

CENTRE OF
RESEARCH
EXCELLENCE

Safer Families



Early engagement with families in the health sector to address domestic abuse and family violence: **Policy directions**

Safer Families Centre

Briefing Paper

Hegarty K, Gleeson S, Brown S, Humphreys C, Wheeler J, Hooker L, Tarzia L, WEAVERs member (anonymous), on behalf of the Centre

29th October 2020

Contact:

k.hegarty@unimelb.edu.au

Suggested citation:

Hegarty K, Gleeson S, Brown S, Humphreys C, Wheeler J, Hooker L, Tarzia L. Early Engagement with families in the health sector to address domestic abuse and family violence: Policy directions. Safer Families Centre. 2020.



Introduction

At the Safer Families Centre, we address the problem of inadequate identification and response to domestic abuse and family violence in health services.

This paper aims to discuss with policy makers and health service managers, **early engagement in the health sector** to address domestic abuse and family violence (DAFV), particularly in the context of social recovery from the pandemic. The Australian Government and State governments have prioritised keeping families safe through implementation of the *National Plan to Reduce Violence against Women and their Children 2010-2022*¹ and through recommendations arising from Inquiries and a Victorian Royal Commission.² Despite these initiatives, there remains a gap in terms of policy and practice, with the health sector lagging behind other sectors to engage with families experiencing DAFV.

Definitions of Early Engagement

- Acting as soon as possible to tackle issues for women, children and families before they become more difficult to reverse;
- Providing help that is earlier than the current tertiary response;
- Any work with children, even if they have had exposure to violence between parents, to help break intergenerational impacts including risk of perpetration.

Early engagement can be a principle across the prevention spectrum rather than a focus on any given sector.

This paper outlines the background underpinning the need for work in the health sector, the evidence to engage and respond to survivors and the actions for transforming health system policy.

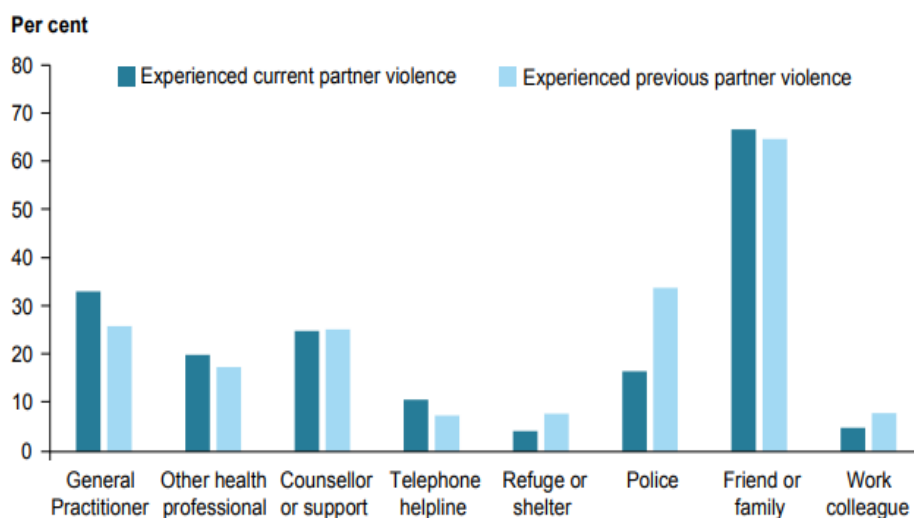
In this paper, we draw on the largest evidence base for the health sector, that of men’s use of DAFV against female partners, although we are aware that men are also victims and DAFV occurs in same-sex relationships. With a focus on survivors in this paper, we plan to disseminate separate papers on men who use DAFV and children experiencing DAFV. We also acknowledge the role of cultural and historical trauma that can impact individuals and communities across generations in addition to experiences of individual trauma.

Why focus on the health sector?

The potential of the health sector to reach families is large, as the vast majority of people are in contact with health services on a regular basis. General practitioners (GPs) and other health professionals (nurse, psychologist, therapist) are the highest professional group told about DAFV.³ The 2016 Personal Safety Survey shows that for women who disclose DAFV, 53.4% of current and 43.7% of previous survivors seek help from health professionals. GPs are the highest professional group disclosed to by current survivors, even more than police (see figure below).³ However, it needs to be understood that this disclosure rate is only the ‘tip of the iceberg’ of the number of women, men and children affected by DAFV attending health settings. For example, a full time GP is likely to have five women per week attending the clinic with underlying DAFV, which is not identified.⁴

What is early engagement?

The Safer Families Centre defines early engagement as the health sector acting early to identify the warning signs and respond to DAFV. This includes engaging with populations more likely to experience DAFV (e.g. young women) or those with factors associated with DAFV (e.g. mental health issues). Acting early to end DAFV may avoid the trauma impact causing social, behavioural, cognitive and emotional problems in children.^{5 6 7} Thus, engagement of families affected by DAFV is a first step to provide ongoing support as recommended by the WHO.⁸



Sources of advice and support sought by women who experienced partner violence, 2016.³

Despite the vast majority of families experiencing DAFV attending health services,⁹ only a minority of survivor women and/or children are recognised in health care settings.¹⁰

Why a Public Health Approach?

Prevention is needed at the primary level through whole of community programs to prevent violence before it happens¹¹ but “early engagement” through health services has the potential to reach families before crisis and safety responses or specialist therapeutic services are needed (see Figure).

The World Health Organization (WHO) identifies the crucial role of an effective health system.^{9, 10} Early engagement through health services needs further research, support and implementation strategies to ensure pathways to safety and well-being for families.

To date, there has been only limited investment in strengthening the health sector to engage early and often with families who are or may be experiencing DAFV. Evidence shows that this is likely to improve the safety, health and well-being of children and their parents or carers.⁸



Why is early engagement through the health sector needed?

The Safer Families Centre suggest there has been a large focus on primary and tertiary prevention in Australian policy. Engagement and support through health services to promote pathways to safety and healing for women and children has had less investment than police and other sectors, despite being the main group from which survivors seek help.

Movement restrictions as a result of the pandemic exacerbate social isolation and accessibility to services making the health sector an important place for early engagement.^{12, 13} General practice, antenatal, maternal and child health and other early childhood, and emergency services are key places for early engagement to promote social recovery. All health practitioners are crucial given their pivotal role in identification, risk and safety assessment, response and referral capacity. Further, we know that women want to be asked directly about DAFV by supportive practitioners, typically making multiple visits to health practitioners before disclosure.¹⁴ The WHO recommends a broad systems-based approach to enable sustained change in health practitioner behaviour.⁸

Some practitioners see all members of a family; however, many are ill equipped to identify and respond to women and children exposed to DAFV or to men who use DAFV. Unfortunately, there is evidence that practitioners often lack essential skills¹⁰ with many barriers¹⁵ needing to be overcome including:

- personal barriers (reluctance to “interfere”, difficulty relinquishing control, unwillingness to take responsibility);
- resource barriers (women being accompanied, inadequate training, lack of time and referrals);
- perceptions and attitudes (victim-blaming, health professional’s attitudes to violence);
- fear patients will be offended, not knowing what to do if a woman disclosed); and
- patient-related barriers (language, cultural, confidentiality, mandatory reporting of children)^{16, 17, 18, 19}

In addition, there is clustering of adversity including alcohol, drug use, housing insecurity, histories of complex trauma, mental health disorders, gambling and poverty that need to be considered. We also acknowledge the inter-relationship between DAFV, sexual violence and child abuse, recognising direct and indirect ways in which children can be harmed. There is a need for a tailored response through the health sector to children, young people and parents as experiences vary for families, with people at different stages of readiness to take action.^{20, 21}

SAFER FAMILIES CENTRE OF RESEARCH EXCELLENCE

We build innovative, sustainable programs and practical tools for health practitioners to identify the warning signs early, provide a first line response and promote safety, wellbeing and healing. Our research spans:

- A. Understanding the dynamics of abuse and resilience;
- B. Developing and testing early identification and first line responses for all members of the family;
- C. Evaluating child, parent and carer programs for safety and resilience.

We work in partnership with survivors to create change within health sector policy and practice that reflects the realities of those with lived experience.

See our Experts by Experience Framework at:
dvwic.org.au/members/experts-by-experience/

The Safer Families Centre researches and collaborates to transform the health sector to address DAFV. We are working for a future where health services can support any member of a family affected by DAFV.

Why do we need to focus on Aboriginal and Torres Strait Islander families?

Aboriginal and Torres Strait Islander families experience a disproportionate level of DAFV related to past and present trauma.²² The impact of colonisation and legacy of extreme social disadvantage contribute to higher rates of DAFV and children in 'out of home care'.²³

Data on longer-term consequences of DAFV are sparse, as researchers often fail to engage with Aboriginal communities in ways that would promote sustained participation in research. Aboriginal peoples have repeatedly stressed the importance of Aboriginal communities being empowered to identify and implement 'solutions' to DAFV.²²

Partnerships between researchers and Aboriginal community organisations and communities, capacity building, and knowledge exchange are key.²⁴ In collaboration with our Aboriginal Leadership Group, the Safer Families Centre draws on the voices of Aboriginal and Torres Strait Islander Peoples to develop programs to benefit Aboriginal and Torres Strait Islander communities and families.

Evidence overview of early engagement in the health sector

Identification

Who should we ask in health settings: Screening or case-finding?

Screening:

Consistent use of a validated set of short questions to detect DAFV in all patients

Case finding:

Using the opportunity of the clinical encounter to check for DAFV in symptomatic patients

The aim of asking about DAFV is not only to elicit disclosures, but to promote early engagement to promote respectful relationships. An empathic response from a trusted health provider can reinforce a patient's understanding that they are entitled to healthy relationships. Many practitioners, policy makers and researchers misuse the term 'screening' to mean asking about DAFV. In the health context it has a specific meaning of a consistent use with all patients of a set of short questions to detect DAFV. A Cochrane systematic review¹⁴ reinforces that evidence suggests that screening and initial response by a health professional increases identification with no increase in referrals or changes in women's experience of violence or wellbeing.

For antenatal care there may be sufficient evidence to recommend a benefit of screening all women attending, with two antenatal studies showing improvement in outcomes for women.¹⁴ This does not mean midwives, doctors and nurses in other health settings should refrain from asking about DAFV, if patients (mostly women and children) are presenting with symptoms and signs (case finding). It is best practice or good clinical assessment to include inquiry about DAFV when a patient has a clinical indicator. There are some settings where asking everybody (routine enquiry) is recommended e.g. in mental health or alcohol and drug services as all patients have symptoms of underlying DAFV.

Do women want to be asked in health settings?

We know that the vast majority of women, whether they have experienced DAFV or not, find being asked about DAFV acceptable, if the questions are asked in a non-judgemental, sensitive way.²⁵⁻²⁷ This includes 'routine screening' where all women are asked even though they have no symptoms or 'case finding' where practitioners ask when there are symptoms or signs. There is some evidence to suggest clinicians should ask more than once as women may not be ready to disclose on the first occasion.^{28, 29} Women may not always feel able to disclose immediately. Reasons for not disclosing include not considering the violence serious enough, embarrassment and shame, fear of the perpetrator and cultural and religious barriers.³⁰

Which ways of asking elicits most disclosures?

Several studies have examined face-to-face versus more distal ways of asking about DAFV such as paper or online.³¹⁻³³ A systematic review of six randomised controlled trials³⁴ showed that responses to face-to-face interviews are not significantly different to self-administered written questionnaires. However, a computer-assisted self-administered screen was found to increase odds of DAFV disclosure by about a third in comparison to face-to-face interviews. Overall, disclosure of DAFV was also 23% higher for computer-assisted self-administered screen in comparison to self-administered written screen in the systematic review.

What should we ask?

Asking general questions about relationships and then funnelling to more specific behavioural questions (e.g. hit, kicked) or emotion-based questions (e.g. fearful, safe) is more likely to elicit disclosures than asking stigmatising-type questions that include having to identify as experiencing DAFV (e.g. are you experiencing domestic violence or physical abuse?).^{16 35}

A 2016 systematic review of 10 tools³⁶ found three tools: Women Abuse Screen Tool; Abuse Assessment Screen; and Humiliation, Afraid, Rape and Kick had stronger psychometric values, assessing all areas of DAFV against a reference standard. However, further testing of questions is critically needed and work has been undertaken by the Safer Families Centre showing the use of fear of partner/ex-partner as a brief question is useful in the research setting.³⁷ Further, a new tool ACTS (Afraid; Controlled; Threatened harm; Slapped, hit, kicked or otherwise physically hurt) has been tested in Victorian antenatal care, showing a high sensitivity and specificity against the gold standard of the Composite Abuse Scale.¹⁶

How many women are likely to disclose and accept a referral?

An Australian study of over 1,500 first time mothers recruited in early pregnancy and followed up for ten years after childbirth, found that discussing experiences of DAFV with a GP was low with 8% of women experiencing DAFV in the first 12 months postpartum disclosing abuse to a GP, 5.9% at four years, and 4.9% at ten years.³⁸ A slightly higher proportion of women experiencing DAFV had discussed this with a mental health professional. The most recent figures from the NSW Health Domestic Violence Routine Screening program (2015) showed that 3.7% of women screened for DAFV were identified as experiencing abuse, with under a third accepting offer of assistance.³⁹ Similarly in a South East Queensland Study,⁴⁰ disclosure was 2% and most women experiencing DAFV declined referral. In a Victorian Maternal and Child Health population, disclosure was 1.3% and less than 1% accepted a referral.⁴¹

How many practitioners are likely to ask about DAFV?

Findings from a review reported low rates of routine screening ranging from 2% to 50% across 35 studies, with the majority of studies showing rates of between 10 to 20%.⁴² There are many barriers as to why practitioners may not sustain inquiry about DAFV. Evidence shows that only half of health professionals in the systematic reviews undertaken find screening acceptable.^{25 43}

Some health professionals do not see it as their role, fear offending the patient, and feel they don't have the skills or more importantly, enough time to provide an adequate response.⁴³ Health practitioners are often impeded by system barriers including the presence of the partner or do not feel supported through a lack of training, referral or support services.¹⁵

Factors increasing a health professional's likelihood of identifying women experiencing DAFV include recognising silent cues, having scripted questions, interdisciplinary collaboration and access to resources and referral services.⁴⁴

First line response

What is the recommended response after identification?

The WHO recommends that all health professionals should be trained in a first line response called LIVES (see Box).¹⁰ Assessing safety and risk and understanding women's readiness to take action are often the main new skills health practitioners need to acquire.⁴⁵ This includes understanding that many women may not wish to access formal support services for 'domestic abuse victims', as they do not self-identify as experiencing DAFV.⁴⁶

Current recommendations for first line response (LIVES)

- L**isten to the woman closely, with empathy, without judging;
- I**nquire about and respond to her various needs and concerns;
- V**alidate experiences - Show her that you understand and believe her. Assure her that she is not to blame;
- E**nhance safety - Discuss a plan to protect herself and children from harm;
- S**upport and follow-up - Help her connect to information, services and social support.

Online responses such as safety decision aids and healthy relationship tools show mixed evidence in randomised controlled trials but can encourage women to self-reflect on their relationships.⁴⁷

In addition to LIVES, which addresses 'what' practitioners should do, a systematic review of 31 interview and focus group studies globally with women survivors suggests 'how' practitioners should approach women (see CARE model).⁴⁸



CARE Model for first line response

Women expect from health practitioners a LIVES response in the context of a CARE model.⁴⁸ Providing women with choice and control, practical action, recognising their experience and connecting emotionally through kindness and empathy. The SUSTAIN study (2020), found that all health practitioners valued such woman-centred care and agency for women experiencing family violence.¹⁶

Ongoing response

How can we help survivors to recover and heal?

There is limited evidence as to what responses assist with recovery from DAFV, however they can be categorised into the following areas: referral to DAFV services for comprehensive safety planning and advocacy such as through home visitation and peer support programs; parenting and mother-child responses; and psychological treatments. For long term interventions, the most promising results have been from:

- advocacy programs, focusing on empowerment, safety and resources, including home visiting⁴⁹
- specific psychological treatments (Cognitive Behaviour Therapy, Trauma informed Cognitive Behaviour Therapy).⁵⁰

Holistic healing models have not been formally tested by randomised controlled trials but show promise. In the context of sexual violence, there is a lack of evidence to support the effectiveness of interventions to support healing and recovery, particularly over time.⁵¹

Children living with DAFV need an offer of individual and group work, including mother-child psychotherapeutic interventions^{52, 53} Ultimately, we need to work with people who use violence, especially men who are fathers, to reduce the impact on women and children. We are developing discussion briefs on children and men who use violence as separate briefing papers. However, we highlight here the need to strengthen the evidence base in these areas.

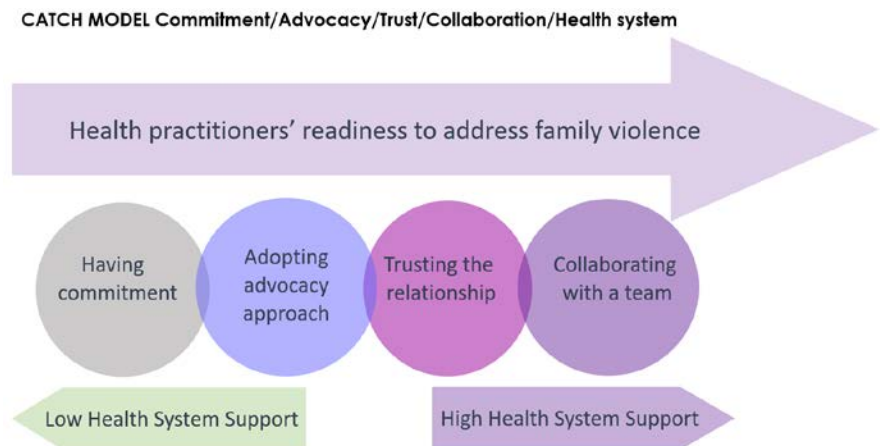
What assists health professionals to be ready to identify and respond?

Addressing readiness in education and training is more likely to enable clinicians to become physically and emotionally equipped for the work. A recent systematic review of 47 qualitative studies exploring health professionals' readiness to address DAFV provides some insight into areas on which to concentrate.⁵⁴

Five themes were identified as enhancing health practitioner readiness:

- Having a commitment;
 - Adopting an advocacy approach;
 - Trusting the relationship;
 - Collaborating with a team; and
 - Being supported by the health system.
- (See CATCH Model).⁵⁴

When practitioners have a personal **commitment** to this area, which might be motivated from a human rights, child rights or a feminist lens or a personal experience of DAFV, their readiness to address DAFV is enhanced.



The CATCH model also shows that employing a woman centred or **advocacy approach** with survivors giving positive feedback reinforces health practitioners to adopt this approach. Health practitioners' perception that the clinical setting is ideal for responding to DAFV is strengthened by **trusting that the relationship** is the best setting to engage with survivors and their families. A further factor enhancing readiness involves health practitioners **collaborating with a team** including with specialist professionals. However, strong **health systems support** is needed to facilitate practitioners to engage with the work to address DAFV.⁵⁴

System support

What whole of health system response should be implemented?

Health system changes occurring in isolation (e.g. training of staff or introduction of policies alone) are unlikely to improve patient outcomes based on existing systematic review evidence.⁸ Improving patient outcomes in the context of DAFV will require patient centred care, but also a 'whole of system' health service response and systems change.

At a health provider level, changes could include;

- promoting a culture of gender equity;
- adopting trauma informed principles and approaches (see table of Guiding Principles of Trauma-Informed Care on page 7);
- allowing sufficient consultation time and
- promoting awareness of DAFV protocols and referrals.

At a systems level, change might involve:

- development of protocols;
- provision of workforce support and mentoring;
- appointment of clinical champions;
- allocation of finances to DAFV services; and
- information systems for evaluation.

Implementing such changes requires work at many levels within the system. A survey of health clinics across Europe found several factors encouraged best practice responses including:

1. Committed leadership;
2. Regular training (with mandatory attendance) of a range of staff from front-desk workers to health care providers;
3. Use of the train the trainer model so that on-site trainers are available for the ongoing training, and
4. A clear referral pathway.⁵⁵

Using trauma and violence informed care approaches

A whole of systems approach also applies to embedding principles of trauma and violence informed care. Approaches in care that recognise the connections between violence, trauma, negative health outcomes and behaviours will work to enhance safety, control and resilience, and minimize the potential for harm and re-traumatization for people seeking support for DAFV.⁵⁶ There have however, been very few evaluations of such approaches.⁵⁷

Following are a set of principles to embed in all aspects and levels of practice and service delivery to help adopt a trauma and violence-informed approach.⁵⁸

Guiding Principles of Trauma-Informed Care⁵⁹

Principles	Description
Safety	<ul style="list-style-type: none"> • Staff and clients feel physically, psychologically, emotionally, spiritually and culturally safe • Compassion, empathy, affirmation and validation is employed to establish and maintain safety and trust • Self-care and safety plans are established for both workers and clients • Staff have responsibility to challenge issues of unsafety • Recognition and prevention of retraumatization
Trustworthiness & Transparency	<ul style="list-style-type: none"> • Operations and decisions within the organisation are conducted with transparency • Building and maintaining trust amongst staff, clients, and families is valued • Client expectations about how the service, treatment and care is clarified at the outset, including sensitivity regarding unintentional re-enactment of trauma, and managing this
Peer Support & mutual self-help	<ul style="list-style-type: none"> • Those with lived experiences of trauma and their family members referred to as 'survivors' or 'experts by experience', provide peer support for establishing safety, building trust, enhancing collaboration, promoting healing and recovery, fostering hope, connection and empowerment
Collaboration & mutuality	<ul style="list-style-type: none"> • True partnering between staff, clients and their families/carers with meaningful and equal sharing of power and decision-making • Workers make decisions with (not for) clients ensuring there are no 'us and them' dynamics • There is awareness of and communication about each other's trauma triggers and safety needs and recognition of the need for tailored support
Empowerment, voice & choice	<ul style="list-style-type: none"> • The organisation ensures that the individual strengths of their staff and clients are recognized, built upon and validated • The organisation recognises that each client requires a person-centred approach and that the experience of trauma may be a unifying aspect for staff and clients • Decision making and goal setting is shared, and self-advocacy skills cultivated. Staff are seen as facilitators, not controllers of recovery • Re-traumatisation is actively resisted by fostering empowerment, choice (providing options) and ensuring voices are heard in a supportive way
Respect for diversity and inclusiveness	<ul style="list-style-type: none"> • The organisation actively works to prevent stereotypes and biases based on gender, race, age, ethnicity, sexual orientation, ability or geography • The organisation promotes the healing value of traditional cultural connections, recognises historical trauma and identifies and responds appropriately to complex and intergenerational traumas • Communication and care are accessible for peoples with disabilities, and there is an understanding that trauma can impact brain development and cognitive functioning
Strengths based and skill building approach	<ul style="list-style-type: none"> • The organisation promotes resiliency and coping skills for managing triggers and fostering empowerment • Working with a strengths-based approach helps to ensure continuity of supports following a client's involvement with a service

Advocacy and Actions

This section of our paper summarises work done by governments and the health sector to improve the health system's response to DAFV (see box below). Following this, we make recommendations to build on these initiatives and create a more sustainable and effective response by the health sector to DAFV.

Current initiatives

Commonwealth examples

National Plan to Reduce Violence against Women and their Children 2010-2022. Fourth action plan includes:

- Expansion of Recognise, Respond and Refer program (whole of practice DAFV training for general practice staff)
- Update of *RACGP Abuse and Violence – Working with our patients in general practice (The White Book)*;
- Provision of short training courses for a range of primary care providers across Australia.

DV-Alert: National training program for frontline workers to better understand and identify DAFV and improve referral and support skills.

Primary Health Networks: For example, *Primary Care Pathways to Safety* providing in-practice DAFV education and support (North West Melbourne PHN).

Training for health professionals and frontline workers to enhance recognition and response to *sexual violence* (consortium led by Monash University Department of Forensic Medicine).

State examples

VIC: *Royal Commission into Family Violence* has 8 recommendations in relation to the health system:

- **Rec 3:** Implement revised DAFV Risk Assessment & Risk Management Framework (MARAM).
- **Rec 95:** Whole-of-hospital model for responding to family violence (SHRFV).
- **Rec 96:** Routine screening for FV in all public antenatal settings.
- **Rec 98:** DAFV advisers in AOD and MH services.
- **Rec 102:** DAFV learning agenda by RACGP, RANZCP and psychologists' peak bodies.
- **Rec 103:** Mandatory requirement for GPs to complete DAFV training as part of their CPD.
- **Rec 105:** Consider Medicare item number for DAFV counselling and therapeutic service.
- **Rec 146:** Increased funding for Aboriginal community-controlled organisations.
- **Rec 207:** Inclusion of universal and secondary service systems in 10-year industry plan.

QLD: Special Taskforce on Domestic and Family Violence *Not Now, Not Ever* report highlighted the role of health practitioners and the need for training at undergraduate and postgraduate levels.

Recommendations

Advocate for early engagement work

1. Stronger investment in organisational capacity and systems change in the health sector with funding to support activities that:
 - Shift the paradigm that largely puts DAFV into the 'social and justice' basket and not 'health'. For example, include 'health settings' as one of the Rolling Action Priorities alongside the current legal and housing priorities in Victoria's Rolling Action Plan 2020-2023. Future Commonwealth plans should include a stronger focus on health systems.
 - Offer a culturally safe, strengths-based suite of first line responses tailored to context, including responses to all members of the family.
 - Ensure health environments are private and sensitive.
 - Use trauma informed care principles and a strengths-based approach rather than a deficit model in work on DAFV.
 - Provide workplace support for health practitioners, who may have their own experience of DAFV.
 - Support approaches that respond to holistic needs, not just focused on safety and risk assessment and management.

Primary care reform

2. Develop special GP Medicare item numbers (like the Mental Health Assessment item numbers) to develop family safety plans and follow up for women and children experiencing DAFV.
 - o Identified and accredited specialised services (e.g. social workers and psychologists who have had extra family violence training) could have access to special item numbers for counselling for up to 10 sessions annually,
 - o A family-based safety plan could allow mother-child psychotherapy and group work; and men who use violence could use their plan to access behaviour change programs.
3. Investment in co-design, implementation and evaluation of integrated models of care across universal health services (antenatal care, maternal and child health/early childhood health services, general practice) and with specialised family violence and sexual assault services.
4. Prioritise primary health practitioners as part of the Victoria's Rolling Action Plan 2020-2023, including expanded focus on the health sector in the RAP's industry plan for workforce development.
5. Strengthen data collection systems in general practice and maternal and child health services.

Hospital system reform

6. Fund health coordinators of DAFV in all regions and clinical family violence leads in all state hospitals.
7. Co-locate other related services for survivors in large maternity hospitals e.g. legal, housing, finance services.
8. Improve hospital data to be able to identify DAFV, including in certain populations, Aboriginal and Torres Strait Islander people, LGBTI+, CALD groups, and people with disability.

Improve referral pathways

9. Improve linkages between services and develop clearer referral pathways to support women, men, children and families experiencing complex circumstances that compound risk and undermine family safety e.g. drug/alcohol dependence, mental health problems and DAFV.
10. Expand provision of specialist family violence support services that can liaise with primary and mental health care and provide more seamless avenues for 'warm referrals' from primary care, antenatal care, sexual and reproductive health care, and hospital emergency departments. This would include services for women, adolescents, children and men.
11. Include family violence and sexual assault workers as part of general practitioners Medicare Team Care Arrangement and General Practice Management Plan so GPs can refer for five sessions.
12. Lobby Australian Psychological Society, and Royal Australian New Zealand Psychiatry College to identify on their databases those who are specifically trained to support women and children impacted by DAFV.
13. Strengthen and clarify health referrals to support and safety hubs (e.g. Orange Door), from general practice, antenatal, maternal and child health, community health and emergency services.
14. Fund integrated hubs in the community with a focus on healing, housing and legal needs for survivors recovering from DAFV.
15. Address the siloed nature and underfunding of Sexual Assault services across the nation to enable referrals from the health system more seamless.

Mental Health service reform

16. Support policies that acknowledge more than the dual diagnosis of mental health and alcohol/drug but incorporates a third axis of DAFV and sexual violence.
17. Ensure trauma and violence informed approaches are the norm in mental health and substance use services, including support for services to integrate more effectively to provide care to patients experiencing multiple issues.
18. Greater integration and collaboration between DAFV, mental health and sexual violence services, reflecting the bi-directional relationship between DAFV, SV and MH.

Aboriginal and Torres Strait Islander reforms

The following principles of advocacy and action for effective policy are adapted from a Safer Families Centre Aboriginal and Torres Strait Islander policy and practice Roundtable held in 2019. *

19. Develop policy development processes that are responsive, and evidence based and not reactive, with intersectoral collaborations inclusive of community and frontline worker expertise including:
 - o Undertaking strengths-based approaches, trust and relationship building; really listening with intent and getting the language right,
 - o Implementing practice that is responsive to local needs and delivering intended outcomes.
20. Engage both men and women in solving family violence.
21. Strong collaborations needed at every level across communities, researchers, service providers, government and nongovernment. Aboriginal and non-Aboriginal people and services working together with shared understandings proactively reducing tensions such as those arising from competition.

Focus on Children

22. Prioritise responses that focus on ameliorating the intergenerational effect on children and young people.
23. Support children to be active agents in decision making, ensuring agency and choice is appropriate for age and development stage.
24. Facilitate responses to children and young people in their own right, while recognising that they may prefer to be seen with adults that they trust.
25. Consider the issues that create vulnerability to DAFV for children and that impact on their well-being: housing, poverty, adequate food, stable schooling, attention to their physical and mental health.
26. Increase support for parent-child relationship strengthening, recovery and healing which speaks against argument that child needs to be "rescued".
27. Expand the provision of mother-child psychotherapy, group and individual services through mental health, community health and women's health services.

**Participants of the Roundtable included senior representatives from Aboriginal Health Council of SA; Kornar Winmil Yunti Aboriginal Corporation; Nunga Mi:Minar; SA Departments of Aboriginal Affairs, Health Networks, Human Services, Drug and Alcohol Services and Treasury. Also, in attendance was the Commissioner for Aboriginal Children and Young people, Commissioner for Aboriginal Engagement, Manager Women's Safety Strategy and researchers from Safer Families Centre, University of Melbourne, University of SA and South Australia Health and Medical Research Institute (SAHMRI)*

Future directions in research and evaluation

This section outlines what is needed in continuing research and evaluation.

Enhanced responses

1. Evaluation of a coordinated national and state-wide health system response to DAFV over the next 5 years, which avoids multiple small projects and integrates State and Commonwealth, philanthropic and non-government funds.
2. Implementation and evaluation of trauma and violence informed approaches.
3. Transform and test systems to overcome current barriers for women and children to access support from the health sector.
4. Conducting and evaluating new models of care for pregnant women, and for child and mother-child responses in Australia as these show the most promise.
5. Sexual violence research within the context of DAFV across prevalence, impacts and responses.
6. Mobilise innovation for health services to engage effectively with women experiencing psychological violence and coercive control, including an effective dialogue about key messaging.

Greater emphasis on working with men who use violence

7. Research with men who use DAFV across the spectrum of drivers, prevalence, early engagement and response.

Greater support for Aboriginal and Torres Strait Islander community led research

8. Outcomes focused research and implementation within Aboriginal and Torres Strait Islander communities with bottom up approaches utilised.
9. Aboriginal and Torres Strait Islander leadership at all levels of decision making including co design and translation of findings into policy and practice; Self-determination and voice first.
10. Implementation and evaluation of community driven, trauma and violence informed approaches to engagement and support of Aboriginal and Torres Strait Islander families experiencing DAFV that work to break down barriers currently limiting families' access to support from the health sector.
11. Capacity and capability building of Aboriginal and Torres Strait Islander people at community, researcher, business, specialist worker, policy and practice levels, including research skills such as data collection methods.
12. Facilitation of education and training in cultural competency for non-Aboriginal people involved in research and implementation.
13. Research, policy and practice setting up Aboriginal parameters at the point of early engagement, including measurements and accountability at all levels, including back to Aboriginal and Torres Strait Islander communities.

Advancing online support

14. Further development and evaluation of technological responses, similar to *mhealth* and *ehealth*.
15. Evaluations of the use of telemedicine, telemental health and telefamily violence responses delivered to women in shelters, rural areas and for women with disabilities. Trial of telementoring for rural health practitioners.
16. Implementation and evaluation of trauma and violence informed approaches in telehealth platforms (urgent in context of COVID-19 impacts).

References

1. Council of Australian Governments. National Plan to Reduce Violence against Women and their Children 2010-2022. Canberra: Australian Government, 2010.
2. Victorian Government. Royal Commission into Family Violence Melbourne: Victorian Government; 2016 [12/4/16]. Available from: <http://www.rcfv.com.au/>.
3. Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia 2018. Cat. no. FDV 2. Canberra: AIHW; 2018.
4. Hegarty K, et al. Prevalence and associations of partner abuse in women attending general practice: a cross-sectional survey. *Aust NZ J Public Health*. 2002;26(5):437-42.
5. Gilbert R, et al. Burden and consequences of child maltreatment in high-income countries. *The Lancet*. 2009;373:68-81.
6. Gartland D, et al. The case for early intervention to reduce the impact of intimate partner abuse on child outcomes: results of an Australian cohort of first time mothers. *Birth*. 2014;41(4):374-83.
7. Gartland D, et al. Intergenerational Impacts of Family Violence - Mothers and Children in a Large Prospective Pregnancy Cohort Study. *EclinicalMedicine*. 2019;15:51-61. *EclinicalMedicine*. 2019;15:51-61.
8. Garcia-Moreno C, et al. The health-systems response to violence against women. *The Lancet*. 2015;385:1567-79.
9. World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, Switzerland: WHO; 2013.
10. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva, Switzerland: WHO, 2013.
11. Our Watch, et al. Change the story: A shared framework for the primary prevention of violence against women and their children in Australia. Melbourne: Our Watch, 2015.
12. Morgan A, et al. Social isolation, time spent at home, financial stress and domestic violence during the COVID-19 pandemic. Canberra: Australian Institute of Criminology, 2020.
13. Boxall H, et al. The prevalence of domestic violence among women during the COVID-19 pandemic. *Statistical Bulletin* no. 28. . Canberra: Australian Institute of Criminology, 2020.
14. O'Doherty L, et al. Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews*. 2015(7 Art No CD007007).
15. Sprague S, et al. Barriers to screening for intimate partner violence. *Women Health*. 2012;52(6):587-605.
16. Hegarty K, et al. Sustainability of identification and response to domestic violence in antenatal care: The SUSTAIN Study. 2020.
17. O'Reilly R, et al. Opportunistic domestic violence screening for pregnant and post-partum women by community based health care providers. *BMC women's health*. 2018;18(1):128.
18. LoGiudice J. Prenatal Screening for Intimate Partner Violence: A Qualitative Meta-Synthesis. *Applied Nursing Research*. 2015;28(1).
19. Hooker L, et al. Applying normalization process theory to understand implementation of a family violence screening and care model in maternal and child health nursing practice: a mixed method process evaluation of a randomised controlled trial. *Implementation Science*. 2015;10(1):39.
20. Reisenhofer S, et al. Women's journey to safety - The Transtheoretical model in clinical practice when working with women experiencing Intimate Partner Violence: A scientific review and clinical guidance. *Patient Educ Couns*. 2013;93(3):536-48.
21. Garcia-Moreno C, et al. The health systems response to violence against women. *The Lancet*. 2014;385(9977):1567-79.
22. Atkinson J. Trauma trails, recreating song lines: the transgenerational effects of trauma in Indigenous Australia. North Melbourne: Spinifex Press; 2002.
23. Australian Institute of Health and Welfare. Child Protection Australia 2013-2014. Canberra: Australian Institute of Health and Welfare, 2015.
24. Cripps K, et al. Communities working to reduce Indigenous family violence. NSW: Indigenous Justice Clearinghouse, 2012.
25. Feder G, et al. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment*. 2009;13(16):iii-iv, xi-xiii, 1-113, 37-347.

26. Zink T, et al. Accuracy of five domestic violence screening questions with nongraphic language. *Clin Pediatr (Phila)*. 2007;46(2):127-34.
27. Zink T, et al. Mothers' Comfort with Screening Questions about Sensitive Issues, Including Domestic Violence. *J Am Board Fam Med*. 2006;19(4):358-67.
28. O'Reilly R, et al. Screening and intervention for domestic violence during pregnancy care: a systematic review. *Trauma Violence Abuse*. 2010;11(4):190-201.
29. Spangaro J, et al. The elusive search for definitive evidence on routine screening for intimate partner violence. *Trauma Violence Abuse*. 2009;10(1):55-68.
30. Hegarty K, et al. Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. *Australian & New Zealand Journal of Public Health*. 2001;25(5):433-7 5p.
31. Ahmad F, et al. Computer-assisted screening for intimate partner violence and control: a randomized trial. *Ann Intern Med*. 2009;151(2):93-102.
32. Kataoka Y, et al. Self-administered questionnaire versus interview as a screening method for intimate partner violence in the prenatal setting in Japan: a randomised controlled trial. *BMC Pregnancy Childbirth*. 2011;10:84.
33. Webster J, et al. Screening for partner violence: direct questioning or self-report? *Obstetrics & Gynecology*. 2004;103(2):299-303.
34. Hussain N, et al. A Comparison of the Types of Screening Tool Administration Methods Used for the Detection of Intimate Partner Violence: A Systematic Review and Meta-Analysis. *Trauma, Violence & Abuse*. 2015;16(1):60-9.
35. Taft A, et al. Maternal and child health nurse screening and care for mothers experiencing domestic violence (MOVE): a cluster randomised trial. *BMC Medicine*. 2015;13(150).
36. Arkins B, et al. Measures for screening for intimate partner violence: a systematic review. *Journal of Psychiatric & Mental Health Nursing*. 2016;23(3/4):217-35.
37. Signorelli M, et al. How valid is the question of fear of a partner in identifying intimate partner abuse? A cross-sectional analysis of four studies. *JIV*. 2020;0886260520934439.
38. Woolhouse H, et al. Psychotropic medication use and intimate partner violence at 4 years postpartum: results from an Australian pregnancy cohort study. *J Affect Disord*. 2019;251:71-7.
39. NSW Ministry of Health. Domestic Violence Routine Screening November 2015 - Snapshot 13. North Sydney: NSW Ministry of Health; 2016.
40. Baird K, et al. Longitudinal evaluation of a training program to promote routine antenatal enquiry for domestic violence by midwives. *Women Birth*. 2018 (Jan 15).
41. Hooker L, et al. Victorian Maternal and Child Health nurses' family violence practices and training needs: a cross sectional analysis of routine data. *Australian Journal of Primary Health*. 2020.
42. Alvarez C, et al. Provider screening and counseling for intimate partner violence: a systematic review of practices and influencing factors *Trauma Viol Abuse*. 2016:1-17.
43. Stayton C, et al. Mutable influences on intimate partner abuse screening in health care settings. *Trauma Viol Abuse*. 2005;6(4):271-85.
44. Commonwealth Department of Health. Clinical Practice Guidelines: Pregnancy Care. Canberra: Australian Government Department of Health, 2018.
45. Hegarty K, et al. A brief counseling intervention by health professionals utilising the 'readiness to change' concept for women experiencing intimate partner abuse: The weave project. *J Fam Stud*. 2008;14(2-3):376-88.
46. Hegarty K, et al. Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial. *The Lancet*. 2013;382(9888):249-58.
47. Hegarty K, et al. Protocol for a randomised controlled trial of a web-based healthy relationship tool and safety decision aid for women experiencing domestic violence (I-DECIDE). *BMC Public Health*. 2015;15(736).
48. Tarzia L, et al. Women's experiences and expectations after disclosure of intimate partner abuse to a healthcare provider: A qualitative meta-synthesis. *BMJ Open*. 2020;accepted.
49. Rivas C, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *The Cochrane Database of Systematic Reviews*. 2015;[Online first](12).
50. Hameed M, et al. Psychological therapies for women who experience intimate partner violence. *Cochrane database of systematic reviews*. 2020(7).
51. Hegarty K, et al. Interventions to support recovery after domestic and sexual violence in primary care. *International Review of Psychiatry*. 2016;28(5):519-32.

52. Hooker L, et al. Domestic and family violence and parenting: Mixed method insights into impact and support needs: State of knowledge paper. ANROWS Landscapes, 2016.
53. Howarth E, et al. The Effectiveness of Targeted Interventions for Children Exposed to Domestic Violence: Measuring Success in Ways that Matter to Children, Parents and Professionals. *Child Abuse Review*. 2015;24:297-310.
54. Hegarty K, et al. Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis. *PLoS one*. 2020;15(6):e0234067.
55. Bacchus L, et al. Health sector responses to domestic violence in Europe: a comparison of promising intervention models in maternity and primary care settings. London, (United Kingdom): London School of Hygiene and Tropical Medicine, 2012.
56. Public Health Agency of Canada. Trauma and Violence informed approaches to policy and practice Canada [cited 2020 9/09/20].
57. Quadara A. Implementing trauma-informed systems of care in health settings: The WITH study. State of knowledge paper. Alexandria, NSW: Australia's National Research Organization for Women's Safety, 2015.
58. Varcoe C, et al. VEGA Briefing Note on Trauma- and Violence-Informed Care. VEGA Project and PreVAiL Research Network, 2016.
59. Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. Rockville: US Department of Health and Human Services, 2014 Contract No.: HHS Publication No (SMA 14-4884).