Evidence Brief #2

Translating evidence to inform policy and practice in the health sector.

#2

Identifying and responding to domestic abuse and family violence: Implications for the health sector

The **Safer Families Centre** strives to reflect in all our work the voices of: people with lived experience of domestic abuse and family violence; and health practitioners. This brief draws on global evidence from syntheses of studies about what victim survivors say they expect from health practitioners. We also focus on studies of the barriers health practitioners face, what makes them ready to do the work and how they need to be supported to address domestic abuse.

This evidence brief:

- Identifies barriers health practitioners may experience when addressing domestic abuse;
- Outlines system changes that will enable health practitioners to undertake this work;
- Represents the stories of victim survivors and health practitioners who participated in global research studies; and
- Calls on the government and health services to consider key policy and practice recommendations for hospitals, health services and primary care.

Looking through the eyes of victim survivors and health practitioners shines a light on solutions to addressing domestic abuse that are more likely to be effective.

This brief uses case studies to illustrate:

Survivors' expectations of identification and response; Practitioners' personal and structural barriers; and Readiness of practitioners to undertake the work.

Domestic abuse and family violence is not only physical; it can be sexual, emotional, psychological, social, cultural, financial, spiritual. This abuse can be in person or technology facilitated.

This brief should be read in conjunction with **Evidence brief #1: 'Intimate partner violence in the first decade of motherhood'** and **Evidence brief #3: 'Translating evidence of all-of-family responses for domestic abuse and family violence'** in the series; **'Translating evidence to inform policy and practice in the sector'.**[1]

Introduction

The World Health Organisation[2] has called for worldwide systems change to strengthen health sector responses to domestic abuse to enhance health and well-being, particularly for women in the community. Health practitioners are the most common professional group that women turn to for support as shown in the figure below from the Australian Institute of Health and Welfare report.[3]

Figure 1 Services women turn to for support

However, not all health practitioners are equipped to ask about domestic abuse, nor are ready to provide an empathic first line response. In this brief we recommend what needs to change in the health sector for optimal identification and response to domestic abuse.

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2023 Recommended System Changes

The **World Health Organisation** calls for broad systems change to strengthen the health sector response. Australia's National Plan to End Violence Against Women and Children 2022 - 2032 also emphasises early intervention and systems reform for family, domestic and sexual violence.

The **Safer Families Centre** provides organisations with guidance, training and tools to transform the health system response to women and children impacted by domestic abuse and family violence so that they have access to culturally and emotionally safe pathways to healing and recovery.

Safer Families Centre recommends the following systems reforms:

Health organisation change

Foster

- Trauma and violence informed, and culturally safe approaches
- Committed leadership across hospitals, health services and primary care

Fund

- Victim survivor co-design of health sector reform
- Allocation of finances that support better linkages between health and specialist sectors
- Care navigators to assist more holistic and tailored pathways to care for victim survivors
- Trauma and violence informed healing services

Staff support

Resource

- Clear domestic abuse protocols and referral pathways
- Regular mandatory on-site training for all staff (not just clinical)
- Capacity building of staff to engage with people who use violence to seek help
- Education and training in cultural competency and awareness
- Peer victim survivor workforce e.g. for support groups
- Workforce support for staff victim survivors
- Community of practice offered to all staff working with victim survivors
- Appointment of clinical champions to mentor staff

Practitioner-survivor engagement

Provide

- Universal education for all women attending antenatal care
- Continuity of care with a provider or team to promote trust
- Sufficient consultation time
- Ongoing use of tele-health
- Technological tools for identification and response

Recommendations are drawn from the evidence from synthesis of studies about victim survivors,[4,5] health practitioners[6,7,8] and the voices of those with lived experience of domestic and family violence.[9]

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Layla (Survivor)

Layla is pregnant with her fourth child and attending shared antenatal care at the hospital and with her local GP. This pregnancy was not really what she wanted as she already has three daughters under five but her husband insisted that they try for a boy. Her husband has always been controlling of her, where she goes, what she does, who she talks to and she is fearful of him.

She feels frustrated that whenever she goes to the doctor they always seem so busy.

There are no signs in her own language about what services the hospital or GP offer. She generally gets by with talking to the staff in English.

She is never asked about how things are going at home. She often wonders what would happen if she told the doctors and midwives about the bad things that happen at home. She has told one friend only.

Below we illustrate with quotes from survivors how Layla's experience could have been different.

Survivor expectations on how health practitioners should identify domestic abuse

Themes from 34 studies[4]

But if you ... see a booklet ...and in the circle it identifies what kind of man is an abusive man. When I read that .. I said, "I have all of that," and I didn't know I was abused. So if you see in the doctor's office those little things - could identify "This happens to me." And they might have some numbers in the back that say, "Don't worry, there are people here who can help you. You will not be deported," ... something that links you directly in a doctor's office that can help you.[10 (p5564)]

Don't just straight out jump into it. Just make friends with them or something first. At least get some type of relationship with them, make them comfortable.[13 (p799)]

I'm not gonna wanna sit here and tell all my personal information to someone who's having an 'I don't care' attitude. Someone that's (looking) at me in my eyes and telling me, "oh I'm here for you, this is what I do, if you need anyone to talk to I'm here." I would want to tell my story to them.[11 (p37)]

It felt really safe talking to [the nurse] about [my abusive experiences]. She let me know everything that I tell her will be confidential. She just listened, listened really well.[12 (p11)]

Knowing that other Koori girls go there, you know what I mean? If I went to a non-Aboriginal place I would have felt more—I don't know, not as comfortable[13 (p796)]

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Monique (General Practitioner)

Monique has been a GP for 15 years and does quite a lot of mental health consultations with her patients. She has always felt frustrated that whenever she has discussed domestic abuse in these consultations, she just ends up giving the same advice over and over again. She thinks she probably should get a different approach.

Working in a small rural practice, she feels like she is tackling the problem all on her own as she doesn't really have people to refer to easily. She wonders if she could just talk to other practitioners about these patients or get a secondary opinion from someone who knows more about this area, she might be able to work with patients better.

She sees a community of practice advertised and decides to go one evening. She finds it very helpful that what she has been doing - listening, inquiring about needs, validating experiences - is actually what survivors want. She realises that she just needs to build on the patient's strengths to enhance safety in ways that the victim survivor thinks will work. Further she needs to offer ongoing support and plant the right seeds for hope and change.

She realises it is enough to be their ongoing ally as she would be with any other chronic condition.

Indigenous voices

Themes from six studies[14]

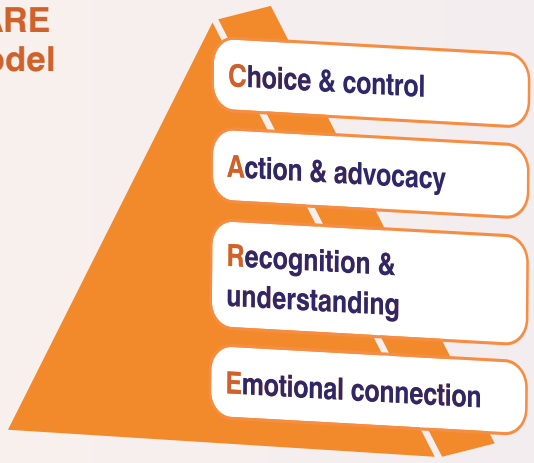
A synthesis of voices highlighted that Indigenous peoples want their health care practitioners to have an effective level of cultural awareness that promotes connecting for trust and strengthening safety. These findings have been synthesized into a model for how health care practitioners can provide care that meets the needs of Indigenous peoples experiencing FV.

Survivor expectations on how health practitioners should respond

Themes from 43 studies[5]

Safer Families Centre recommends that health practitioners provide women experiencing domestic abuse with a LIVES response in the context of a CARE framework. This way of working provides victim survivors with choice and control, practical action and advocacy, and recognises their experience. How the practitioner cares is important, demonstrating that they connect emotionally through kindness and empathy shown to the victim survivor.

CARE Model



First line response guideline

The World Health Organisation[2] recommends using the LIVES model as a first line of response when seeing patients experiencing domestic abuse.

LIVES Model

- **Listen**
- **Inquire about needs**
- **Validate experience**
- **Enhance safety**
- **Support**

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Roland (Obstetric doctor)

Roland is a doctor who has worked in antenatal care for 25 years. He doesn't think addressing domestic abuse is his role, rather he feels that social workers are better suited to dealing with it. He has never asked anybody about domestic abuse and he is not sure the health setting is the right place to do that. He believes very few of his patients experience domestic abuse.

However, he is under pressure from his clinic team to be part of a whole new program in the family violence area. He is surprised how supportive of the work the senior medical managers are. He attends the training reluctantly and there is now a prompt and guidelines in place on his computer. He is surprised to learn that a recent audit of screening in antenatal care revealed 60% of women had been asked about domestic abuse by his colleagues. Of these women, 10% disclosed experiencing domestic abuse. He begins to wonder what would happen if he did ask. Would they tell him?

Below are quotes illustrating how some practitioners feel like Roland.

Practitioners' Personal Barriers

Themes from 29 studies[6]

I can't interfere

Highlights the belief that domestic abuse is a "private matter" and practitioners fear causing harm by intervening

I don't have control

Illustrates that practitioners feel frustrated when their advice is not followed

It's not my job

Illuminates beliefs that addressing domestic abuse should be someone else's responsibility

I don't want to deepen the tension between the couple. If I take sides or agree with the wife, I might have made an early judgment. This might be harmful to their relationship.[15 (p.7)]

I don't know at what point you turn around and say "have you been a victim of domestic violence?" I think it has the potential to scare some people off.[16 (p.192)]

I offer [to set them up with] social work services, but when they refuse, I just want to shake them, because I can't help them.[17 (p.240)] If you are a therapist, you want to fix someone.

If somebody talks about something that you have no idea about, it makes you feel helpless because you feel like you can't do anything to help them.[18 (p.227)]

Should we be addressing this? Because I think so many things are coming under the role of psychiatry when actually they are not mental health problems. I suppose I struggle a bit with us taking on these things …perhaps we should be directing people elsewhere.[16 (p.191)]

Women are adults and should be able to bring up the issue of abuse themselves if they want help.[19 (p.33)]

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Desi (Midwife)

Desi is a midwife who has worked at a major hospital for 10 years. She has rarely asked a patient about domestic abuse because often partners or other family members also attend appointments. She worries she might make things worse as she hasn't had any training on how to identify and address domestic abuse. She wants to help but just isn't sure what to do and has such limited time with patients.

She decides to go to training and is given scripts for how to ask and respond with validating statements and tips for how to get patients alone. She now understands that it is how she acts that will help survivors. She feels more confident.

She offers patients information about healthy relationships and resources. She asks a few patients directly and although none of them disclose, they all say they are pleased the hospital is doing this work. She tries to give survivors choice and control and warm supportive referrals to the services they want when they feel ready to go.

Practitioners' Structural Barriers

Themes from 43 studies[7]

Working in suboptimal environments

Reflects the practitioner's frustration at the limited time they have with patients and the lack of privacy

Lack of system support

Highlights the lack of management support and inadequate training, resources, policies and response protocols

Impact of societal beliefs

Normalisation of victim blaming including myths that women will lie or domestic abuse only presents in certain types of women

What helps practitioners become ready to do the work?

Themes from 47 studies[8]

CATCH model

Commitment

Arises from a human rights, child rights, feminist lens or a personal experience of family violence

Advocacy

Trying out a woman centred approach with positive feedback encourages health practitioners

Trust

Belief that the health setting is a good place to develop patients' trust and do this complex work

Collaboration

Working with others in a strong team approach supports the practitioner to be able to do the work

Health system support

System support is crucial for practitioners to actively engage with the work and address domestic and family violence

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This evidence brief is a summary of key research undertaken by the team at the Safer Families Centre.

For further information about our programs of work, please visit our website:
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