Royal Commission into Family Violence

WITNESS STATEMENT OF KELSEY LEE HEGARTY

I, Kelsey Lee Hegarty, Professor of General Practice and General Practitioner, University of Melbourne, Parkville, in the State of Victoria, say as follows:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Current role

2. I am a Professor of General Practice at the University of Melbourne and a practicing general practitioner in Clifton Hill. I am also Director of the Postgraduate Primary Care Nursing course at the University of Melbourne.

3. I currently lead an Abuse and Violence in primary care research program. My current research focus includes the evidence base for interventions to prevent and respond to violence against women, educational and complex interventions around identification of family violence including perpetrators in primary care settings, and responding to women and children exposed to abuse through primary care and through the use of new technologies.

Background and qualifications

4. During the last decade, I have contributed at both national and international levels to the domestic and family violence field. I co-edited a book on “Intimate partner abuse for health professionals” and I am on three Cochrane systematic reviews of screening, advocacy and psychological interventions for domestic violence.

5. I played a significant role in the development of Royal Australian College of General Practitioners (**RACGP**) White Book on Abuse and Violence and an online RACGP learning module on Domestic Violence for general practitioners. I have developed an innovative domestic violence curriculum for health practitioners and I regularly teach domestic violence and mental health issues to undergraduates and postgraduate medical and nursing practitioners.

6. In 2013/4 I was a Temporary Clinical Advisor to the World Health Organisation (**WHO**) and on the guidelines group that developed the recommendations for health practitioners entitled “Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines” and also “Health care for women subjected to intimate partner violence and sexual violence: a clinical handbook”. I also am currently chair of the governance group of the Domestic Violence Resource Centre Victoria.

7. I hold the following qualifications:

   7.1. Bachelor of Medicine and Bachelor of Surgery from the University of Queensland;

   7.2. Doctor of Philosophy from the University of Melbourne; and

   7.3. Fellowship of the RACGP.

8. My doctoral thesis examined the prevalence of domestic violence in general practice, and as part of this research I developed a new measure of domestic violence called the Composite Abuse Scale [1], which is the first validated multi-dimensional measure of partner abuse. It has been used extensively globally and is available in 10 languages. Attached to this statement and marked “**KH-1**” is a copy of my curriculum vitae which includes my publication record.

9. A list of the key references informing this statement is attached and marked “**KH-2**”. The majority of this evidence is from the intimate partner violence against women field. Where a number appears in square brackets in my statement, it corresponds to the list of reference material in attachment “**KH-2**”.

Why respond to family violence in health-care settings?

10. Family violence damages the social and economic fabric of communities, as well as the mental and physical health of individual women, men, adolescents and children. Globally, one in three women experience physical or sexual violence at the hand of their partners and are more likely to experience severe combined physical, emotional and sexual abuse than men [2]. The World Health Organization has prioritised preventing and reducing the extensive damage from family violence especially on children, and identified the crucial role of an effective health system [2, 3]. Intimate partner violence and direct child abuse are overlapping in around half of families.

11. Unfortunately, health services have lagged behind other agencies in responding appropriately to this issue [4] despite the fact that at least 80% of women experiencing abuse seek help at some point from health services, usually general practice. Abused women use medical services more frequently because of increased rates of emotional health issues and physical health issues. Estimates are that up to five abused women per week per doctor attend unsuspecting general practitioners (**GPs**) with around 12% of women attending general practice being afraid of their partners in the last 12 months [5]. One or two of these women will have experienced severe intimate partner abuse (e.g. raped, attacked with a weapon, locked in their home or not allowed to work). These figures are from a survey of 1836 consecutive women attending 20 randomly chosen Brisbane general practices (response rate 78.5%). Overall, one in three women in current relationships attending routine general practice clinics had experienced partner abuse in their lifetime. Abused women were more likely to be younger, separated or divorced, to have experienced child abuse, and to have come from a violent family [6].

12. Some health practitioners (**HPs**) also see men who use violence in their relationships or have experienced abuse as a child or by their partners e.g. GPs, alcohol and drug services. As GPs are family doctors, they also see whole family and the children, although very little training is provided to GPs to be able to manage children and men in family violence situations. Maternal and child health nurses are also ideally placed to intervene through their contact with women and children. Mental health, alcohol and drug services, emergency departments, antenatal and children's services are all key places for intervention for family violence.

13. The limited research into disclosure to HPs and inquiry by HPs reveals low rates of either with around one third of abused women ever disclosing abuse and an inquiry rate by HPs of around 1 in 10 [7]. However, research suggests that women want to be asked directly about abuse by supportive HPs. Women suffering the effects of family violence typically make 7-8 visits to health professionals before disclosure. Unfortunately, if women do disclose family violence to their HP, there is sometimes evidence of an inappropriate, poor quality response.

14. Evidence of best practice informing this statement includes systematic reviews of health care interventions [8] [9] [10] [11] [12] and of qualitative studies [13], consensus guidelines [14], WHO guidelines and clinical handbook, and evaluation

of health-based family violence studies [15] [16] [17] [18]. Attached to this statement and marked "**KH-3**" is a copy of an article I co-authored entitled "The health-systems response to violence against women".

Current RACGP and World Health Organisation Guidelines

15. The RACGP recommends that patients and their children need to have a safe first line response at three levels:

15.1. *First response:* Patients need to be responded to at any initial disclosure with good communication skills including active listening and non-judgemental support. These first line skills are often taught to some level at undergraduate and postgraduate level in most health courses but are not specific to family violence content.

15.2. *Safety and needs assessment response:* Families need to have their safety and needs assessed at the time of disclosure. They then can be guided to appropriate ongoing care, which might include the health practitioner seeing the patient for ongoing support, "warm" referral to advocacy (including housing, financial, legal, police) or psychological services or crisis support.

15.3. *Pathway to safety:* Health practitioners need an understanding of family violence services and access to resources and referrals in local areas to assist them in keeping patients and children safe.

16. The RACGP membership covers the vast majority of general practitioners in Victoria (5848/7800 GPs in 2014). Training for general practitioners is undertaken at two levels: vocational training and continuing professional development. Vocational training for medical graduates wishing to specialise in general practice is provided by the Australian General Practice Training (**AGPT**) program, an Australian Government funded initiative. The AGPT program is three to four years of full-time training offered in urban, regional and rural locations nationally, delivered through approved training providers across Australia. The two endpoints of the AGPT program are the Fellowship of the Australian College of Rural and Remote Medicine (**FACRRM**) and the Fellowship of the Royal Australian College of General Practitioners (**FRACGP**). The RACGP Quality Improvement and Continuing Professional Development (**QI&CPD**) supports Australian GPs in providing the best possible care for patients. The QI&CPD Program recognises ongoing education in improving the quality of everyday clinical practice by promoting the development

and maintenance of general practice skills and lifelong learning. The RACGP QI & CPD program is recognised by the Australian Health Practitioner Regulation Agency and Medicare. The RACGP also offers online Active Learning Modules that GPs can undertake as part of this QI and CPD program.

17. The RACGP has outlined nine steps to intervention – the 9 Rs [19]

> Health practitioners need to understand their:
>
> **Role** with patients who are experiencing abuse and violence
>
> **Readiness** to be open to
>
> **Recognise** symptoms of abuse and violence, ask directly and sensitively and
>
> **Respond** to disclosures of violence with empathic listening and explore
>
> **Risk** and safety issues
>
> **Review** the patient for follow-up and support
>
> **Refer** appropriately and
>
> **Reflect** on their own attitudes and management of abuse and violence
>
> **Respect** for patients, colleagues and themselves is an overarching principle of this sensitive work

18. The WHO guidelines for intimate partner violence and sexual violence against women were released last year based on systematic reviews of evidence and expert consensus views and include the following recommendations:

18.1. Women centred care for all survivors;

18.2. Training for all health professionals in first line response;

18.3. Case finding rather than screening, except in antenatal care;

18.4. Written information on partner violence in private areas;

18.5. No mandatory reporting for partner violence;

18.6. Trauma informed psychological treatments can assist women who have left the relationship; and

18.7. Mother-child interventions – pregnant women should be offered empowerment counselling and psychotherapeutic counselling to assist women and their children to heal.

19. The WHO has developed a clinical handbook, which is currently being trialled in draft format. I was involved with the development of the clinical handbook. A simple mnemonic reminds practitioners what an evidence-based, woman-centred first line response should incorporate: **LIVES** - Listen, Inquire about needs, Validate experiences, Enhance safety, ensure ongoing Support.

Evidence for early identification in health care settings

20. Intimate partner violence is linked to a range of negative health effects and outcomes, yet, to date, there is little evidence to support effective interventions in health settings [20]. This is in part because of the difficulty in addressing women's varied experiences and responses to violence, as well as their individual circumstances and readiness for action. Women experience abuse at the hands of their partners in varying ways with varying effects and they require most likely varying responses from HPs [21].

21. There are many barriers to discussing family violence including shame, worries about being judged or believed, and concerns about confidentiality. Intimate partner violence interventions in health care settings have mostly focused on screening and referral to formal services. There are however many barriers to HPs screening including having insufficient time or skills, feeling overwhelmed by the emotional nature of the work or even because of their own experience of family violence [10].

22. A recent update of a Cochrane screening review [10] reinforces that screening and initial response by a HP increases identification with no increase in referrals or changes in women's experience of violence or wellbeing. The WHO has recommended that only in antenatal care may there be enough evidence for screening.

23. This does not mean doctors and nurses should not ask if patients (mostly women and children) are presenting with symptoms and respond when women feel ready to disclose. All health professionals should listen, believe, inquire about needs, validate the patient's experience, enhance safety and offer ongoing support. Assessing safety and risk is often the only new skill that health professionals need to acquire. This first line response and follow up is vital for women to feel able to take action in the future to heal and to increase their families' safety.

24. The WHO recommends that women are asked in health settings when there are clinical indicators of family violence. Clinical indicators include emotional health

issues (e.g. depression, anxiety, insomnia, suicide, eating disorders) or physical health issues (e.g. chronic pain, diarrhoea, injuries) or reproductive issues (e.g. sexually transmitted infections, miscarriage, low birth weight) or children's issues (e.g. behavioural or learning problems, anxiety, self-harm) [22]. These WHO guidelines did not explore partner violence for men as victims or perpetrators, direct child abuse or elder abuse. There are separate guides e.g. preventing child maltreatment: a guide to taking action and generating evidence at http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/elderabusefacts.pdf. In particular, the WHO recommends working to reduce alcohol consumption in adults with children in their care to prevent child abuse and neglect.

25. The RACGP White Book has made the following statement and recommendations on child abuse. Child abuse is most commonly perpetrated by someone within the family or known to the child with children under one years of age particularly vulnerable. Recommendations include

25.1. Identifying families at risk (e.g. where intimate partner violence is co-occurring) and referring patient to parent training programs and nurse home visitation programs, both of which have been shown to be effective.

25.2. Alcohol screening and brief interventions by HPs can reduce alcohol intake which can in turn ameliorate child abuse and neglect.

Screening Tools in Australia

26. There have been several government projects that have developed screening tools for family violence for use in health settings in Australia. I discuss some of these projects further below

26.1. NSW health Routine Screening program (http://www.kidsfamilies.health.nsw.gov.au/current-work/programs/programs-and-initiatives/domestic-violence-routine-screening/) For over a decade, NSW has had a screening program in antenatal, mental health, drug and alcohol, and child services that has been evaluated for one month every year. They use a standard set of questions and more recently have updated risk assessment questions (http://www.domesticviolence.nsw.gov.au/services). Below are the most recent figures I could find for the November 2013

snapshot showing that women are being screened and identified with under a third accepting offer of assistance.

Key Findings - November 2013	
Eligible women who attended a service	25,062
Eligible women who were screened	14,940 (59.6% of eligible women)
Eligible women screened who were identified as having experienced domestic violence in the previous 12 months	826 (5.5% of women screened)
Women accepting an offer of assistance	219 (26.5% of women identified as having experienced domestic violence)
Notifications or Referrals (Reports to the Department of Family and Community Services (FACS), Notifications/reports to the NSW Police Force, Other)	861

26.2. The Victorian government also has a screening tool that includes family violence questions. The Service Coordination Tool Templates 2012 (https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/service-coordination-tool-templates) include a single page screener for health and social needs that asks “Have you felt afraid of someone who hurts you or controls you?”. The service provider is then sent to a safety module that has further questions including about children experiencing the parental abuse and whether the person has made a safety plan. There are also referral templates.

26.3. In 2009, the Commonwealth government provided $1.1 million funding to develop the Common Approach to Assessment, Referral and Support (**CAARS**) by the Australian Research Alliance for Children and Youth. The CAARS approach also now known as ‘The Common Approach’ can be used in multiple front line settings including health to identify the needs of vulnerable families (https://www.aracy.org.au/projects/the-common-approach). I was on the large expert Taskforce and the Technical Advisory Group which met several times over a two year period. The CAARS resource kit includes a wheel (key domains of well-being) that service providers can

use with clients, questionnaires for young people, parents and carers. There is a domain or safety and a separate domain on relationships that include questions about safety and abuse. The resource kit also has professional guidance on conversation prompts for children, youth and parents. It was evaluated positively across four health sites in 2011/12 and found that it can be used flexibly by practitioners. Further implementation requires coaching in how to use the tools.

What response is best after identification?

27. Although early identification of women experiencing family violence is important, referral to formal domestic violence services at the point of identification as the only response may be problematic. Many women may not wish to access formal support services for 'domestic violence victims', as they do not self-identify as such. Furthermore, formal family violence support services are frequently overburdened and may not be able to cope with increased demand. Consequently, I believe the response to family violence in primary care health settings can do more than simply refer to specialised services. For example, I recently led an evaluation of women centred care by GPs, known as the Weave study [23].

28. Weave was a cluster randomised controlled trial testing the effect of brief counselling by Victorian GPs for women afraid of a partner/ex-partner. The study involved 272 women attending 55 GPs. Half the GPs were trained to provide supportive counselling, and their participating patients were invited to attend this counselling. The other half received a basic resource kit only, and provided usual care to their participating patients. Women's outcomes were measured at baseline, 6 months, 12 months and 24 months. The study found that trained GPs enquired more about safety of the women and their children, and that depression outcomes were better for women invited to attend the counselling. There were no significant effects on women's general quality of life, a general mental health score, anxiety or level of comfort to discuss fear of a partner with the GP.

29. The Weave study showed that GPs could be trained to respond in a supportive, woman-centred way, and that their knowledge, skills and attitudes were improved. Furthermore, women fearful of a partner in the last 12 months reported that the GP inquired more about safety of women and children and that they had less depressive symptoms at 12 months, although their quality of life measure was not statistically different between the intervention and comparison groups.

30. The Psychosocial Readiness Model was used to underpin the Weave intervention. In brief, the model describes the interplay of factors that may motivate a woman experiencing domestic violence to engage in positive behaviour change. It describes readiness as a continuum with a balance of internal and external factors determining how the woman moves from maintaining the status quo through to a desire for action. Rather than categorising women into a particular 'stage', the Psychosocial Readiness Model takes into account the fluid and changeable nature of women's needs and wishes. It also acknowledges that women may define different things as 'actions', including health-seeking behaviours that do not have the end goal of leaving the abuser.

31. Researchers increasingly support the use of this model in a domestic violence context. Three internal factors are described as key to a woman's readiness to change:

    31.1. *Awareness* is the woman's recognition that what she is experiencing is abuse. A higher level of awareness/acceptance is usually linked to a greater desire for change.

    31.2. *Self-efficacy* is the woman's belief that she is able to achieve difficult tasks, or cope with adversity.

    31.3. *Perceived support* describes the woman's sense that she is supported by those in her environment. It may not reflect the level of actual support that is available.

    In addition to the three internal factors, the model acknowledges the impact that external situational events can have on the change continuum. For example, gaining or losing employment, having access to an independent source of income, or a sudden health crisis. Safety planning and risk assessment were also part of the intervention.

32. Some patients are unable to access health care or are reluctant to disclose face to face with HPs as they fear judgemental attitudes. I-DECIDE (www.idecide.org.au) builds on the Weave project and is an online healthy relationship tool and safety decision aid we have developed for women experiencing partner violence. I-DECIDE builds on the IRIS project conducted by Glass and colleagues in the United States. The IRIS online intervention is informed by Dutton's empowerment model and focuses on reducing women's decisional conflict and increasing safety

behaviours. Preliminary work suggests that women felt more supported and had less decisional conflict after only a single use. Subsequent work is being conducted in Canada and in New Zealand to develop similar interventions (www.icanplan4safety.ca and www.isafe.org.nz). I-DECIDE has been adapted for the Australian context, but it also places greater emphasis on helping women to self-reflect, and self-manage, and focuses more broadly on healthy relationships. It is informed by the Psychosocial Readiness Model.

33. Beyond first-line and ongoing women centred support, advocacy by health-care providers [24] with additional training or by specialist family violence services appears to be beneficial for some women. Advocacy involves providing women with information and psychological support to help them access community resources. For example, linking survivors with legal, police, housing and financial services. Trials of advocacy [8] or support interventions for women who have sought help from shelters report some reduction in violence and possible improvement in mental health outcomes. Safety planning that is delivered face to face by health practitioners or by telephone counsellors has to date only limited evidence [25]. Although the WHO recommends referrals for trauma-informed mental health counselling and mother child counselling there is a distinct lack of availability and accessibility in Australia

Educational programs for health practitioners

34. Undergraduate and graduate training of the medical and nursing professions lacks any mandatory content on intimate partner violence. In a review of Australian medical schools [26] twelve of the eighteen medical schools delivered intimate partner violence education (median time spent per course = two hours). Intimate partner violence content was typically included as part of Obstetrics and Gynaecology or General Practice curriculum. Barriers included time constraints and lack of faculty commitment, resources and funding. The two schools that successfully implemented a comprehensive intimate partner violence curriculum used an integrated, advocacy-based approach, with careful forward planning. Thus most Australian pre-vocational medical students receive little or no intimate partner violence education. The need remains for a more consistent, comprehensive approach to intimate partner violence education in medical and other health practitioner degrees.

35. The Common Risk Assessment Framework training has been delivered to many maternal and child health nurses but has not reached GPs to any great extent. Health Practitioners are supposed to have Level 1 Training which does not incorporate safety assessment to any great extent and I would argue that all women and children need to have a brief risk assessment at the point of disclosure as part of a first line response.

36. The Department of General Practice at the University of Melbourne (in conjunction with the RACGP) have received funding from the Commonwealth Department of Social Services that has resulted in:

36.1. An update of the RACGP publication Abuse and Violence: Working with our patients in general practice manual (White Book) (edited by Libby Hindmarsh and Kelsey Hegarty and available since 1998) which can be downloaded at:

http://www.racgp.org.au/your-practice/guidelines/whitebook/

We recommend the AMA toolkit produced with the NSW legal service and did not replicate this in our program. *Supporting patients experiencing family violence – a resource for medical practitioners* toolkit can be downloaded at: https://ama.com.au/article/ama-family-violence-resource

36.2. An update of the RACGP gplearning online Active Learning Module on Domestic Violence available for RACGP members and Aboriginal health workers.

36.3. Current project to set up a separate primary care specific support and information line through 1800RESPECT specifically for GPs, which will also be able to respond to the needs of Aboriginal health workers. This will be available in 2016. Similar services exist for mental health and drug and alcohol, incorporated into existing services. There is an opportunity to extend further and promote the 1800RESPECT service whereby general practitioners and Aboriginal health workers call for information and support on how to handle difficult issues, for example threats of homicide by perpetrators, when to call the police, or what to do when a women doesn't want to see a family violence advocate.

36.4. A series of webinars have also been organised in 2015 by the RACGP with three already completed and several others planned:

36.4.1. Aboriginal Family Violence – The impact on women (Feb 16)

36.4.2. Aboriginal Family Violence – The impact on children (Feb 25)

36.4.3. Elder abuse – Let's talk about how to recognise, respond and explore risk (July 28 and 29)

37. The Department of General Practice at the University of Melbourne has also received funding from Bayside Medicare Local in 2015 to roll out the Weave program across the Bayside area, incorporating a greater focus on risk assessment, whilst retaining a tailored approach where women's readiness to action is taken into account. The program successfully recruited five general practices in the Bayside Medicare Local region and delivered training to 35 staff across the five recruited practices. Training included distance learning, an interactive whole of practice session, a clinical practice session and follow up to connect the clinics to resources and local referral services.

38. Any training needs to be evaluated in terms of women's and children's outcomes as most health professional training results in self-reported change in knowledge, attitudes and confidence in skills in asking and responding to family violence. A new Cochrane review undertaken by WHO later this year will evaluate educational interventions for intimate partner violence. Further a curriculum is being developed for partner violence at preservice and in service levels for global health practitioners.

39. Health Professionals can be trained in this response but to change health professional behaviour, training needs to have multiple methods [27] such as patient audit, feedback, role play, reflection on attitudes, use of consumer voices, modelling of respectful behaviours whilst teaching and in the workplace, and champions. However training in knowledge and skills of asking and first line response and assisted referral is insufficient by itself, the health system needs to be supportive of such women centred care.

Health system response

40. A whole of system response [4] involves in addition to women or patient centred care promoting at the health provider level:

40.1. a culture of gender equitable attitudes;

40.2. trauma informed principles (respect, privacy, confidentiality, safety);

40.3. a context of sufficient time allowed in consultations;

40.4. supportive environment with leaflets and posters; and

40.5. an awareness about protocols and referrals.

41. At the system level there needs to be:

41.1. coordination of internal and external referrals;

41.2. protocols;

41.3. workforce support and mentoring;

41.4. appointment of champions;

41.5. finances need to be allocated to services for family violence;

41.6. leadership and governance demonstrated by policies;

41.7. appropriate design of spaces; and

41.8. information systems for evaluation.

42. Over the last 10 years in the US, Dr Brigid McCaw and Kaiser Permanente have undertaken system changes in health (https://xnet.kp.org/domesticviolence/) with a demonstrated six fold increase in identification of members during that time. The program involves information for participants and a supportive environment, routine clinician screening and referral supported by online tools and resources, online support services, including mental health care and/or acccess to a crisis line and community linkages to domestic violence advocacy services. It is difficult to know if the increase in numbers identified is from the program only or from other influences and what proportion of the numbers represent the membership base. The US system is very different to the Australian system with doctors and nurses being employed by Kaiser Permanente, and electronic health records being more widespread. The program is sustained by a part time doctor director, a full time program director and administrative support, a part time analytic and health education consultant. Each medical facility has a multidisciplinary team chaired by a physician champion to establish the approach, provide training and respond to quality improvement data. Obviously some of the lessons learnt would be helpful to designing Australian health system reform.

43. In Victoria, there have been three programs that have attempted system change to some extent within a health setting that I have been involved in:

43.1. the ANEW program at the Mercy Hospital for Women;

43.2. the MOVE program led by Professor Angela Taft in maternal and child health services; and

43.3. evaluation of the Acting on the Warning Signs program at The Royal Women's Hospital.

I describe each of these programs briefly below.

ANEW program at the Mercy Hospital for Women

44. The ANEW program [28] (2001-2003) funded by the Victorian Department of Human Services provided an alternative to psychosocial risk-screening in pregnancy by offering a training program (ANEW) in advanced communication skills and common psychosocial issues to all midwives working in the antenatal clinic and selected antenatal doctors. It also attempted to change the hospital culture at the time and overcome the barriers to implementing psychosocial care. The 6 month program aimed to improve identification and support of women with psychosocial issues in pregnancy. The program involved a commitment of one to two hours per week (when double staff quotas were present for midwives, and in the evening for medical practitioners). A comprehensive workbook for the program outlined the four workshops, provided scripts for role-plays, information sheets on woman-centred care, effective communication, domestic violence, maternal depression, child sexual abuse, financial issues in pregnancy, screening in public health and simple problem solving techniques. The program was implemented successfully at the Mercy Hospital for Women.

45. The support of midwifery management for the program was high, as demonstrated by the release of midwifery staff during usual work hours to complete the program. Educational program participants (n = 22/27) (similar to many other training programs) self-reported that they were significantly more likely to ask directly about domestic violence, past sexual abuse, and concerns about caring for the baby. They were less likely to report that psychosocial issues made them feel overwhelmed, and they reported significant gains in knowledge of psychosocial issues, and competence in dealing with them. However, HP report is not sufficient

and we need to examine what effect ANEW had on women attending the Mercy Hospital for Women.

46. ANEW women's outcomes [29] were also positive in the after surveys. Of the eligible women, 78.2 percent (584/747) participated in a pre-ANEW survey and 73.3 percent (481/657) in a post-ANEW survey. After ANEW, women were significantly more likely to report that midwives asked questions that helped them to talk about psychosocial problems and that they would feel more comfortable to discuss with midwives a range of psychosocial issues if they were experiencing them (coping after birth for midwives, feeling depressed); and women were more comfortable to discuss with doctors concerns relating to sex or their relationships. The ANEW program evaluation suggested trends of better communication by health professionals for pregnant women and should be evaluated using rigorous methods in other settings.

47. In 2004, ANEW was subsequently rolled out across Sunshine, and Barwon area hospitals through a Train the Trainer program teaching selected midwives to be trainers. It was also utilised to train postnatal midwives in 2006. Again the HP self-reported outcomes were positive (21 midwives). Following the intervention, participants were more likely to feel competent at identifying women in an abusive relationship and encouraging women to talk about any psychosocial issues. Soon after the Mercy Hospital for Women moved to a new site and there was a change in government.

MOVE Project

48. The MOVE project (led by Professor Angela Taft and Leesa Hooker) aimed to test using a randomised controlled trial (http://www.biomedcentral.com/1741-7015/13/150/abstract) whether a theory-informed, maternal and child health nurse designed model increased and sustained domestic violence screening, disclosure, safety planning and referrals compared with usual care. The intervention was nurse led and involved nurse mentors, strengthened relationships with domestic violence services, nurse safety, a self-completion maternal health screening checklist at three or four month consultations and domestic violence clinical guidelines. Usual care involved government mandated face-to-face domestic violence screening at four weeks postpartum and follow-up as required. The intervention did not find any significant difference in screening rates which overall were around a third of patients, similar to a systematic reviews findings of how often HPs screen when

mandated to do so. Referrals remained low in both groups (<1%). However, safety planning rates were 3 times to 4 times higher.

Acting on the Warning Signs project at The Royal Women's Hospital

49. The Royal Women's Hospital (**The Women's**) has for more than a decade had a focus on violence against women with leadership within senior management at the hospital, police, The Women's Clinical Practice Guideline, on-going staff training, and more recently several externally funded projects to further strengthen this focus. The Acting on the Warning Signs project exemplifies the strengthening of this hospital response. The implementation involved not only a once a week legal clinic (now expanded to more sessions), but also staff training and extensive relationship building between Inner Melbourne Community Legal service and The Women's to strengthen the Legal Advocacy-Health Alliance .

50. In 2014, the University of Melbourne evaluation of the first 12 months of the Acting on the Warning Signs program (including both the training and the co-location of the legal clinic within the hospital) demonstrated that although the training was successful and women attended the legal clinic in greater numbers, early intervention requires greater system changes within the hospital setting. Recommendations included:

50.1. Sustained system changes within a large hospital such as The Women's would require more staff to be trained and more than a part time designated manager. The current program trained almost 10% of clinical staff, who clearly self-reported changes in their confidence, knowledge and skills, however a larger critical mass of trained and sensitised staff are needed to sustain changes. Appointment of a funded hospital clinical lead in addition to the legal manager might be useful.

50.2. In order to make an ongoing greater impact on referral:

50.2.1. health professionals need to perceive a greater need to ask about family violence through the support of an ongoing hospital wide campaign on family violence;

50.2.2. it needs to be associated with other system changes that assist women to access help e.g. more posters, warm referrals (women supported and accompanied to the legal clinic);

50.2.3. effective, good quality databases/recording systems are required to capture and track referrals within The Women's, including demographics and reasons for presentation.

51. The innovative Acting on the Warning Signs Legal Advocacy-Health Alliance of engagement and training of over 100 health professionals did build capacity, confidence and willingness of participating health professionals to identify signs of family violence. Health professionals clearly increased their knowledge of legal options. Appropriate legal assistance from the outreach service was provided alongside other services as part of a multifaceted response within the hospital. Over the five year development of the legal clinic since 2009 at The Women's there has been a steady increase in referrals reported by Inner Melbourne Community Legal. Greater referrals from health professionals might be visible with better data capture of referrals and may occur with greater availability of the Inner Melbourne Community Legal outreach service. The further development of the model in the next phase to increase the number of legal assistance sessions, on-going (and possibly mandatory) family violence training, stronger, practical support for women to access the legal clinic, and experimenting with whether legal support can be provided directly without the intermediary social work support service provide promising extensions for the future development of the legal service within the hospital.

The importance of mental health care services in the context of family violence

52. Currently, both nationally and in Victoria, there is policy and guideline work around trauma-informed care and practice (MHCC and ASCA), gender sensitivity, connection of services and family violence sector reform. Yet, despite this innovative work and the fact that mental health and family violence services are likely to have a shared client group, it does not appear to be common for services to communicate with each other, provide cross-referrals, or to address issues outside their scope of expertise. Further, there is likely to be a lack of training of mental health practitioners both private and public, similar to the experience in the United Kingdom. Further, very few undergraduate/graduate programs for training of psychologists and psychiatrists incorporate core training on family violence.

53. Evidence indicates that health systems globally face the same issue of siloed service delivery even though the problems caused by family violence (including sexual violence), alcohol and other drug use and mental health are multidirectional.

This is despite two decades of published literature proclaiming the benefits of inter-sectoral collaboration for meeting the needs of people affected by violence, alcohol and other drug use (otherwise termed substance use), and mental health, as well as a growing focus on trauma-informed care.

Mental health, drug & alcohol, and family violence/child protection

54. The prevalence of substance use and co-morbid mental health issues like depression, anxiety, self-destructiveness, post-traumatic stress disorder and suicidal behaviour is documented as higher in women who have experienced family violence. It is not surprising then that family violence and alcohol and other drug specific services ultimately end up providing care for the same women. While simultaneously targeting substance misuse and family violence is more effective than addressing either as a single issue, it is surprising that joined-up service provision and responsive care remains elusive and that service models often exist in philosophical tension; siloed approaches are more common than not. Partnerships that coordinate interventions would improve outcomes for women and children yet these remain underdeveloped.

Mental health, sexual violence and trauma-informed care

55. In Australia, one in five women have experienced sexual violence, mostly perpetrated by someone they know, and often an intimate partner. There is a strong association between sexual violence and mental health problems for these women. Mental health and sexual violence services often have a shared client group, and ideally, women would have a pathway to safety and wellbeing no matter which service they approach first, i.e. “No Wrong Door”. However, although nationally and at various state levels there is policy/guideline work around trauma-informed care and practice, gender sensitivity, connection of services and family violence sector reform, it does not appear to be very common for services to communicate with each other, provide cross-referrals, or address issues outside their scope of expertise. While it is true that sector specific trauma-informed guidelines have been implemented to varying degrees by services, there is a gap around how services can implement trauma-informed practice to work more effectively when both issues are present. This is an issue for the family violence sector as sexual violence is a common component of family violence, and because the majority of sexual violence against women is perpetrated by an intimate partner.

56. The Department of General Practice at the University of Melbourne has been funded by the Australian National Organisation for Women's Safety (**ANROWS**) to build, implement and evaluate a trauma-informed "systems model of care" that is responsive to women's needs. The model will take a whole of organization approach for services, including: environment, management, direct contact, practitioner support, referral pathways, information sharing, protocols and policies, and community linkages.

57. To develop the systems model, we will draw on existing literature and interviews with women who have experienced both mental health problems and sexual violence. We will examine the directionality of the relationship between mental health and sexual violence, pathways to safety and care, and the benefits of digital storytelling as a therapeutic process. This material will be used in consultation with stakeholders to build the systems model. We will then implement the model in three settings - a tertiary women's hospital with a sexual violence service, an area mental health service and a community mental health service.

58. The systems model has the potential to improve women's experience by recognising and responding to their complex pathways to safety and care, no matter which service they approach first.

Responding to perpetrators in health settings

59. The Department of General Practice at the University of Melbourne has received funding from the Australian Primary Health Care Research Institute (**APHCRI**) to explore the ways that GPs can respond to men who use violence in relationships. The PEARL project will run until early 2016, and will canvas the views of men who have used violence and GPs, to determine:

    59.1. the most effective ways for GPs to identify men who are using violence;

    59.2. the most effective ways for GPs to respond when violence is identified or disclosed by male patients (including referral pathways); and

    59.3. what types of interventions might improve identification and response to men who use violence within health settings.

    59.4. whether men see technological interventions available on internet and smart phones as a useful idea for early intervention.

60. Preliminary data suggests that it is difficult to engage men in the initial help-seeking process when they are using violence in relationships. Men may be unaware that there is a problem with their use of violence, or may not be sufficiently incentivised to change their behaviour. In our preliminary group discussions with men, they have suggested that help-seeking would be very much dependent upon the "right person asking the right questions", which highlights the importance of training and education for health professionals.

61. We have also received funding from Macedon Ranges and North West Medicare Local to deliver an educational program to health practitioners working in general practice on how to identify and respond to men who use violence in their relationships. We have recruited five practices with up to 40 staff and are in the process of delivering this training.

Recommendations

62. The response of health professionals to family violence could be improved by:

Workforce development

62.1. . Mandatory training of all health professionals in child safeguarding that includes family violence. Cardio Pulmonary Resuscitation is the only mandatory training at the moment. A regular update on family violence tied to registration through Australian Health Practitioner Regulation Agency would ensure a trained work force to provide a WHO first line response. In the United Kingdom there is mandatory Child and Adult Safeguarding training for all health practitioners;

62.2. Mandatory training in family violence counselling to be included in courses training psychologists and psychiatrists;

62.3. Ensure training in family violence of mental health and substance use professionals;

62.4. Ensure training in family violence of all headspace workers to identify and respond to young people experiencing abuse;

62.5. Mandatory undergraduate education for doctors, nurses, social worker, psychologists;

62.6. Curriculum to include tailoring of first line responses to women to take into account their readiness for action and types of violence, in addition to risk assessment and safety planning.

Technology Solutions (ehealth) for first line response for those who can't access healthcare

62.7. Victorian government to enhance the online community hub of resources (e.g. at DVRCV) to include I-DECIDE About my relationship for women experiencing family violence.

62.8. Disseminate I-DECIDE through government/sector/community/police channels.

62.9. Provide funding to translate technological interventions into multiple languages or simplified/pictorial formats (for CALD populations).

62.10. Provide funding to develop technological interventions for Aboriginal and Torres Strait Islander people.

62.11. Provide funding to partner with Universities (e.g. the Melbourne Research Alliance to end Violence against women and their children) and industry to develop and evaluate technology to address men's violence in relationships.

62.12. Provide funding to partner with Universities to develop and evaluate technology to address the needs of children witnessing family violence in the home.

Referral pathways

62.13. More funding for specialist family violence support services that can liaise with primary and mental health care and to where primary care, antenatal care, emergency departments can refer. This would include services for women, adolescents, children and men;

62.14. Lobby Commonwealth government to develop special GP Medicare item numbers (similar to the Mental Health Assessment or Diabetes or Asthma item numbers) to develop family safety plans and follow up for women and children experiencing family violence. Identified and accredited specialised services (e.g. social workers and family violence psychologists who have had

extra family violence training) could have access to special item numbers for counselling for up to 10 sessions annually. Some women may meet criteria for mental health care plans but some may not. A family based safety plan would allow mother child work and group work which have both been found to be the most effective when women and their children are affected by family violence; Men who use violence could use their plan to access behaviour change programs;

62.15. Fund more accessible and affordable mother child group and individual services through community health and women's health services;

62.16. Lobby the Commonwealth government to include family violence workers as part of general practitioners Medicare Team Care Arrangement and General Practice Management Plan so GPs can refer for five sessions;

62.17. Lobby Australian Psychological Society, and Royal Australian New Zealand Psychiatry College to identify those who are trained especially in family violence, in particular partner violence on their databases.

Hospital system reform

62.18. Fund co-ordinators of family violence in all public health services and clinical family violence leads in all state hospitals.

62.19. Priority should be given for projects that focus on ameliorating the intergenerational effect on children. Large maternity hospitals are a key focus for early intervention with mothers and children in their early years.

62.20. Co locate other services in large maternity hospitals e.g. legal, housing, finance services;

62.21. Ensure hospital environments are private and sensitive to the needs of patients experiencing family violence using trauma informed care principles;

62.22. Improve databases including hospital and maternal and child health nurse data to be able to identify family violence, including subgroups e.g. Aboriginal and Torres Strait Islander people, LGBTI, CALD, disability.

Policy

62.23. Victorian government support policy directions to support more than dual diagnosis in mental health but incorporates a third axis of family violence and sexual violence;

62.24. Ensure that trauma informed services are the norm in mental health and substance use services;

62.25. Support for services to integrate more effectively to provide trauma-informed care to patients experiencing multiple issues such as mental health and sexual violence and/or substance misuse;

62.26. Coordinate a state-wide health system response to family violence over the next five years, which avoids multiple small projects and integrates State and Commonwealth, philanthropic and non government funds.

Research and evaluation

There is an urgent need for:

62.27. Perpetrator research across the spectrum of drivers, prevalence, and interventions.

62.28. Sexual violence research within the context of partner violence across the spectrum of prevalence, effects and interventions.

62.29. Child interventions and mother child interventions need to be conducted and evaluated in Australia as these show the most promise.

62.30. Technological interventions, similar to mhealth and ehealth should be a priority for further development and evaluation.

62.31. Evaluations of the use of telemedicine, telemental health and telefamily violence interventions delivered to women in shelters, rural areas and with disabled women.

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