic violence, and it is well validated for this purpose (Campbell et al., 2009). The revised Danger Assessment tool has 20 items in addition to a calendar for estimating incidence of DV in the past 12 months. The Nicholls et al. (2013) review identified 11 published studies on the Danger Assessment, including two specifically focusing on pregnancy. This review noted the importance of the Danger Assessment to the field of DV risk assessment, providing victims with a tool to inform their decision-making. At least one study found that use of the DA increased women’s understanding of the level of danger they were in (Stuart and Campbell, 1989, cited in Nicholls et al., 2013). An adaptation of the Danger Assessment has been developed in the USA specifically for use in emergency departments to identify victims at highest risk of suffering severe injury or potentially lethal assault by a partner (Snider et al., 2009). The original 20-item tool was distilled into five questions (numbering indicates their position in the original tool): 1) Has the physical violence increased in frequency or severity over the past 6 months?; 2) Has he (the abuser) ever used a weapon or threatened you with a weapon?; 8) Do you believe he is capable of killing you?; 11) Have you ever been beaten by him while you were pregnant?; and 12) Is he violently and constantly jealous of you? A positive answer to any three questions was found to have a sensitivity of 83% to predict serious assaults within two years, enabling clinicians to rapidly differentiate patients requiring comprehensive safety interventions (Snider et al., 2009).

A further recent adaptation of the Danger Assessment has been developed for use with women from culturally and linguistically diverse communities. Based on testing with a sample of 148 women, the revised Danger Assessment for Immigrant Women (DA-I) consists of 26 items and predicts any and severe DV at a nine-month follow-up significantly better than the original DA and women’s own predictions of risk (Messing et al., 2013).

5.2.2.2 Safety planning

No reviews were identified which looked specifically at safety planning; however, this is often incorporated into other types of intervention. Of the six interventions which were provided to women identified as having experienced abuse in the Nelson et al. (2012) review, four included safety planning as a core element of the intervention. Three of these four interventions resulted in reduced incidence of DV compared to the control groups, while the fourth did not measure DV incidence as an outcome (Nelson et al., 2012).

Although safety planning has been recognised as a response which respects women’s choices, earlier literature which predates the scope of this review sounds a caution about assuming that safety planning is a new concept for women experiencing violence. Davies et al. (1998) observed that most women who experience violence are active on a daily basis in monitoring their own and their children’s safety, and suggest that this knowledge should preface and be reflected in discussions with women on the subject.

A promising new intervention which also adapts the Danger Assessment, yet to be launched but for which evidence is mounting, is the DV Decision Aid or IRIS tool (Internet-based Intervention to Improve Mental Health Outcomes for Abused Women). This brings together risk assessment, safety planning and respect for women’s capacity to make safe choices.
through an online tool, without accessing specialist services. The decision aid provides feedback about risk for lethal violence, options for safety, assistance with setting priorities for safety, and a safety plan personalised to the user (Glass et al., 2009). In the first study of the tool, 69% of the 90 women who used it reported severe to extreme danger, though only 60% of this subgroup reported having made a safety plan prior to using it. Women reported that the decision aid was useful and provided much-needed privacy for making safety decisions (Glass et al., 2009). A large five-year evaluation of the tool commenced in 2010 which will measure: safety-seeking behaviours; exposure to violence by an intimate partner/ex-partner; impact on mental health; and safety decision processes while in an unsafe relationship. The study, which has reported early progress (Bloom et al., 2014), will involve 720 women currently in abusive relationships who have safe computer access.

The tool is also the subject of parallel Australian and New Zealand studies currently being conducted by Kelsey Hegarty (University of Melbourne) and Jane Koziol-McLain (Auckland University of Technology). With potential to be used independently by women experiencing abuse, as well as by health professionals, this tool may be able to assist women to determine their level of risk, priorities and options, in an evidence-based manner.

5.2.3 Benefits

Structured tools provide for assessment of the risk of death and/or repeated experiences of violence in a way that is systematic and based on evidence regarding known risk factors and predictors. This provides opportunities to inform women and plan for intervention, including high-intensity protection by law enforcement agencies where needed or interagency safety planning processes.

5.2.4 Limitations

In determining the appropriate choice of risk assessment tools, consideration needs to be given to the setting and training needs required for different tools, as well as the population in which the tool is to be used, taking into account whether the tool has been validated in a similar sample. Those using tools need to be cautious in the interpretation of results, making the limitations clear to any users of the assessment.

5.2.5 Recommendations

8. A structured risk assessment tool should be selected for use by NSW Health frontline staff which should be used in preference to professional judgement alone, in order to support decisions and planning in responding to DV.

9. Training should be provided in the use of a selected risk assessment tool in line with the recommendations outlined in 5.7, Training.

10. Safety planning should be undertaken by the health service with all women identified as currently experiencing domestic violence, recognising that most women who experience DV are already active agents in relation to their own and their children’s safety. Structured tools for safety planning may provide valuable resources for health workers responding to women disclosing DV.

11. Safety planning is an activity best undertaken by social workers attached to hospital clinics, wards and centres, as it is a complex task requiring professional judgement...
based on specialist knowledge of DV, skilled interviewing, time and privacy not necessarily afforded to other health professionals.

5.3 First line responses

5.3.1 Description

First line responses, sometimes referred to in the literature as advocacy interventions, provide abused women with information and support which aim to empower them and assist in their accessing community resources such as legal, housing, financial advice, parenting support, education on safety behaviours or psychological interventions (Ramsay et al., 2009; World Health Organization, 2013; National Institute for Health and Care Excellence, 2014). The WHO recommends that as a minimum, frontline support by health workers responding to abuse should entail:

- non-judgemental support and validation of the woman’s account
- practical care that responds to the woman’s concerns
- asking about the history of violence and careful listening without pressure to talk
- assistance accessing information about resources including legal and other services
- assistance to increase safety
- provision or mobilisation of social support (World Health Organization, 2013).

5.3.2 Evidence base

The evidence for the effectiveness of first line responses or advocacy is growing, particularly for women who have actively sought help or are in a refuge (Feder et al., 2009). Recognition of the value of this type of response resulted in a determination that availability of first line responses in emergency departments was a priority in a review conducted for the UK’s Department of Health (Ramsay et al., 2005).

A systematic review of the effectiveness of first line responses found a wide range of outcomes reported (Ramsay et al., 2009). First line responses with women in antenatal care may have led to a reduction in minor physical abuse; led to improved postnatal depression in abused pregnant women; and reduced psychological distress in women who attended a hospital emergency department (Ramsay et al., 2009). Findings from an intensive advocacy intervention showed women who received the intervention in shelters experienced less physical and emotional abuse with some evidence of improved quality of life (Ramsay et al., 2009).

A different review of studies completed since 1990 concluded that supportive advocacy in community settings reduced the frequency of re-abuse relative to no-treatment controls, although rates of re-abuse remained concerningly high (Eckhardt et al., 2013). The WHO has also found that first line responses or advocacy along with empowerment interventions may decrease the likelihood of recurrence of DV for some women, although it concluded that there is insufficient evidence to determine what effect these interventions have on women’s mental health outcome or quality of life (World Health Organization, 2013). The WHO guidelines draw on three trials of brief-duration empowerment interventions conducted in an antenatal clinic, a refuge and community health centres in Hong Kong, which provided clear evidence of some benefits in health and abuse outcomes (World
Health Organization, 2013). Of these, the trial conducted in an antenatal clinic, which is of most relevance to health services, involved an intervention in which women were provided with 30-minute sessions of counselling with midwives trained in empathetic understanding, who provided advice on safety and other related information. The follow-up period was six weeks, at which point the intervention group showed reduced psychological abuse and a reduction in minor abuse, improved quality of life and physical functioning, and less depression (Tiwari et al, 2005).

5.3.3 Benefits
First line responses may lead to reduced postnatal depression for pregnant women, as well as decreased distress for women who attend the emergency department. All frontline staff can be trained to provide first line responses to women who have experienced DV.

5.3.4 Limitations
In the WHO review first line responses were coupled with ‘empowerment’ interventions, the components of which were not clearly identified. It is important to ensure that first line responses are respectful, empathic and supportive. Women’s feelings about abuse are complex (Feder et al., 2006), however, and the process of making decisions about safety is gradual (Sharps et al., 2007). For this reason sustained support and/or intensive counselling is often required for women to become safe and/or address the impact of trauma.

5.3.5 Recommendations
12. Supportive advocacy should be a prioritised intervention for community health services.
13. Resources for distribution and referral pathways for each health unit should be identified and regularly reviewed by a designated senior person attached to that unit/clinic.

5.4 Counselling with adults who have experienced domestic violence
5.4.1 Description
Counselling in relation to experiences of domestic violence provides support to address safety and decisions about a relationship with an abuser, as well as the traumatic effects of abuse. There is an increased risk of mental health issues among women who have experienced DV, particularly anxiety, posttraumatic stress disorder and depression (Potito et al., 2009), which counselling may either prevent or address.

5.4.2 Evidence base
In line with its specific focus on women, the WHO concluded in its review of interventions for DV that some form of individual cognitive behavioural therapy (CBT) for women who have experienced DV may reduce PTSD and depression (during pregnancy), compared to no intervention, with one study reporting better birth outcomes (World Health Organization, 2013). The WHO draws on five studies evaluating ‘psychological / mental health interventions’ or individual counselling interventions for women, and reports that measures and outcomes varied widely. It also notes that a review of group work interventions found that the majority of studies reported positive outcomes (World Health Organization, 2013).
One of the most significant studies included in the WHO review produced results of direct relevance to health services, particularly antenatal services (Kiely et al., 2010; El Mohandes et al., 2011). This randomised control trial with 336 women who had experienced DV in the past 12 months compared individually tailored counselling administered by a social worker with usual care. The counselling occurred immediately after antenatal care visits for eight sessions lasting 35 minutes (+/-15 minutes), and in two sessions provided in the postnatal period. Smoking and depression were also addressed during the counselling. The main focus of the DV counselling was on safety behaviours and community resources available. Women in the intervention experienced half as many incidents of DV both during pregnancy and postnatally, compared to those receiving usual care; fewer very preterm infants (1.5% vs. 6.6%; p=0.03), and increased mean gestational age (38.2 vs. 36.9 weeks; p=0.016) (Kiely et al., 2010). This study formed the basis of the recommendation by the US Institute of Medicine for two to eight counselling sessions at the time of antenatal visits by a specifically trained hospital social worker for antenatal patients identified as currently experiencing DV, to both reduce pregnancy-related DV and improve birth outcomes for children exposed to DV (Institute of Medicine, 2011). The IOM also recommended provision of integrated interventions which target smoking and depression, suggesting that this may be key to the acceptability, uptake and outcomes of the program (Institute of Medicine, 2011).

Pregnancy is a time of particular risk, as a history of abuse increases the risk of depression and PTSD, which in turn increases the risk of pregnancy and neonatal complications, postpartum depression, and ability to breastfeed (Kendall-Tackett, 2007). These factors point to expanded possibilities for integrated interventions for women at this time. Access to onsite social work services may also be central elements, with local research finding that referral and uptake rates of counselling were highest where these services were located at the designated service for antenatal and postnatal visits (Spangaro et al., 2010b).

The Kiely / El Mohandes study was one of four trials of counselling provided after identification of abuse which informed the conclusions of the US Nelson et al. (2012) review. Key results were reduced incidence of DV and improved birth outcomes for pregnant women (Kiely et al., 2010, El Mohandes et al., 2011), reduced DV for new mothers (Bair-Merritt et al., 2010, Taft et al., 2011), and reduced pregnancy coercion and unsafe relationships for women in family-planning clinics (Miller et al., 2011). Other studies of counselling interventions reviewed by Nelson and colleagues had less successful results. One of these studies delivered nurse case management, with an average of 22 contacts per person, 80% of which occurred by telephone (Curry et al., 2006). A second involved distributing a wallet-sized card, safety planning and referral (McFarlane et al., 2006). Both studies found no significant differences between intervention and control groups. This raises the possibility that sustained face-to-face interventions are required to bring about change.

A separate review of the evidence for interventions for those who have experienced domestic violence, concluded from analysis of 15 studies that a range of therapeutic approaches have been shown to produce enhancements in emotional functioning, finding as did the WHO strongest support for CBT approaches in reducing negative symptomatic effects of DV (Eckhardt et al., 2013). Caution should be used in interpreting these results,
however, as CBT is an approach that, due to its at times prescriptive nature, lends itself more readily to systematic measurement than some other forms of counselling intervention, and is therefore easier to gauge the success of. In line with the results of the Nelson review it was found that brief interventions for those who experience DV have less consistently positive effects than interventions of longer duration. Although several studies found significant increases in safety behaviours, the review concluded that it was unclear whether brief safety interventions produced a longer term reduction in DV (Eckhardt et al., 2013).

In a study published subsequent to these reviews, an intervention comprising one to six sessions of counselling on relationship and emotional issues delivered by trained GPs to women experiencing abuse did not have an impact on safety or quality of life, but did lead to significantly reduced depression in the intervention group compared to the control group at 12-month follow-up (Hegarty et al., 2013).

5.4.3 Benefits

Emerging evidence points to the potential for reduced incidence and severity of DV, increased adoption of safety behaviours, reduced depressive symptoms and better outcomes for infants among women receiving counselling. Taken together the studies point to a clear positive value of counselling interventions, for which social workers in hospitals seem well placed, particularly in settings which have ongoing contact with patients over a sustained period, such as antenatal clinics.

5.4.4 Limitations

Women’s responses to abuse are characterised by ambivalent feelings towards the abuser, uncertainty as to the nature of their experiences, and feelings of stigma and shame (Gunter, 2007; Moe, 2007). Further, women’s needs vary depending on their life circumstances, as well as the nature and duration of the abuse. Women’s interest in and responsiveness to counselling interventions will vary though this does not negate the importance of making them available and accessible within the health-care setting.

5.4.5 Recommendations

14. Women who are identified in hospital and community health services as experiencing domestic violence either currently or the past 12 months should be provided with six to eight sessions of counselling to address the impact of the abuse.

15. Antenatal patients should be a priority for this counselling, which should be provided onsite, timed to occur alongside antenatal and postnatal visits, and should address depression and other issues, such as breastfeeding, as well as exposure to domestic violence.

16. Counselling should be provided by social workers who have participated in specialist domestic violence training (see 5.7, Training).

17. Community health services should be supported to provide group work intervention for women affected by domestic violence.
5.5  Mother–child interventions

5.5.1  Description

Exposure to domestic violence causes long-term psychological, emotional, physical, developmental and behavioural problems for children (Van der Kolk, 2005; Holt et al., 2008; Hickman et al., 2013), increasing their vulnerability to many other adversities including lifetime risk of victimisation (Finkelhor et al., 2009). Current literature suggests that a strong relationship with a non-abusive parent is protective against the impact of violence (Buchanan, 2008). However, women face many challenges and difficulties when parenting in the context of domestic violence (Lapierre, 2010). The actions of domestic violence offenders often directly and indirectly undermine the relationship between mothers and their children, negatively impacting attachment (Buchanan, 2008). Traditionally responses to children’s exposure to DV have focused on child protection considerations and women’s obligations to protect. An emerging body of literature indicates the value of combined interventions that strengthen the mother–child relationship in the aftermath of violence (Morris et al., 2011; Humphreys, 2014).

5.5.2  Evidence base


A fourth study, of a less intensive intervention, found significant improvements to anxiety and behaviours and reduced PTSD among participating children who received eight sessions of cognitive behavioural therapy compared to those who received child-centred therapy (Cohen et al., 2011). The separate sessions for mother and child in both intervention types were mostly parallel (with the same therapist at each visit) rather than conjoint, apart from two combined sessions in the CBT group where both mother and child were present. Child-centred therapy comprised establishment of an empowering and trusting relationship between therapist and client; encouragement of the child and parent to direct the content of their own treatment; active listening, reflection and empathy on the part of the therapist; encouragement to talk about feelings; and the therapist’s belief in the child’s and parent’s respective abilities to develop positive coping strategies. The CBT intervention involved psycho-education about trauma; relaxation skills to manage stress; expression and modulation of upsetting feelings and beliefs; cognitive coping skills; development of a narrative about the child’s DV experiences; and joint child–parent sessions during which the child was encouraged to share DV experiences directly with the mother (Cohen et al., 2011). The WHO concluded that of the studies reviewed, the quality of evidence was sufficiently

The NICE guidelines echo the WHO position recommending health services address the emotional, psychological and physical harms arising from a child being affected by domestic violence with interventions that aim to strengthen the relationship between the child or young person and their non-abusive parent or carer (National Institute for Health and Care Excellence, 2014).

This type of intervention may have particular benefits when delivered in group work programs. A trial of a 10-session therapeutic group with 181 children and their mothers compared mother–child intervention, child-only intervention and no intervention (those on a waiting list) (Graham-Bermann and Miller, 2013). Eighty-one per cent of all the women were diagnosed with PTSD. Women in all three groups improved but those with the greatest reduction in traumatic stress were those attending mother–child groups, with 85% no longer diagnosed with PTSD (Graham-Bermann and Miller, 2013). The mother’s posttraumatic stress was directly relevant to outcomes for the children, being found to mediate the change in child adjustment following the intervention. Improvements experienced by children included reduced internalising and externalising behaviour problems (Graham-Bermann et al., 2011). The finding of a mother’s own improvement in mental health being associated with positive changes in children’s behavioural problems was also found in another study, reinforcing the value of conjoint work (Grip et al., 2013).

5.5.3 Benefits
Mother–child interventions after DV have the capacity to improve children’s behaviours and self-esteem, reduce traumatic stress levels among both children and mothers, and reduce PTSD and anxiety in children.

5.5.4 Limitations
Provision of mother–child dyad work is resource intensive and requires specialist training to deliver; however, the severe long-term impact on children resulting from exposure to violence, including increased lifetime exposure to abuse, and the health costs this entails suggest this is likely to be a cost-effective endeavour.

5.5.5 Recommendations
18. Child and family teams, specialist child protection counselling services and community health centres with capacity to respond to children affected by domestic violence should provide at least eight sessions of mother–child dyad counselling.

19. Mother-child interventions after DV should include combined group work programs.

5.6 Child protection notification

5.6.1 Description
The strong link between inter-familial violence and child abuse and the risks to children from both are now widely acknowledged (Mathews et al., 2008), with recognition that
children exposed to domestic violence are subjected to a range of psychological and behavioural impacts (Richards, 2011). In some cases this exposure can be considered a form of child abuse (Flood and Fergus, 2008) requiring a statutory child protection notification. Mandatory child protection notification or reporting requires professionals such as police, teachers, health workers and welfare workers to report suspected child abuse. Making a mandatory child protection notification when a child is considered to be at risk as a result of exposure to domestic violence is practice in many jurisdictions including NSW.

5.6.2 Evidence base

Child protection notifications, including those in relation to domestic violence, doubled in Australia over the five years from 2003 to 2007 (Douglas et al., 2009), resulting in an inundated child protection system (Humphreys, 2008). There is evidence that over-reporting continues to be a problem, with calls for careful assessment to underpin reporting decisions (Laing et al., 2013) and for risk to be assessed respectfully and transparently (Curry et al., 2006). Locally, health workers also report frustration with lack of response by the statutory child protection agency to notifications made after violence is detected through routine screening (Spangaro et al., 2011a).

Although it is often assumed that people subject to child protection notifications would oppose the notification, a qualitative study with women who had been in this position found that on the whole they supported laws for mandatory reporting to address domestic violence. The women related that it helped them to make changes in their and their children’s lives (Antle et al., 2010), particularly when the notification was made in a context of openness and transparency. For Aboriginal women, however, past experiences of forced removal of Aboriginal children and the current overrepresentation of Aboriginal children in out-of-home care give rise to particular concerns about the involvement of child protection services (Humphreys, 2008).

There is now wide recognition that both the child protection and domestic violence sectors need to work in collaborative partnerships to develop integrated responses that lead to higher quality intervention and services (Potito et al., 2009). The need for this is highlighted by research findings that statutory child protection responses often focus on women’s responsibility to protect their children and lack focus on the domestic violence (Humphreys and Absler, 2011). Multi-agency responses, including multi-agency training and policies directed at violent men, and clear safety assessment tools which separately address risk and protective factors from both parents, were all features of an intervention conducted in a London borough which had promising outcomes (Humphreys and Absler, 2011). Health professionals straddle both these domains and research suggests that they require specific training, which needs to be regularly updated, on the crossovers between domestic violence and child abuse, and the harm caused by exposure to domestic violence (Mathews et al., 2008).

5.6.3 Benefits

Child protection notification allows statutory agencies to take action to protect children who are at risk from exposure to domestic violence, in cases where this is warranted.
5.6.4 Limitations

Child protection notifications alone are not sufficient to bring about safety for children and careful assessment is required in order to determine the need and basis for making reports.

5.6.5 Recommendation

20. Child protection notification practice should be supported by specialist training on domestic violence and children at risk conducted in a multi-agency context.

5.7 Training

5.7.1 Description

The complexity of domestic violence warrants workers receiving wide-ranging training covering the dynamics and nature of abuse, the impact on women and children, legal responsibilities, safety, first line support, how to identify abuse, available services and inappropriate attitudes by health-care providers (World Health Organization, 2013; Stover and Lent, 2014; National Institute for Health and Care Excellence, 2014).

In recognition of the diverse needs of health-care providers in this field the British NICE guidelines identify four tiers of training on domestic violence:

**Level 1.** Staff should be trained to respond to a disclosure of domestic violence sensitively and in a way that ensures safety. They should also be able to direct people to specialist services. The guidelines direct that in health services this level of training is for physiotherapists, speech therapists, dentists, care assistants, receptionists and interpreters.

**Level 2.** Staff should be trained to ask about domestic violence in a way that makes it easier to disclose. This involves an understanding of the nature and extent of domestic violence, its impact and the role of professionals in intervening safely. Staff should also be able to respond with empathy and understanding, assess someone’s immediate safety and offer referral to specialist services. Typically this level of training is for generalist nurses, emergency department doctors, ambulance staff, mental health professionals, midwives, early childhood health nurses, paediatricians, and alcohol and other drug workers.

Training to provide a specialist response should equip staff with a more detailed understanding of domestic violence and abuse and more specialist skills.

**Level 3.** Staff should be trained to provide an initial response that includes risk assessment, safety planning and continued liaison with specialist support services. Typically this is for social workers, unit-level champions for DV response and those involved in multi-agency risk assessment conferences.

**Level 4.** Staff are trained to give expert advice and support to people experiencing domestic violence and abuse. These are specialists in domestic violence; in NSW for example, they are domestic violence workers or sexual assault service counsellors.

The NICE guidelines further suggest that training be provided to senior managers or those in strategic roles in the health services to raise awareness of, and address misconceptions.
about, domestic violence issues and the specialist services and training needed to provide people with effective support. The guidelines note that higher levels of training should include increasing amounts of face-to-face interaction, although Level 1 training can be delivered mostly online or by distance learning. Face-to-face training covers the practicalities of enabling someone to disclose that they are affected by domestic violence and abuse and how to respond (National Institute for Health and Care Excellence, 2014). Of note in the NSW context is that the advisory group for these guidelines considered the relationship between domestic violence and child protection training; though agreeing that there are obvious links between them, the group did not necessarily think they should be combined but that this should be researched further.

5.7.2 Evidence base

The importance of health professionals receiving education in order to improve identification and responses was repeatedly highlighted in the literature (Minsky-Kelly et al., 2005; Seftaoui, 2009; World Health Organization, 2013; Stover and Lent, 2014). Training has been identified as a key enabler in establishing and maintaining screening (Curry et al., 2006; Feder et al., 2009, Feder et al., 2011; O’Campo et al., 2011; Spangaro et al., 2011a).

Many medical officers, in particular, have no formal domestic violence training and this may lead to failures to identify and respond to those who are experiencing domestic violence (Feder et al., 2011). A training and support program conducted with general practitioners and administrative staff led to increased referrals to specialist DV services and an increase in disclosure of abuse by women experiencing domestic violence (Feder et al., 2011). The authors concluded that training sessions containing case studies and practical components that support health workers in asking about violence and responding effectively, carried out by specialist DV service providers, increased the effectiveness of training. It appeared that referral rates to those services in this study increased because the training was given by the specialist DV service providers to whom referrals were to be made, and that these providers were available for GPs to consult with. The value of close collaboration with community-based advocacy services and regularly consolidated team training was also reinforced in a review of evidence on interventions (Ramsay et al., 2005).

Apart from work-based training, the literature identifies the need for domestic violence to be included in the curriculum of undergraduate education for health professionals. US research regarding university education of health professionals indicated that little specific training in DV was being provided, with child maltreatment issues covered more often (Ramos, 2009). Similarly in the UK reviewers recommended that training on the identification of women experiencing domestic violence and frontline support be integrated into undergraduate and postgraduate clinician education (Ramsay et al., 2005, Alhabib et al., 2010; World Health Organization, 2013).

5.7.3 Benefits

Training and systemic changes by health services can increase identification (Feder et al., 2011) and improve the standard of clinical assessment of domestic violence.
Limitations

Training alone is insufficient to improve identification and referral by health professionals in response to DV without addressing system-wide and individual hospital department barriers (Minsky-Kelly et al., 2005; Plichta, 2007). This was confirmed in a study which found that training alone did not lead to change and that the introduction of specialist documentation tools was also required (Ritchie et al., 2013).

Recommendations

Training of health professionals about DV needs to be:

1. accompanied by systems changes and monitoring
2. introduced at the undergraduate level
3. tiered as appropriate to the needs of the health professionals, in line with the four-level approach recommended for British health services as specified at Section 5.7.1
   - Level 1 – all frontline staff,
   - Level 2 – health professionals who screen or otherwise identify DV,
   - Level 3 – social workers providing referral responses, risk assessment and safety planning,
   - Level 4 – specialist DV / sexual assault professionals
4. delivered where possible by the service providers to whom health workers are expected to refer those experiencing DV
5. where possible by the service providers to whom health workers are expected to refer women identified as experiencing DV
6. updated annually and delivered in such a way that new staff are identified and trained to the required level of competence
7. provided in conjunction with health workers having access to on-call consultation with service providers, which may include hospital/clinic social workers with specialised DV training and skills, when responding to complex DV matters.

System-level responses

Description

Individual policy initiatives implemented in diverse health settings require a strong health policy framework, leadership and system changes for both their introduction and maintenance (Plichta, 2007).

Evidence base

System-level change

A British systematic review of 10 studies in various health settings found that system-level interventions with at least some training plus support materials increased referral rates for women identified as experiencing DV. Longer term follow-up indicated that reinforcement
and training of new staff was also needed to sustain the effect (Ramsay et al., 2005). Since that review a cluster randomised control trial across 48 British general practice clinics has been published, in which a system change intervention was introduced involving: provision of training to clinicians and administrative staff; development of a simple referral pathway to a single non-government organisation; a representative of that NGO providing the original training, attending quarterly meetings with clinicians, feeding back anonymised data about referrals, and being available for consultation; templates to record notes in the electronic record; and appointment of a champion at each practice who received additional training (Feder et al., 2011). The outcomes of the study were compelling, with a 21-fold increase in referrals to advocacy services and a threefold increase of documentation of the abuse in the medical notes (Feder et al., 2011).

A second study reporting an organisational change approach was undertaken in a regional health service in New Zealand. The approach involved obtaining senior management support; collaborating with the community; developing resources to support practice, research and evaluation; and training. Monitoring included auditing over 6000 clinical records to assess rates of screening for domestic violence, identification of abuse and referrals made, along with quality of assessments (Wills et al., 2008). The outcomes of the multi-level intervention included an increase in referrals to specialist services from 10 per quarter to 70 per quarter, and increased identifications of domestic violence among women who presented at the service for another reason, from 30 to 80 per six-month period (Wills et al., 2008).

Another system-change approach, titled the Healthcare Can Change from Within model, was tested in three primary care clinics and an emergency department within a large healthcare system in Wisconsin, USA, using two other primary care clinics for a usual-care comparison on selected variables (Ambuel et al., 2013). Outcome measures included staff knowledge and attitudes, as well as system characteristics (clinic policies, procedures, patient education materials, and DV documentation in patient records). Health workers reported increased self-efficacy, understanding of referral resources, and understanding of legal issues, though DV knowledge was unchanged. Changes included implementation of new policies and procedures, increased patient education, and increased documentation of DV screening, which was reported to be sustained at two-year follow-up (Ambuel et al., 2013).

The program components identified in all three studies parallel the four elements identified by O’Campo et al. (2011), discussed at 5.1, Routine screening, which represent a comprehensive approach to implementation: 1) institutional support; 2) effective screening protocols; 3) thorough initial and ongoing training; and 4) immediate access or referrals to onsite and/or offsite support services. Similarly in NSW the introduction of screening was facilitated by brief, scripted questions embedded into assessment schedules, training and access to referral services (Spangaro et al., 2011a).

The importance of champions and measures to ensure accurate documentation of presentations are other elements of successful system changes emphasised in a recent review of DV best practice in the Australian context (Laing et al., 2013). Another study on a DV initiative in the health service (in Ohio, USA) reiterated the value of champions, finding a
fourfold increase in application of an intervention after appointment of champions in each unit (Scribano et al., 2011). From a staff perspective, studies reiterate the importance of: systemic prioritisation of and resources for DV; onsite resources; adequate time to make assessments for DV; focused DV training; and a team or systemic approach (Chang et al., 2009, D’Avolio, 2011).

### 5.8.2.2 Privacy provisions

Privacy, or lack of it, is a key issue for women using health services who have experienced DV, particularly in maternity services, when family or partners are often present, which impedes responses to DV (Bacchus et al., 2007; Furniss et al., 2007). A related issue is that partners who accompany women to health visits are twice as likely to be interfering in the woman’s access to health care (McCloskey et al., 2007). Lack of privacy, a particular challenge when women are accompanied by a partner or family member, was raised by health workers at 10 NSW Health screening sites as a barrier to asking women about abuse (Spangaro et al., 2011a). Such concerns have prompted recommendations that patients be given time alone with a health worker as a matter of course, including the UK Confidential Enquiry into Maternal Deaths 1997–1999 (Bacchus et al., 2007). While in NSW, the Health Records and Information Privacy Act (2002) and the NSW Health Privacy Manual (PD 2005-593) provide thorough guidance with respect to written information, they do not address patients’ need for time alone with health workers. Many patients have information or questions they prefer not to raise in the presence of their kin. Making time alone creates unobtrusive opportunities to ask or share sensitive information, possibly increasing the accuracy of patient histories. Individuals who are experiencing coercion or other forms of abuse by a family member can then be asked about abuse in real privacy without raising suspicion among abusive partners (Boyle et al., 2004). This measure would also relieve the burden from health workers conducting screening to create privacy without suspicion. The UK Confidential Enquiry into Maternal Deaths 1997–1999 recommended that every woman is interviewed alone at least once during the antenatal period (Bacchus et al., 2007).

### 5.8.2.3 Information sharing

Information sharing, particularly across agencies, is an area that can be challenging in the health context where patient confidentiality is an accepted core practice. New initiatives to increase multi-sectoral collaboration require attention to protocols in this area. The British NICE guidelines for health services and systems responding to domestic violence contain comprehensive advice recommending development of clear protocols and methods for sharing information, within and between agencies that address people at risk of, experiencing or perpetrating domestic violence (National Institute for Health and Care Excellence, 2014). Recommendations include the following:

- Clearly define the range of information that can be shared and with whom (this includes sharing information with health or children’s services on a perpetrator’s criminal history).
- Ensure protocols and methods encourage staff to:
  - remember their professional duty of confidentiality
- determine when the duty of confidentiality might have to be breached: information should be shared only with the person’s consent unless they are at serious risk, and within agreed multi-agency information-sharing protocols
- note that information sharing without consent risks losing trust and may endanger a person’s safety.

- Ensure information-sharing methods are secure and will not put anyone involved at risk.
- Ensure the protocols and methods are regularly monitored.
- Identify and train key contacts responsible for advising on the safe sharing of domestic violence and abuse-related information.
- Ensure all staff who need to share information are trained to use the protocols so that they do not decline to cooperate because of being overcautious or for fear of reprisal (National Institute for Health and Care Excellence, 2014).

5.8.2.4 Quality improvement tools

A number of tools have been developed in the USA to introduce improvements in the quality of system-wide responses to DV. These include the Delphi Instrument for Domestic Violence for Hospital Programs and the associated Delphi Instrument for Domestic Violence for Primary Health Care Clinics, which has been validated in 32 primary health-care practices in Ohio and Minnesota (Zink and Fisher, 2007).

5.8.3 Benefits

Multi-level, system-wide change programs for health responses to DV appear more likely to bring about wholesale change, which is more likely to be sustained than single-level interventions.

5.8.4 Limitations

System-level change requires more effort and resources to implement and monitor; however, the considerably enhanced outcomes point to the long-term cost-effectiveness of this path.

5.8.5 Recommendations

28. Implementation of a revised policy requires a multi-dimensional approach integrating the four tiers of training, as well as systematic provision of mentoring; ongoing education and consultation; systems for information sharing; auditing and monitoring; documentation tools; and documented simple referral pathways with immediate response when current DV is identified.

28. Champions of the revised DV policy should be appointed at the unit, professional and program level in each Local Health District. These champions are identified personnel with interest in supporting implementation and who receive as a minimum, Level 3 training.

29. Provision should be made in the overarching NSW Health privacy policy for all episodes of care of adults to automatically include time alone with the health worker.
5.9  Multi-agency collaboration

5.9.1  Description

Increased emphasis on ‘joined up solutions to joined up problems’ has been a key trend in social policy over the past decade in OECD countries, which has been strongly influential in Australian policy development (Potito et al., 2009). The Beijing Declaration and Platform for Action arising from the United Nations Fourth World Conference on Women, Strategic Objective 1 required all governments to take integrated measures to prevent and eliminate violence against women, which acted as a catalyst for the growth in integrated or multi-agency responses to domestic violence (Coy et al., 2008).

Integrated services for domestic violence have been defined as coordinated, appropriate and consistent responses aimed at enhancing safety, reducing secondary victimisation and holding abusers to account for their violence (Mulroney, 2003: 2). Integrated services are partly or wholly co-located responses comprising inter-agency teams that generally respond at a particular point in either the abuse or service interface, such as at presentation to court or police call-out. In discussing integrated or multi-agency responses to DV a distinction needs to be made between integrated services and integrated systems, which comprise jurisdiction-wide models that encompass multiple tiers of management, changes to core agency practice, diverse aspects of service delivery, shared protocols and, often, integrated courts and a legislative base (Australian Domestic and Family Violence Clearinghouse, 2010).

5.9.2  Evidence base

A number of studies have highlighted the failings in single-system responses to DV (Potito et al., 2009; Murphy, 2010), with much evidence of the links between DV and child abuse (National Crime Prevention, 2001; Mathews et al., 2008; Hamby et al., 2010), as well as between DV and substance-related issues (Wathen et al., 2008; El Mohandes et al., 2011; Fernandez-Montalvo et al., 2011). It is suggested that a more effective response for these sectors is to work collaboratively, with a focus on providing comprehensive services for women and children with co-occurring problems (Potito et al., 2009; Murphy, 2010; El Mohandes et al., 2011). An important aspect of integrated responses to domestic violence is information sharing across services, which is reported by service users as positive as it reduces the stress for those who have experienced abuse of repeating the story many times to different services (Messing et al., 2013).

Multi-agency responses involve considerable commitment from each agency. Issues to consider are: the power dynamics between organisations such as child protection and court services, working with relatively resource-poor services like domestic violence NGOs; building trust between agencies that may traditionally have conflicting policies; setting goals and outcomes; and addressing the absence of policies focused on collaborative work (Malik et al., 2008; Potito et al., 2009; Murphy, 2010; El Mohandes et al., 2011).

Multi-agency collaboration to provide an integrated response to domestic violence can minimise duplication of services and offer women who are extremely vulnerable, including Indigenous women, opportunities for services from other agencies that may not otherwise have been accessed (Australian Domestic and Family Violence Clearinghouse, 2010). Integrated responses also bring different working models and perspectives to the table, and
increase access to and coordination across services when multiple co-occurring issues are present (Potito et al., 2009; Murphy, 2010; El Mohandes et al., 2011). An evaluation of a British integrated response at multiple sites found evidence that the greater the number of agencies involved with women, children and men, the greater the safety of women and children (Howarth et al., 2009, in Laing et al., 2013). A review of the literature on integrated responses to DV conducted by the Australian Domestic and Family Violence Clearinghouse in 2010 identified the following benefits in the named integration projects: strengthened relationships between child protection agencies and domestic violence services (Greenbook Program, USA); reduced offending by offender program completers (Duluth Domestic Abuse Intervention Project, USA); increased reporting of incidents, increased charges and reduced retractions of police reports (Cheshire Project, UK); increased conviction of DV offenders and reduced AVO application withdrawals (Northampton Sunflower Centre, UK); increased rates of conviction and supervision sentences (Judicial Oversight Demonstration Projects, USA); and reduced reports of violence from women after 12 months (Multi-Agency Risk Assessment Conferences, Wales).

The review came to four key conclusions in respect of integrated responses for DV:

1. Although the evidence suggests there is much to be gained from integrated responses, a single picture of the extent to which change can be achieved and a single model for achieving it does not emerge.

2. Active leadership is required to establish and maintain integrated responses. Even though it may be within the current remit of agencies addressing domestic violence to work together, integrated responses require a new way of working which may add to workloads and require new positions. For integrated responses to be successful, it is essential to have robust governance arrangements that operate at multiple levels from frontline up to senior levels, champions, clearly defined outcomes, monitoring, and accountability strategies.

3. Successful integration strategies benefit from the inclusion of a range of agencies, including as a minimum: criminal justice, child protection, corrections, housing, advocacy and diverse programs within the health system. The review concluded that a broad range of agencies permits the introduction of emerging models that can address complex needs and contain preventive elements. These can include ways to hold perpetrators accountable in situations where, although abuse is occurring, a crime may not have been committed (e.g. in coercive, controlling relationships).

4. Based on the evidence a systemic response should include: multiple entry points for clients, independent advocates, high-risk management groups, pro-arrest policies, enhanced investigation, early intervention for offenders, information sharing and case tracking (Australian Domestic and Family Violence Clearinghouse, 2010).

5.9.3 Benefits

The diverse benefits of multi-agency collaboration can include improved access to services by vulnerable women, enhanced responses to those experiencing multiple problems, strengthened relationships between agencies, increased reporting of incidents, increased
charges and reduced retractions of police reports and AVO applications, increased conviction of DV offenders and reduced reported violence by women.

5.9.4 Limitations

Multi-agency collaboration requires additional time, resources and commitment from senior management of participating agencies.

5.9.5 Recommendations

30. Multi-agency responses should include combined referral and assessment systems, simplified information sharing with active use of this facility between agencies, and local inter-agency networks which are actively maintained through regular structured and unstructured contact.

31. Multi-agency collaboration requires champions at the senior level of each LHD; robust governance arrangements that operate at multiple levels from the frontline to senior levels of agencies; clearly defined outcomes; and monitoring; and accountability strategies, to successfully address barriers to collaboration.

5.10 Home-visiting interventions

5.10.1 Description

Home-visiting programs as early intervention strategies for vulnerable families with infants or young children have proliferated in the USA and many other jurisdictions in the past 15 years (Chamberlain, 2008; Stubbs and Achat, 2012). In a sample of 118 families involved in the NSW Sustained Home Visiting Program, the mean number of risk factors for general vulnerability as defined in criteria for program entry was eight, most commonly a history or current experience of domestic violence (51%) and current mental health symptoms (49%) (Stubbs and Achat, 2012). Although most programs do not target domestic violence, one study of this type of program suggested that DV has a disproportionate impact on home-visited families (Chamberlain, 2008).

5.10.2 Evidence base

A study of one child-focused, home-visiting program identified the need for skill-based training and assessment tools designed for home visitation; the benefits of building partnerships between home visitors and DV services; and the need for protocols that explicitly address DV (Chamberlain, 2008).

Two randomised control studies of home-visiting programs which measured incidence of DV were found in this review. In a long-term Hawaiian study, mothers who had given birth to an infant at risk of abuse received monthly home visits by para-professionals for three years to promote child health and reduce abuse. It was found that on long-term follow-up (seven to nine years), incidence of violence had decreased in both the control and intervention with no difference between groups (Bair-Merritt et al., 2010). The second study specifically targeted culturally and linguistically diverse mothers of young children attending primary care clinics in Melbourne who received 12 months of weekly home visits from trained and supervised local mothers (English and Vietnamese-speaking) offering non-professional befriending, advocacy, parenting support and referrals. The intervention group had
significantly lower mean abuse scores, leading the authors to conclude that non-professional mentor, mother support appears promising for improving safety among mothers experiencing domestic violence (Taft et al., 2011).

For neither of these studies was any information provided as to the protocols for achieving worker/visitor safety, nor was the intervention provided in any manner other than through home visiting, precluding any conclusions about the uptake of services when home visiting is not available.

Little information was identified in the literature on how safety was assessed in order to conduct home visits or on provision of services in clinics as an alternative to home visits. The lack of existing material was noted in one study which provided recommendations for reducing risk to be incorporated into agency safety and home-visiting procedures (Tiwari et al., 2010). This study recommended that all staff be familiar with the agency’s safety policies and receive training in crisis intervention, personal safety techniques, risk assessment and de-escalation techniques (Tiwari et al., 2010). It was suggested that preparation for a home visit should involve the worker conducting a comprehensive risk assessment prior to the visit so that the worker is clear about why they are visiting the client, the client’s needs and their history, which should include previous violent episodes or risks and the living conditions (Tiwari et al., 2010). Other significant recommendations are for workers to attend in pairs or request a police escort where necessary, and to consider a comprehensive checklist of safety items in the risk assessment, including transport, parking, and observation of client and others’ body language (Tiwari et al., 2010).

5.10.3 Benefits
A number of programs successfully engage in home visiting with women who have experienced abuse. Home visiting may enable women who are isolated to access services that they would not otherwise have the benefit of. It should not be presumed that because a woman has experienced past abuse, that she continues to live with the person who abused her, nor that that person is a threat to others.

5.10.4 Limitations
When service providers are unclear of the location of the offender, nature of abuse or ongoing threat posed to the woman or any health workers who visit, uncertainty and potential risks remain.

5.10.5 Recommendations
Further work should be done to identify:

32. health services that currently engage in home visiting, which may include patients who have experienced or demonstrated aggressive behaviour, to determine current risk assessment and safety protocols

33. a risk assessment and safety protocol based on consultation with agencies or research projects where home visiting occurs.
5.11 Responses to perpetrators of domestic violence

5.11.1 Description

Because health services provide care for all members of the community, those who perpetrate abuse, as well as those who experience abuse, may be identified in the context of a presentation to a health service. Alternatively those who experience abuse or abusers themselves may request treatment for the problem from health services. As a related issue more than 60% of children continue to live with or visit their fathers regularly following an incident of domestic violence (Israel and Stover, 2009). Services working with children affected by domestic violence may therefore confront questions about having contact with these fathers.

Three categories of intervention can be identified in relation to responses to those who abuse or assault their partners: 1) treatment that aims to reduce or stop the abusive behaviour (perpetrator treatment); 2) treatment for health problems unrelated to the abusive behaviour; 3) inclusion in interventions for children affected by the abusive behaviour with an aim to improving outcomes for the child or children.

5.11.2 Evidence base

5.11.2.1 Perpetrator treatment programs

According to Bennett and Williams (2001) (cited in Stover and Morgos, 2013), about 80% of participants in programs designed for abusive men are referred by the court following an arrest.

Two major reviews of the evidence for the effectiveness of perpetrator treatment programs have been conducted in the past two years. A European review analysed 12 studies which had systematically evaluated perpetrator program effectiveness, finding that although some modest changes were found, high drop-out rates from programs, reliance on self-reported measures and short follow-up periods limited the conclusions that could be drawn (Akoensi et al., 2013). In the only study in this review which included a control group, re-offending rates at 12 months were 33% (compared to 69% in the control group) (Dobash et al., 1999). These re-abuse rates were reported by female partners of the program participants. Police and prosecution records indicated that marginally more men in the treatment group appeared in arrest and prosecution records than men in the control group. The Dobash study was one of only a few studies reported in the review to attempt to triangulate police reports with data from other sources, which is recommended in light of the known limits to police and self-report data (Akoensi et al., 2013).

The second review by authors from the USA summarised studies published since 1990 which used randomised or quasi-experimental designs and compared an intervention program to a relevant comparison group. Thirty studies investigated the effectiveness of programs aimed at domestic violence perpetrators. The authors concluded that: 1) the available data from a relatively small number of studies, many with serious methodological limitations, simply did not allow for clear conclusions about effectiveness; and 2) that there were simply too few clear, unbiased studies with sufficient evidence of internal and external validity to properly answer the research question of whether perpetrator programs are effective at preventing
future episodes of DV (Eckhardt et al., 2013: p 223). It was noted that these results repeated those of an earlier review by Smedslund et al. in 2011.

Unsurprisingly the NICE guidelines for British health services conclude that there is a lack of consistent evidence on the effectiveness of programs for people who perpetrate domestic violence and abuse. Further, while interventions with people who have experienced domestic violence are likely to be cost-effective, this conclusion could not be extrapolated to interventions with perpetrators (National Institute for Health and Care Excellence, 2014).

5.11.2.2 Perpetrators accessing other health services

No specific literature on responses by generalist health services to those who abuse partners was identified. Services with a higher likelihood of identifying patients as being perpetrators are mental health and substance abuse services, as attendance at this type of service may be mandated by court direction. Of relevance are the findings from the Akoensi et al. review (2013) of perpetrator programs, which found that there was little correlation between general psychological improvements and re-offending.

A major global study on men’s offending conducted in six countries supports this finding. The UN Multi-country Study on Men and Violence in Asia and the Pacific, based on interviews with over 10,000 men, found support for existing theories on how underlying gender inequalities and power imbalance between women and men are the foundational causes of violence against women. The results indicated that men’s use of violence against women is associated with a complex interplay of factors at the individual, relationship, community and greater society levels which are best understood as existing within a broader environment of pervasive gender inequality. Consequently, simply stopping one factor, such as alcohol abuse, will not end violence against women (Fulu et al., 2013). The study found that across countries, violence was strongly associated with controlling behaviour, quarrelling, depression, having transactional sex and/or multiple sexual partners, and having experienced child abuse, among other factors.

These findings point to the need for alertness to indicators of domestic violence by patients and for risk assessments where deemed necessary; however, they indicate that treatment of an underlying health problem will not automatically resolve abusive behaviour, although health services, in particular mental health and AOD services, may have an important part to play in multi-agency responses to reduce risks posed by perpetrators (Laing et al., 2013). Regardless of the rationale for treatment provision, prior perpetration of DV is not a reason to deny access to health services where this does not pose risk to health workers. On this point, it should be noted that most perpetrators’ acts of violence and abuse are specific to their intimate relationships, committed in the context of unequal gender relations and views of entitlement (Fulu et al., 2013), and should not automatically be assumed to pose risks beyond this context.

A challenging element for health professionals in this area is that many perpetrators of domestic violence will present themselves as victims of abuse, with avoidance and projection of responsibility onto others, particularly the victim being central aspects of domestic violence perpetration (Hamel, 2012, Laing et al., 2013). These authors cite research by Bagshaw et al. (2010) which found that in accounts of victimisation by men and
women, men were more likely to report verbal and emotional abuse from female partners and failure to function in a stereotypical family role as abusive, than women who were more likely to report fear, threat physical and sexual abuse. For this reason disclosure of histories of having experienced DV by men who do not otherwise demonstrate indicators of DV, but display possible indicators of perpetration, need to be carefully assessed.

5.11.2.3 **Perpetrators’ inclusion in child protection interventions**

Stover and Morgos (2013) canvas the evidence and considerations for including some men who have committed domestic violence in family or father–child-focused interventions, noting that the inclusion of fathers or consideration of what role they may play in the recovery of their children has not been well explored in the research or clinical literature. The authors preface their paper by noting that this type of intervention has long been discounted as dangerous and unethical, but that understanding by the field about the heterogeneity of dynamics in families where DV is occurring is becoming more nuanced and that for some offenders, benefits may result. The paper predominantly focuses on benefits to the perpetrator, rather than to the children, though it is noted that some perpetrators hold genuine concerns about parenting skills and the effects of domestic violence on their children, and may be suitable for inclusion in interventions aimed at children.

The authors are clear that some DV perpetrators should not be considered for inclusion in family-focused intervention, particularly those whose motivation is to meet their own emotional needs, and that careful assessment is needed of the motivation, potential danger and psychological functioning of the father which considers: the nature and severity of abusive behaviour; dangerousness/lethality; coercion and control; substance abuse; psychological symptoms; personality characteristics and attachment; trauma history; childhood family life; parenting beliefs and behaviours; life stress; the impact of the abuse on his children; motivation for change and participation in treatment; co-parenting relationship; impact of the abuse on the mother/partner; and criminal and child protection history via record review or inter-agency contact. Risk factors identified by Stover and Morgos which would preclude work with fathers are:

- no-contact orders
- severe violence (attempted strangulation, use of weapon)
- the father’s denial of past history of violence despite reports of violence in the criminal record or by his female partner
- a high score on any measure of lethality
- a high use of coercion and control whereby the father controls most aspects of the mother’s and family life
- a significant current fear of the father by his current or former partner that cannot be resolved with safety planning
- substance dependence that is currently untreated
- suicidal ideation and intent
- high criminality, lack of empathy, and manipulation of others to get what he wants
• high levels of hostility and aggression toward the child and strong beliefs in corporal punishment, which would require individual intervention before considering father–child work
• fear on the part of the child about being with his or her father (Stover and Morgos, 2013).

The authors note several group programs for perpetrators which address parenting issues, including the Evolve Program, which devotes several group sessions to fatherhood and domestic violence; Caring Dads: Helping Fathers Value Their Children, which provides parenting skills over 17 group sessions; and the Restorative Parenting Program, another group intervention designed to help men who perpetrate DV restore their relationships with their children by taking responsibility for their abusive behaviour and the impact it has had on their families.

5.11.3 Benefits
Work with fathers who have exposed their children to domestic violence has the potential to address safety and the impact of the abuse on children where safety and suitability criteria can be met.

5.11.4 Limitations
The consensus from large reviews is that there is a lack of consistent evidence on the effectiveness of programs for people who perpetrate domestic violence.

5.11.5 Recommendations
34. Based on the evidence, NSW Health services should not provide treatment for the perpetration of domestic violence.

35. Health services accessed by perpetrators that do not attempt to treat the perpetration of abuse should continue to be provided unless there are clear indications of a risk to health workers.

36. Consideration should be given to inclusion of perpetrators of domestic violence in child protection interventions for the purposes of increasing children and young person’s safety and reducing self-blame, where no known risk factors preclude this.
6. PROGRAM-SPECIFIC CONSIDERATIONS

6.1 Hospital wards

The prevalence of physical and emotional abuse is higher among women who present to hospitals than in the population as a whole, based on a review of prevalence studies which included three studies conducted in the general hospital setting (Alhabib et al., 2010). This points to the need for hospital-based health professionals to be alert to the fact that many patients are experiencing current abuse.

No specific literature was identified which addressed responses to domestic violence in hospital wards; however, see these sections of this review:

- 5.2 Risk assessment and safety planning
- 5.3 First line responses
- 5.4 Counselling with adults who have experienced domestic violence
- 5.6 Child protection notification
- 5.7 Training
- 5.8 System-level responses
- 5.11 Responses to perpetrators of domestic violence

6.2 Emergency departments

Based on 18 different studies, approximately 38% of women who present to emergency departments (EDs) have experienced lifetime physical abuse (Alhabib et al., 2010). Much of the abuse experienced is recent, with one New Zealand study finding that 12–14% of women screened in EDs had reported domestic violence in the past 12 months (Koziol-McLain et al., 2010).

Many common health presentations to the emergency department are indicators for domestic violence which warrant asking about current abuse. According to the WHO these include frequent presentations; intrusive presence of partner; unexplained injury; chronic gastrointestinal, reproductive or genitourinary symptoms; repeated vaginal bleeding; traumatic injury, particularly if repeated and with vague or implausible explanations; and problems with the central nervous system including headaches, cognitive problems or hearing loss (World Health Organization, 2013).

In a separate review of 262 studies on the pattern of injuries associated with DV among women presenting to EDs, it was found that unwitnessed head, neck or facial injuries are significant markers for domestic violence. Conversely, extremity injuries are less likely to have been the consequence of DV (Wu et al., 2010). Indicators of choking or strangling are another area for close observation in EDs, as this is both a predictor of future homicide by the abuser (Campbell, 2003) and a hidden yet widespread form of abuse. Among a sample of 1000 pregnant women, 34% of those reporting DV described being choked (Bullock et al., 2006).

Despite its high prevalence, domestic violence remains under-identified in emergency departments. One study found that 72% of women who attended an ED after an incident were not identified as victims of abuse, leading the authors to conclude that victims
frequently used the ED for health care, but were unlikely to be identified or to receive any intervention for abuse in that setting (Rhodes et al., 2011). Canadian research found that only 30% of EDs surveyed had policies and procedures guiding responses to DV, suggesting that this should be a priority (McClennan et al., 2008). From a patient perspective, responses in EDs appear to be at a lower standard than in other program areas, with a qualitative study of women’s health-care experiences in different settings reporting that responses to disclosures made in ED were characterised as unhelpful, whereas the majority of disclosures in obstetrics/gynaecology and general practice were characterised as beneficial (Liebschutz et al., 2008).

A range of different initiatives have been trialed in emergency departments to improve identification and responsiveness. A survey of over 400 Finnish ED professionals found that participants from units with written procedures for handling domestic violence reported having helped women more often than those from units where no procedures existed. Participants also reported that intervention was facilitated by collaborative working relationships with DV specialists and by opportunities to consult and receive training from them (Leppäkoski and Paavilainen, 2013). In another trial, comparison of a specific diagnostic protocol for injured women who presented to the emergency department resulted in a 38-fold increase in identification of DV when compared with the standard procedure (Halpern et al., 2009).

In a NSW study focusing on improving the quality of responses in EDs, a participatory action research project was initiated through which nursing staff were trained to identify three key actions in a pathway for domestic violence presentations to the ED. Six months after training, nurses reported improved confidence, practice and skills in the identification of and response to domestic violence (Boursnell and Prosser, 2010).

Emergency departments are a common setting for screening in the USA (Phelan, 2007). However, on the whole screening rates in EDs tend to be low, averaging 20-25% of eligible presentations (McCloskey et al., 2005; Stayton and Duncan, 2005; Kothari and Rhodes, 2006; Plichta, 2007). An Australian study described the introduction of ED screening by nurses with women aged over 16 years in a South Australian hospital using a three-item screening tool. The results included an increase of 213% in referrals to the social work department, which was a major aim of the study. The initiative had cautious support of staff, particularly at times of the day when the social worker was available to provide immediate response. Staff agreed that the ED is an appropriate place to ask about domestic and family violence, although issues regarding safety, privacy, time and training were also identified (Power et al., 2011).

A recent and innovative screening initiative in a paediatric ED invited caregivers to complete a computerised screening tool on home safety risks, with an emphasis on domestic partner violence. Using home safety screening kiosks, caregivers completed the computerised tool containing DV-related and non–DV related questions. An ED social worker received an automated text page and printed summary of the findings when a caregiver identified DV occurring in the home. Fourteen per cent of the computerised screenings led to positive indications of DV, leading the authors to conclude that the initiative provided a consistent
opportunity to conduct unobtrusive, private screening for DV and other home safety concerns (Scribano et al., 2011).

6.2.1 Recommendation

37. The development and trial of an integrated strategy to increase identification and documentation, and provide first line responses to those presenting to emergency departments who have experienced recent domestic violence, which could include a trial of targeted screening, is urgently indicated.

6.3 Antenatal services

Pregnancy is a time when the prevalence and intensity of domestic violence tends to escalate (Campbell et al., 2007), which significantly increases the risk of maternal and neonatal morbidity and mortality. Women with histories of past abuse are at increased risk of depression and posttraumatic stress disorder during pregnancy, which in turn increase the risk of labour, birth and neonatal complications (Kendall-Tackett, 2007). The same author found that women who have experienced past or current abuse are also at high risk for postpartum depression and often their ability to breastfeed is also affected. A review of 30 studies found that women exposed to domestic violence were 1.4 times more likely to have a preterm birth and 1.5 times more likely to have a low birth-weight infant (Shah and Shah, 2010). For this reason screening in the antenatal and postnatal settings is recommended by the WHO and other key health bodies. See also 5.1, Routine screening.

The WHO has also recommended that pregnant women who disclose abuse should be offered up to 12 sessions of counselling including a safety component (World Health Organization, 2013). A key study informing this recommendation was a randomised trial of counselling that included domestic violence as well as other health risks during pregnancy and postpartum, which reported less violence and better infant outcomes among women receiving counselling compared to those who did not (Kiely et al., 2010). Women in the counselling group had significantly fewer very preterm (<33 weeks) and very low birth-weight (<1500 grams) newborns, and increased gestational age (38.2 versus 36.9 weeks) (Kiely et al., 2010).

See also 5.4, Counselling with adults who have experienced domestic violence.

6.4 Child and family services

Exposure to domestic violence is well established as a cause of long-term psychological, emotional, physical, developmental and behavioural problems for children (Van der Kolk, 2005; Holt et al., 2008; Hickman et al., 2013), which also increases their vulnerability to many other adversities, including lifetime risk of victimisation (Finkelhor et al., 2009). See also:

5.1 Routine screening
5.2 Risk assessment and safety planning
5.3 First line responses
5.4 Counselling with adults who have experienced domestic violence
5.5 Mother–child interventions
5.6 Child protection notification
6.5 Community health centres

No specific literature describing interventions in community health was identified; however, most of the interventions outlined in this review are highly relevant to this sector. See:

5.2 Risk assessment and safety planning
5.3 First line responses
5.4 Counselling with adults who have experienced domestic violence
5.5 Mother–child interventions
5.6 Child protection notification
5.7 Training
5.8 System-level responses
5.9 Multi-agency collaboration
5.10 Home-visiting interventions
5.11 Responses to perpetrators of domestic violence

6.6 Alcohol and other drugs services

Women who are identified as having experienced domestic violence in the past 12 months were found in a large Canadian study to be 1.7 times more likely to have a drug problem and twice as likely to have a partner with a substance problem (Wathen et al., 2008). In a separate study of women using domestic violence refuges approximately 68% scored moderate to high risk for substance use. The overlap between these two issues is reinforced by findings that among men in treatment for substance abuse there are high levels of perpetration of domestic violence (Fernandez-Montalvo et al., 2011). Similarly alcohol use in women who are experiencing DV was found to be associated with experiencing higher rates of violence (El Mohandes et al., 2011). Other research names the overlap between these two issues as bi-directional, pointing to the problems created by service delivery silos (Humphreys et al., 2005). Of those who are may need to access substance abuse treatment, domestic violence is found to impact on their ability to access and complete this type of treatment and increases chance of relapse (Galvani, 2006). Both the Humphreys and Galvani papers emphasise the need for substance use service providers to receive comprehensive training in responding to DV.

Integrated interventions responding to both substance use and DV bear promise. A study on a 12 week group program for women in methadone maintenance focussing on both relapse prevention and increasing safety reported high levels of attendance and completion, reduced DV incidents and some improvements in substance use (Gilbert et al., 2006). Increased domestic violence related self-efficacy and reduced substance using days were also reported from participants in integrated or linked substance and DV programs in Illinois (Bennett and O'Brien, 2007).

See also:

5.1 Routine screening
6.7 Mental health services

Prevalence of lifetime experiences of physical and sexual abuse by a partner were found to be higher among women in mental health clinics than in any other health setting, or population sample, according to a review of 134 prevalence studies (Alhabib et al., 2010). In a separate review specifically of domestic violence experienced by people with mental health disorders, the average lifetime prevalence for women was 33%, with some studies finding up to 94% (Oram et al., 2013).

Numerous other studies support the strong association between mental health problems and domestic violence (Bengtsson-Tops and Tops, 2007; Bonomi et al., 2007; Martin et al., 2008; Hegarty, 2011; World Health Organization, 2013). Compared to women who had never experienced DV, women with any recent experience of DV (physical, sexual or non-physical) were twice as likely to have minor depressive symptoms and four times as likely to have severe depressive symptoms, with longer duration of abuse being associated with incrementally worse health (Bonomi et al., 2006). The nature of the violence experienced by this group of women is also often serious. In one study of 1382 women who were users of psychiatric care, 46% (638) of the women had been exposed to emotional, sexual and/or physical abuse in adulthood, with 28% reporting moderate physical abuse, 20% threats of being killed, 19% sexual violence, and 12% having experienced serious physical violence (Bengtsson-Tops and Tops, 2007). In a study of pregnant women experiencing DV, higher rates of violence were associated with depression (Kiely et al., 2010). Despite domestic violence being very commonly experienced by individuals with severe mental illness, it has been noted that there is very little research in this setting and that multiple barriers exist to disclosure by those with mental illness (Hegarty, 2011).

A study conducted in England with service users and health professionals in community mental health teams found that barriers to providing effective responses to domestic violence included: limited professional experience and lack of awareness of DV; difficulties in assessment and management of DV; challenges in maintaining therapeutic relationships with patients while obeying reporting requirements; and lack of clear referral pathways (Trevillion et al., 2012). In the same study, service users reported that they wanted professionals to engage in discussion about abuse, provide support and information about domestic violence services. The study found that despite clear policy direction on the need for mental health professionals to routinely enquire about domestic violence, practitioners remain unclear as to their role in identifying and responding to DV disclosures (Trevillion et al., 2012). The paper recommends greater collaborative efforts among the mental health
and domestic violence sectors so that both the mental health and trauma needs of the client can be addressed.

Concomitant to the association between DV and mental illness is evidence that interventions which target women who are experiencing DV can also reduce mental illness. For example an Australian study on an intervention comprising one to six sessions of counselling on relationship and emotional issues delivered by GPs to women experiencing abuse did not impact on safety, quality of life or mental health in general, but did lead to significantly reduced depression in the intervention compared to the control group (Hegarty et al., 2013). In an intervention with pregnant women experiencing both DV and depression which addressed both issues, positive results were found in relation to reduced abuse, birth weight and preterm births. No results on changes to depression were reported, however.

Overall the literature in this area points to the central importance of:

1. training for mental health professionals in identifying, responding to and working in a trauma-informed way with those who have experienced domestic violence (Bengtsson-Tops and Tops, 2007; Oram et al., 2013)
2. systems for identifying DV and assessing risk when identified (Hegarty, 2011; Trevillion et al., 2012; World Health Organization, 2013)
3. facilitated pathways to mental health professionals for women who have been identified as experiencing DV in other health settings (Trevillion et al., 2012; World Health Organization, 2013).

**Recommendations**

38. Mental health and substance use services should develop and offer or partner to provide integrated responses to domestic violence, which address both the presenting issue, as well as safety and trauma issues.

See also:

5.1 Routine screening
5.2 Risk assessment and safety planning
5.3 First line responses
5.4 Counselling with adults who have experienced domestic violence
5.6 Child protection notification
5.7 Training
5.8 System-level responses
5.9 Multi-agency collaboration
5.10 Home-visiting interventions
7. SPECIFIC CONSIDERATIONS FOR VULNERABLE POPULATIONS

7.1 Aboriginal and Torres Strait Islander people

The National Aboriginal Torres Strait Islander Social Survey (2008) suggests that almost one in five Aboriginal people aged 18 years or over reported they had experienced violence in the previous 12 months (Australian Bureau of Statistics 2010). The actual extent of domestic violence among Aboriginal communities is difficult to determine due to under-reporting by victims, lack of appropriate screening by service providers, incomplete identification of Indigenous people in many data sets, and problems associated with the quality and comparability of existing data (Day et al., 2012). However, police data suggests that rates of domestic assault on Aboriginal women are six times higher than for non-Aboriginal women (Nicholas et al., 2012). Further, it has been estimated that Aboriginal women are 35 times more likely to be hospitalised as a result of domestic violence and 10 times more likely to be killed by an abusive partner than non-Aboriginal women (Al-Yaman et al., 2006). They are also less likely to seek help for this abuse due to persistent racism (Lauw et al., 2013).

Another dimension to Aboriginal people’s experience of DV and potential contributor to their unwillingness to seek help for it is the fact that Aboriginal and Torres Strait Islander children are 10 times more likely to be placed in out-of-home care (Matthews and Burton, 2013). High notification and re-notification rates of Indigenous children to child protection services in relation to domestic and family violence, homelessness, and parental problems such as mental health and substance-related issues, indicate the complex family needs experienced in Aboriginal communities (Matthews and Burton, 2013).

An Australian review of the evidence for interventions to prevent domestic violence in Aboriginal communities suggests that effective responses require culturally informed models of violence and notes the need for interventions that effectively manage the risk of perpetrators committing further violence (Day et al., 2012). The NSW Health Aboriginal Family Health Strategy (2011) has been developed to specifically address the extent and impact of domestic violence on Aboriginal families in NSW and the importance of aligning with that program is acknowledged.

The NSW Health Education Centre Against Violence delivers a three-day training course, Competent Responses to Aboriginal Sexual and Family Violence to approximately 3000 health workers per year. The course recognises the ongoing impact of oppression, racism and violence on Aboriginal people’s lives. The course educates health workers about cultural safety, case-management skills that are culturally appropriate, complex interpersonal trauma in an Aboriginal context, concepts of white privilege and the impact that this has on practice, and Aboriginal people’s world view (Gardiner and Wilson, 2012; Herring et al., 2013).

A number of commentators have called for traditional healing to be reflected in interventions for Aboriginal and Torres Strait Islander families. One study of 113 participants who had experienced family and domestic violence reported on using traditional healing in clinical care, involving elders who made use of traditional cultural stories and Aboriginal spirituality with individuals, couples and families (Puchala et al., 2010) This strategy was
seen to be more effective than conventional clinical approaches with authors reporting that of the 69 people who met with the traditional healing elders, a statistically significant change was found in symptom severity from baseline to final interview (Puchala et al., 2010).

As noted in section 5.6, for Aboriginal families past experiences of forced removal of Aboriginal children and the current overrepresentation of Aboriginal children in out-of-home care give rise to particular concerns about the involvement of child protection services (Humphreys, 2008). This points to the need for particular care when providing interventions for Aboriginal women or families with young children, so that care is provided wherever possible in the context of an ongoing relationship and opportunities for trust can be built (Herring et al., 2013, Lauw et al., 2013), thus if a child protection notification is provided, care can be taken to ensure this is done with transparency and respect. Higher rates of under-disclosure of violence by Aboriginal women has also been established in terms of reports to police, with research suggesting that a high proportion of violent victimisation by this group is not disclosed to police (Willis 2011).

The original pilot sites for the NSW Health routine screening program included a rural area with a significant Aboriginal population (Irwin & Waugh, 2001). Discussions with Aboriginal women which were conducted as part of the evaluation indicated support for the program because universal screening meant that the issue would be addressed and that Aboriginal women could feel confident they were not being singled out and asked about abuse because of their Aboriginality. A current and yet to report study on the NSW Health screening program in antenatal services includes Aboriginal and Maternal Infant Health Services. More information in this area is needed to support effective and culturally appropriate responses to Aboriginal families who experience domestic violence.

7.1.1 Recommendations

Key considerations identified in the literature when responding to Aboriginal families where DV has or is occurring are:

39. Cultural competence is a prerequisite for any person working with Aboriginal and Torres Strait Islanders who have experienced domestic violence (Day et al., 2012; Gardiner and Wilson, 2012; Australian Bureau of Statistics, 2013; Herring et al., 2013; Lauw et al., 2013) and training in the area of cultural competence needs to be trauma informed (Herring et al., 2013).

40. In programs and areas where interventions are provided to Aboriginal women or families with young children, care is provided wherever possible in the context of an ongoing relationship so that opportunities for trust are established (Herring et al., 2013, Lauw et al., 2013).

41. Programs require the active and central participation of Aboriginal communities at delivery (Day et al., 2012; Australian Bureau of Statistics, 2013).

42. Programs need to reflect the range of factors that increase domestic violence in Aboriginal communities, particularly intergenerational trauma caused by
colonisation, the disconnection from land and culture, economic exclusion, elevated rates of children being removed from their homes, and persistent racism experienced by Aboriginal people (Day et al., 2012; Lauw et al., 2013), in all levels of programming, from policy, planning and governance.

43. Elements of traditional healing are important components in programs for recovery and prevention of domestic violence in Aboriginal families (Puchala et al., 2010; Gardiner and Wilson, 2012), including in programs to train Aboriginal workers to respond to violence (Lauw et al., 2013).

7.2 People from culturally and linguistically diverse backgrounds

A review of global prevalence studies notes that cultural practices receive a disproportionate level of attention in relation to experiences of domestic violence and suggests that social, political and economic factors may be more important in shaping experiences of violence, even if they fall along cultural lines (Alhabib et al., 2010). The authors note that these factors may include poverty, inequalities, new articulations of patriarchies, and legacies of colonialism and racism.

Two syntheses of the literature conclude that women from culturally and linguistically diverse (CALD) backgrounds face additional risk factors when it comes to addressing DV and are often less likely to report such abuse due to barriers which include language and lack of interpreting services, uncertain immigration status, social isolation, and lack of knowledge about what constitutes domestic violence and legal protections available to them (New Zealand Ministry of Women’s Affairs, 2010; Council of Australian Governments, 2012). Women from CALD communities have been found to be less likely to use mainstream services because they perceive that services are not responsive to their situation and they are fearful of involving police, particularly as they expect that responses may be racist or unhelpful, or place them in jeopardy in their own communities (New Zealand Ministry of Women’s Affairs, 2010). In a British study of women from CALD backgrounds it was found that these women often experience pressure to not only leave their abusive partner, but also to separate from their ethnic community, which may be typified as oppressive towards women (Chantler, et al., 2009). It has also been recognised that despite the growing population of women from diverse cultures in the United States and other countries and their greater vulnerability to domestic violence, there are no culturally appropriate instruments to assess the risk of homicide and future incidence of violence among culturally diverse women (Messing et al., 2013).

7.2.1 Recommendations

Key suggestions in the literature for improved intervention with women from CALD communities who have experienced abuse are:

44. language accessibility, and bilingual or ethnic workers providing same-language support groups

45. culturally sensitive approaches that take into account women’s broader social context including not only culture but also gender, family structures, immigration status, trauma experiences, social class and age
46. community engagement, recognising the need to work with community and religious leaders.

7.3 Lesbian, gay, transgender, bisexual and intersex people

Although some authors in this field suggest that prevalence of domestic violence is comparable in lesbian, gay, bisexual, transgender and intersex (LGBTI) relationships to heterosexual relationships (Ford et al., 2013), others suggest that the rates may be much higher, with studies quoted in the British NICE guidelines reporting that 38% of LGBTI people and 80% of transgender people have experienced emotional, physical or sexual abuse from a partner or ex-partner (Roch et al. 2010 and Donovan et al. 2006, cited in National Institute for Health and Care Excellence, 2014).

The literature also notes that health professionals commonly lack awareness of the prevalence of same-sex domestic violence. It is crucial that health professionals are aware of their own beliefs about homosexuality, and develop cultural understanding and knowledge to enable them to identify DV victims in same-sex relationships in a culturally sensitive way and to help them to provide an appropriate response (Freedberg, 2006).

An online survey of police and professionals from DV services in California found that few had received specific training on responding to LGBTI people who experienced abuse, although 50% had responded to requests for assistance from people who identified as LGBTI (Ford et al., 2013). Risk assessment tools have been identified as another gap in the response to domestic violence experienced by LGBTI people, with acknowledgement that current tools do not yet take account of diverse populations and that tools need to be cross-validated through research with LGBTI people (Nicholls et al., 2013).

Recommendations from the literature for health professionals responding to LGBTI people experiencing DV include: specific training to dispel myths and provide guidance on the most appropriate care for LGBTI people; routine screening and assessments that use gender-neutral terms; and creation of an open and non-judgemental atmosphere to support LGBTI people to disclose their sexual orientation and partner abuse (Freedberg, 2006).

7.4 Children and young people

In a survey conducted in 2001 which does not appear to have been replicated more recently, out of 5000 young Australians aged 12–20, one in four (23%) reported having witnessed an act of physical violence by their father or stepfather against their mother or stepmother (this included throwing things, hitting, or using a knife or a gun against her, as well as threats and attempts to do these things) (National Crime Prevention, 2001).

Children living in homes where domestic violence occurs are at significant risk for child abuse, with one study finding that one-third of young people exposed to DV had also reported experiencing physical abuse in the last year (Hamby et al., 2010). Even where children are not physically abused themselves, there is consensus in the research that negative developmental and behavioural outcomes for children witnessing domestic violence are similar to those of children who have experienced direct physical violence (Humphreys and Houghton, 2008, cited in Flood and Fergus, 2008).
Research on children exposed to domestic violence indicates that common impacts include: anxiety, depression and other mood problems, aggression, anti-social behaviour, trauma symptoms, pervasive fear, low self-esteem, impaired cognitive functioning and increased likelihood of substance abuse (Richards, 2011). Impacts on children are developmentally driven with a recent Australian meta-analysis noting that babies living with domestic violence have high levels of ill-health, poor sleeping habits, excessive screaming and disrupted attachment; pre-school aged children show the greatest behavioural disturbance and older children are more likely to demonstrate impacts through school and social environments (Laing and Humphreys, 2013).

The implications for health service use are clear with research finding that children exposed directly to domestic violence have greater emergency department and primary care use during the abuse period and were 3 times as likely to use mental health services after the abuse ended (Rivara et al., 2007a). This study found that even where violence ended before the child was born significantly greater use of mental health, primary care, specialty care, and pharmacy services occurred than for children of mothers who reported no domestic violence (Rivara et al., 2007a).

There are also links for children with involvement in other systems. A large US study found that families with current domestic violence were substantiated for child abuse at higher rates than other groups and where the violence co-occurred with physical abuse high levels of cumulative risk were found which correlated with a 10 fold increase in placement in out of home care (Kohl et al 2005). Similarly in an Australian study of 364 children in out of home care experiencing the highest rates of placement instability were found to originate from families with multiple risk factors with domestic violence and physical abuse more common than histories of sexual abuse and neglect (Osborne et al, 2008).

Literature on children’s resilience in the face of exposure to domestic violence also suggests that 26-50% of exposed children do not demonstrate negative effects, which may result from protective factor’s in the child’s environment likely to include social support and maternal mental health, though the severity of violence to which the child has been exposed may also be a factor (Laing and Humphreys, 2013).

Young people also suffer from the impact of domestic violence, both through exposure to parental violence, as well as in the course of their own relationships. The 2012 Personal Safety Survey found that younger women are more likely to have recently experienced violence than older women: 13% of women aged 18-24 years had experienced past 12 months violence, a proportion that progressively declines with age (ABS, 2013). Young people are less likely than older people to understand the range and seriousness of behaviours constituting violence and, who is most likely to be victimised (Australian Institute of Criminology et.al, 2010).

No specific studies were identified on screening or risk assessment tools for use with young women, (for example in one major review all but one included study specified age range of 18 years and over) (Taft et al 2013). However the elevated risks young women face point to the value of screening in services where young women are most likely to present. The most recent US review on screening for domestic violence which suggested that screening
produces moderate net benefits, noted the higher risks to younger women and suggested that screening target women of reproductive age which was defined as 14-46 years (Moyer & US Preventive Services Task Force, 2013).

In Australia the *Headspace* services for adolescents and young people at risk of mental health problems include generalized questions about past abuse in the sexuality module of the standardized psycho-social assessment tool. The suggested questions are: 

> Have you had an experience in the past where someone did something to you that you did not feel comfortable with or that made you feel disrespected? And if someone abused you, who would you talk to about this? How do you think you would react to this? 

No further data on the use of the screening tool was identified and this is an area which clearly requires further development.

(See also Section 5.5 Mother-child interventions and Section 5.6 Child protection notification).

### 7.5 People who have experienced prior abuse or are identified as being at high risk of further harm

A range of factors have been identified which elevate risk of further harm including: young age, substance abuse, marital difficulties or economic hardships (Moyer and U.S. Preventive Services Task Force, 2013); having a long-term illness or disability, which was reported to almost double the risk of experiencing domestic violence (Smith et al., 2011, cited in National Institute for Health and Care Excellence, 2014: 28); perpetrator’s access to a gun and previous threat with a weapon, perpetrator’s stepchild in the home, and estrangement, especially from a controlling partner (Campbell et al., 2003).

Being part of a vulnerable group also reduces the likelihood of accessing services for abuse. For example it is estimated that women with disabilities are 40-70% less likely to disclose the abuses they experience (Attard and Price-Kelly, 2010). This renders even more relevant the importance of providing access to trained health service providers and targeted counselling for those who experience domestic violence.

Supportive advocacy in community settings reduces the frequency of re-abuse (Eckhardt et al., 2013) and should be carefully considered as a prioritised intervention for community-based health services. There is also a need to develop interventions for women with intellectual disabilities (Koziol-McLain et al., 2010).
8. SUMMARY OF RECOMMENDATIONS

1. A screening tool which has been fully validated and which includes a scoring system to support health workers to interpret, accurately document and act on the results of the screening questions should be piloted as an alternative to the current screening questions used in NSW Health services.

2. Screening in NSW Health services should be extended to women attending sexual health, HIV, gynaecology, women’s health, and neurological clinics; to health services providing couple or family counselling; and to private health services in the existing programs where screening is conducted who provide care to a significant proportion of at risk women.

3. Access to immediate onsite social work response should be incorporated into screening policies wherever possible to sustain screening rates and best outcomes for women identified as having experienced DV.

4. Comprehensive and ongoing training should be provided to all new staff in screening programs, and frontline staff tasked with screening, should receive annualised continuing education which includes practice opportunities along with recent findings from research and training on culturally competent responses.

5. Health professionals conducting screening should have access to specialist clinical supervision in relation to responding to disclosure.

6. Audited systems are required to ensure that all women who are asked screening questions receive appropriate written resources at the time of screening.

7. In services where patients attend the health service over multiple visits, protocols should be amended so that screening questions are asked at the second visit to the health service with continuity of care of provider from the first visit.

8. A structured risk assessment tool should be selected for use by NSW Health frontline staff which should be used in preference to professional judgement alone, in order to support decisions and planning in responding to DV.

9. Training should be provided in the use of a selected risk assessment tool in line with the recommendations outlined in 6, Program-specific initiatives.

10. Safety planning should be undertaken by the health service with all women identified as currently experiencing domestic violence, recognising that most women who experience DV are already active agents in relation to their own and their children’s safety. Structured tools for safety planning may provide valuable resources for health workers responding to women disclosing DV.

11. Safety planning is an activity best undertaken by social workers attached to hospital clinics, wards and centres, as it is a complex task requiring professional judgement based on specialist knowledge of DV, skilled interviewing, time and privacy not necessarily afforded to other health professionals.

12. Consistent with the recommendations for training, all frontline professionals in health services should receive training, which is updated annually, in the elements of a respectful and empathic first response to those who disclose domestic violence.
13. Resources for distribution and referral pathways for each health unit should be identified and regularly reviewed by a designated senior person attached to that unit/clinic.

14. Women who are identified in hospital and community health services as experiencing domestic violence either currently or the past 12 months should be provided with six to eight sessions of counselling to address the impact of the abuse.

15. Antenatal patients should be a priority for this counselling, which should be provided onsite, timed to occur alongside antenatal and postnatal visits, and should address depression and other issues, such as breastfeeding, as well as exposure to domestic violence.

16. Counselling should be provided by social workers who have participated in specialist domestic violence training.

17. Community health services should consider the possibility of providing group work intervention for women affected by domestic violence.

18. Child and family teams, specialist child protection counselling services and community health centres with capacity to respond to children affected by domestic violence should provide at least eight sessions of mother–child dyad counselling.

19. Mother-child interventions after DV should include combined group work programs.

20. Child protection notification practice should be supported by specialist training on domestic violence and children at risk conducted in a multi-agency context.

Training of health professionals about DV needs to be:

21. accompanied by systems changes and monitoring

22. introduced at the undergraduate level

23. tiered as appropriate to the needs of the health professionals, in line with the four-level approach recommended for British health services as specified at Section 5.7.1 ie.

   Level 1 – all frontline staff,
   Level 2 – health professionals who screen or otherwise identify DV,
   Level 3 – social workers providing referral responses, risk assessment and safety planning,
   Level 4 – specialist DV/ Sexual Assault professionals

24. delivered where possible by the service providers to whom health workers are expected to refer those experiencing DV

25. updated annually and delivered in such a way that new staff are identified and trained to the required level of competence

26. provided in conjunction with health workers having access to on-call consultation with service providers, which may include hospital/clinic social workers with specialised DV training and skills, when responding to complex DV matters.
27. Implementation of a revised policy requires a multi-dimensional approach integrating the four tiers of training, as well as systematic provision of mentoring; ongoing education and consultation; systems for information sharing; auditing and monitoring; documentation tools; and documented simple referral pathways with immediate response when current DV is identified.

28. Champions of the revised DV policy should be appointed at the unit, professional and program level in each Local Health District. These champions are identified personnel with interest in supporting implementation and who receive as a minimum, Level 3 training.

29. Provision should be made in the overarching NSW Health privacy policy for all episodes of care of adults to automatically include time alone with the health provider.

30. Multi-agency responses should include combined referral and assessment systems, simplified information sharing with active use of this facility between agencies, and local inter-agency networks which are actively maintained through regular structured and unstructured contact.

31. Multi-agency collaboration requires champions at the senior level of each Local Health District and also within different offices of NSW Health; robust governance arrangements that operate at multiple levels from the frontline up to senior levels of agencies; clearly defined outcomes; monitoring; and accountability strategies, to successfully address the barriers to collaboration.

Further work should be done to identify:

32. health services that currently engage in home visiting, which may include patients who have experienced or demonstrated aggressive behaviour, to determine current risk assessment and safety protocols

33. a risk assessment and safety protocol based on consultation with agencies or research projects where home visiting occurs.

34. Based on the evidence, NSW Health services should not provide treatment for the perpetration of domestic violence.

35. Health services accessed by perpetrators that do not attempt to treat the perpetration of abuse should continue to be provided unless there are clear indications of a risk to health workers.

36. Consideration should be given to inclusion of perpetrators of domestic violence in child protection interventions for the purposes of increasing children and young person’s safety and reducing self-blame, where no known risk factors preclude this.

37. The development and trial of an integrated strategy to increase identification and documentation, and provide first line responses to those presenting to emergency departments who have experienced recent domestic violence, which could include a trial of targeted screening, is urgently indicated.

38. Mental health and substance use services should develop and offer or partner to provide integrated responses to domestic violence, which address both the presenting issue, as well as safety and trauma issues.
39. Cultural competence is a prerequisite for any person working with Aboriginal and Torres Strait Islanders who have experienced domestic violence (Day et al., 2012; Gardiner and Wilson, 2012; Australian Bureau of Statistics, 2013; Herring et al., 2013; Lauw et al., 2013) and training in the area of cultural competence needs to be trauma informed (Herring et al., 2013).

40. In programs and areas where interventions are provided to Aboriginal women or families with young children, care is provided wherever possible in the context of an ongoing relationship so that opportunities for trust are established (Herring et al., 2013, Lauw et al., 2013).

41. Programs require the active and central participation of Aboriginal communities at delivery (Day et al., 2012; Australian Bureau of Statistics, 2013).

42. Programs need to reflect the range of factors that increase domestic violence in Aboriginal communities, particularly intergenerational trauma caused by colonisation, the disconnection from land and culture, economic exclusion, elevated rates of children being removed from their homes, and persistent racism experienced by Aboriginal people (Day et al., 2012; Lauw et al., 2013), in all levels of programming, from policy, planning and governance.

43. Elements of traditional healing are important components in programs for recovery and prevention of domestic violence in Aboriginal families (Puchala et al., 2010; Gardiner and Wilson, 2012), including in programs to train Aboriginal workers to respond to violence (Lauw et al., 2013).

Key suggestions in the literature for improved intervention with women from CALD communities who have experienced abuse are:

44. language accessibility, and bilingual or ethnic workers providing same-language support groups

45. culturally sensitive approaches that take into account women’s broader social context including not only culture but also gender, family structures, immigration status, trauma experiences, social class and age

46. community engagement, recognising the need to work with community and religious leaders.
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