Melbourne research Alliance to End Violence against women and their children

Submission to the Royal Commission

into Family Violence Victoria

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Introduction

We recognise the need for prevention of family violence and the need to establish a culture of non-violence and gender equality, and to shape appropriate attitudes towards women and children. We see family violence as a gendered issue with women and children more likely to be the victims of violence and men the perpetrators. In this submission, however, our focus is primarily on early intervention and response in health settings and through the use of technology. We also suggest priorities for research in the area of family violence and for coordinated service responses. We will draw on our own work to illustrate effective ways to identify and respond early to family violence, both for women and perpetrators. Linked submissions from the Melbourne research Alliance to End Violence against women and their children will address other aspects.

About the submitters

Professor Kelsey Hegarty leads the Researching Abuse and Violence in primary care program within the Department of General Practice at The University of Melbourne. The program focuses on early intervention and response to abuse and violence within the primary care setting, and through the use of technology. Research areas include counseling interventions for women in general practice, online tools for safety in relationships, early intervention with men who use violence in relationships, experiences of unwanted sexual contact in women, and systems models for mental health and sexual violence services. Dr Laura Tarzia is a Research Fellow working within the Researching Abuse and Violence program and coordinating a range of projects. Jodie Valpied and Kirsty Forsdike are Senior Research Assistants within the program, and Kitty Novy provides administrative support and manages recruitment for research projects. The utilization of research knowledge to strengthen evidence-informed practice is a priority of our work.

This submission

This submission is structured as a collection of briefing papers, each with a different focus. In the introduction of each paper, we provide the context or background to the issue. We outline the challenges, provide relevant evidence from our research, outline recommendations, and provide a reference list at the end. At the top of each briefing paper, we indicate which terms of reference (from 1 to 10) and questions from the Issues Paper (from 1 to 21) the paper relates to. We have taken this approach given the overlap between the terms of reference.

Briefing paper 1:	Addressing Family Violence in Health Settings
Briefing paper 2:	Using Technology to Address Family Violence
Briefing paper 3:	Coordinated Service Responses
Briefing paper 4:	Recommendations for Research into Family Violence

Melbourne Research Alliance to End Violence Against Women and their Children

Briefing Paper No. 1

Addressing Family Violence in Health Settings

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Addressing Family Violence in Health Settings

Relevant to terms of reference: 1 and 4

Introduction

This briefing paper is relevant to points 1 and 4 in the Terms of Reference. In this paper we put forward best practice for strategies and policies for early intervention in primary care health settings to identify and protect those at risk of family violence (FV) and prevent the escalation of violence (1b), support for victims of family violence to address the impacts, particularly on women and children (1c) and perpetrator accountability (1d). We also suggest ways to best evaluate and measure the success of strategies, frameworks, policies programs and services put in place to stop family violence (4). Additionally, the paper addresses questions 4, 5, 9, 10, 11, and 16 from the Issues Paper.

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. [1 2] The World Health Organization (WHO) have prioritised preventing and reducing the extensive damage from family violence especially on children, and identified the crucial role of an effective health system.[3] Unfortunately, health services have lagged behind other agencies in responding appropriately to this issue 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).[4]

As GPs are family doctors, they also see the male perpetrator in the family and the children, although very little training is provided to GPs to be able to manage family violence, in particular the perpetrator's role in the family. Maternal and child health nurses are also ideally placed to intervene through their contact with women and children.[5]

The limited research into disclosure to health practitioners (HPs) and inquiry by HPs reveals low rates of either with around one third of abused women ever disclosing and an inquiry rate of around 1 in 10.[4] However, research suggests that women want to be asked directly about abuse by supportive HPs.[6] Women suffering the effects of FV typically make 7-8 visits to health professionals before disclosure.[7] Unfortunately, if women do disclose FV to their HP, there is evidence of an inappropriate, poor quality response.[8 9]

Evidence of best practice informing this submission includes systematic reviews of health care interventions[10 11] and of qualitative studies[12], international primary care guidelines and evaluation of health-based FV studies.[13 14 5]

Current World Health Organisation Guidelines

The World Health Organisation recommends that women and their children need to have a safe first line response at three levels:-

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 taught at undergraduate and postgraduate level in most health courses.

2. **Safety assessment response**: Families need to have their safety 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, referral to advocacy services or crisis support.
3. **Pathway to safety:** Health practitioners need an understanding of FV services and access to resources and referrals in local areas to assist them in keeping women and children safe.

The World Health Organisation has developed a clinical handbook, which is currently being trialled in draft format. Kelsey Hegarty was involved with the development of the guidelines[15] and 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, Support.**

Evidence for early interventions in health care

FV is linked to a range of negative health effects and outcomes[16], yet, to date, there is little evidence to support effective interventions in health settings.[11,15] 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.[17] FV interventions in health care settings have mostly focused on screening and referral to formal services.[18]. A recent update of a Cochrane Screening review (about to be published) reinforces that screening and initial response 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.[15]

Although early identification of women experiencing DV 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' [17], as they do not self-identify as such. Furthermore, formal FV support services are frequently overburdened and may not be able to cope with increased demand. Consequently, we argue that the response to FV in primary care health settings can do more than simply refer to specialised services. For example, women centred care by general practitioners was recently evaluated in a randomised controlled trial, led by Kelsey Hegarty (see Box 1).[14]

The *weave* study[19] 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.

Box 1. *Weave* was a cluster randomised controlled trial testing the effect of brief counselling by Victorian general practitioners (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 detectable effects on women's general quality of life, overall mental health, anxiety or level of comfort to discuss fear of a partner with the GP. Twenty-four month outcomes and process evaluation results are currently being analysed.

The Psychosocial Readiness Model[20] 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. Researchers[21] 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: *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. *Self-efficacy* is the woman's belief that she is able to achieve difficult tasks, or cope with adversity. *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.

Educational Programs for Health Practitioners

Undergraduate/graduate training of the medical and nursing professions lacks any mandatory content on family violence. A review of medical schools in this country show that some do none, some do around 3 hours and others do up to 12 hours.[22] The Common Risk Assessment Framework has not reached GPs to any great extent, although many maternal and child health nurses have been trained.

We recently received funding from Bayside Medicare Local 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 programme successfully recruited five general practices in the Bayside Medicare Local (BML) 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. The participant manual, facilitator manual, administrator manual, practice checklist, simulated patient cases and audit are available on request.

We have also received funding (in conjunction with the RACGP) from the Commonwealth Department of Social Services that has resulted in:

i. Updating of the Royal Australian College of General Practitioners (RACGP) publication *Abuse and Violence: Working with our patients in general practice Manual (White Book)* edited by Libby Hindmarsh and Kelsey Hegarty available online at http://www.racgp.org.au/your-practice/guidelines/whitebook/
    - We have developed tools for GPs that can be accessed and continue to do this;
    - We recommend the GP toolkit produced by the NSW legal service and did not replicate this;
ii. Updating of the RACGP gplearning online *Active Learning Module on Domestic Violence available for RACGP members and Aboriginal health workers.*
iii. Current project to set up a separate primary care specific support and information line through 1800RESPECT specifically for general practitioners, which will also be able to respond to the needs of Aboriginal health workers (AHWs). This will be available in 2016.

There have been recent calls by the Victorian Coroners Court for a family violence advice line for GPs in this difficult and sensitive area. 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 AHWs call for information and support on how to handle difficult issues e.g. threats of homicide by perpetrators, when to call the police, or what to do when a women doesn't want to see a FV advocate. Many general practitioners and Aboriginal health workers need to support their patients themselves as they are often not ready to be referred to other services.

Responding to Children in Health Settings

The SARAH project was conducted by Anita Morris supervised by Kelsey Hegarty and Cathy Humphreys (Department of Social Work, The University of Melbourne). This study formed part of a PhD project focusing on children's safety at home. It aimed to discover the protective factors that promote children's safety and resilience in the context of family violence. Focus groups were conducted with women, children, GPs and practice nurses,

about appropriate primary care responses to children who experience family violence. Through these focus groups we gained a better understanding of what GPs and other health practitioners can do to assist children who experience family violence. The thesis is available on request.

Responding to Perpetrators in Health Settings

We have received funding from the Australian Primary Health Care Research Institute (APHCRI) to explore the ways that general practitioners 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:

- the most effective ways for GPs to identify men who are using violence and;
- the most effective ways for GPs to respond when violence is identified or disclosed by male patients (including referral pathways) and;
- what types of interventions might improve identification and response to men who use violence within health settings.

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 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. As part of this project, we have also partnered with the former Macedon Ranges and North-West Melbourne Medicare Local in order to deliver targeted education to general practitioners around FV and responding to men in particular.

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 5 practices with up to 40 staff and are in the process of delivering this training. Manuals can be provided on request.

Evaluation of Acting on the Warning Signs Project (Responding in Hospital Settings)

The Acting on the Warning Signs (AOWS) project is a new training programme being provided to health professionals at the Royal Women's Hospital (The Women's) which was evaluated by a team at the University of Melbourne. The new training programme has been established, delivered and coordinated by the Inner Melbourne Community Legal (IMCL) and The Women's. AOWS responds to family violence against women and brings together pathways to justice and health sector training. The evaluation involved workshops with key stakeholders, pre and post staff training surveys, focus groups, client surveys and interviews and analysis of data extracted from IMCL's Information System. The report is available on request.

The importance of mental health care services in the context of FV

The World Health Organisation (WHO) has developed a recommended first line response by health professionals for FV and intimate partner violence.[15] Currently, both nationally and in Victoria, there is policy/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 MH and FV 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 UK experience.[23] Further very few undergraduate/graduate programs for training of psychologists, social workers and psychiatrists incorporate core training on family violence.

Recommendations

- Mandatory training of all health professionals in child safeguarding that includes family violence. CPR is the only mandatory training at the moment, however a regular update on family violence tied to registration through AHPRA would ensure a trained work force to provide a WHO first line response
- Mandatory training of psychologists, social workers and psychiatrists in family violence counselling
- Mandatory undergraduate education for doctors, nurses, social worker, psychologists
- 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
- More funding for support services that can liaise with primary and mental health care and to where primary care, antenatal care, emergency departments can refer
- Lobby Commonwealth government to develop special item numbers (similar to the Mental Health Assessment or Diabetes or Asthma item numbers) to develop Family 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 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 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
- Fund more accessible and affordable mother child group and individual services through community health and women's health services.

- Lobby commonwealth government to include family violence worker as part of Team Care Arrangement and General Practice Management Plan so GPs can refer for 5 sessions
- Lobby Australian Psychological Society, and Royal Australian New Zealand Psychiatry College to identify those who are trained specially in family violence, in particular partner violence on their databases.
- Improve databases including hospital and maternal and child health nurse data to be able to identify family violence, including subgroups e.g. CALD, disability.

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Melbourne Research Alliance to End Violence Against Women and their Children

Briefing Paper No. 2

Using Technology to Address Family Violence

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Using Technology to Address Family Violence

Relevant to terms of reference: 1, 9 and 10

Introduction

This briefing paper is relevant to points 1, 9 and 10 in the Terms of Reference. In this paper we put forward best practice for strategies for early intervention (through technology) to identify and protect those at risk of family violence (FV) and prevent the escalation of violence (1b), support for victims of family violence to address the impacts, particularly on women and children (1c) and perpetrator accountability (1d). We also highlight the potential for technology to appropriately prevent and respond to family violence, through information sharing and data systems (9). We will draw on the expertise of academics working in the field of family violence, including various key publications that are relevant to technology (10). Additionally, the paper addresses questions 4, 5, 11, 16 and 18 from the Issues Paper.

Despite the fact that the World Health Organisation recommends primary care as a key site for identification and response to family violence[1], research suggests that there are barriers to disclosure of FV in health settings, as well as difficulties in responding effectively. These barriers include potential discomfort regarding disclosure if women have had previous negative experiences [2], lack of access to care, and worries about confidentiality [3]. Even when women to disclose, they often do not take up referrals to formal services[4], because they may not identify as someone who is experiencing family violence. This makes interventions within health settings difficult, and may explain why studies have produced mixed results about their effectiveness.[5] The delivery of interventions online has the potential to overcome these barriers, as the intervention can be accessed anonymously, at a time and place of the woman's choosing, without the need to disclose the violence to a third party. The internet is being increasingly harnessed as a method of delivery for interventions to address sensitive, stigmatising conditions [6], including mental health issues [7] and sexual health [8], which suggests that it could also be useful in the family violence field. There are also possibilities for women in remote or rural locations, CALD women, or women with disabilities, who are unable or unwilling to access services face-to-face. To date, however, little research has explored these possibilities. We recently wrote a piece for *The Conversation* outlining some of the potential benefits of technology in the context of FV, which can be found here https://theconversation.com/technology-doesnt-judge-using-the-web-to-address-domestic-violence-37657.

I-DECIDE

I-DECIDE (www.idecide.org.au) is an online healthy relationship tool and safety decision aid we have developed for women experiencing FV. I-DECIDE builds on the IRIS project conducted by Glass and colleagues in the United States [9]. The IRIS online intervention is informed by Dutton's empowerment model[10] 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 [9]. 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[11], which takes into

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account women's self-efficacy, awareness of the abuse, and perceived support in a woman's journey towards positive change (see Fig.1).

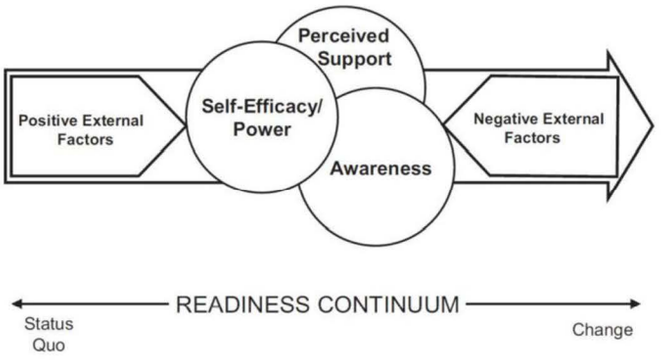

Fig.1 Psychosocial Readiness Model for IPV (Cluss *et al.* 2006)

In addition, I-DECIDE builds on a primary care intervention called *weave*[4], which used counselling techniques such as motivational interviewing [12] and non-directive problem solving [13] to encourage women to take action. It culminates with an individualized plan for action that is responsive to women's priorities and provides links to resources within her state.

The components of I-DECIDE include:

- A healthy relationship tool and self-assessment of level of fear, safety, and relationship health
- Danger Assessment based on a validated scale
- Abuse assessment (using the Composite Abuse Scale, validated and widely used in research)
- Priority setting exercise
- Contemplation exercise (decisions about staying/leaving)
- Motivational interviewing tool (weighing up pros/cons of the relationship)
- Individualised action plan
- Non-directive problem solving (workshopping ways to carry out strategies for safety and wellbeing).

We submitted a journal article (currently under consideration by the journal *Women's Health Issues)* describing the development of I-DECIDE and how its elements relate to the theoretical model in more detail[14]. This is available on request.

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Using Technology to Address Family Violence

Relevant to terms of reference: 1, 9 and 10

I-DECIDE is a potentially critical step between women realizing their relationship is unhealthy, and actually taking action. By responding to women in an individualized way, I-DECIDE may make women's help-seeking more relevant, and increase the likelihood of uptake. Additionally, I-DECIDE is responsive in the advice that it provides to whether women wish to stay, leave, or have already left the relationship. It also ensures that feedback and messaging is provided to women in a non-judgemental way that encourages her to reflect and make sense of

The I-DECIDE project began in July 2013, and recruitment commenced in January 2015. The project is funded by the Australian Research Council (DP130102799). I-DECIDE is being evaluated comprehensively through a randomised controlled trial, which is considered the 'gold-standard' in determining whether an intervention actually works. We will primarily evaluate the website based on outcomes that are linked within the literature to increased capacity for action (self-efficacy) and women's wellbeing (depressive symptoms). The content of I-DECIDE has been designed to promote increased awareness and self-efficacy, while also aiming to improve levels of perceived support, as per its theoretical framework. In addition to assessing the potential benefits for women's health and wellbeing, the I-DECIDE project also responds to an important gap in evidence about the potential for web-based applications to address domestic violence.

Prior to commencing the trial, we piloted I-DECIDE with 23 women who had experienced fear of a partner in the previous six months. Overall, the feedback was very positive. Comments included:

- *"I felt reassured, as though my feeling afraid or unsafe was taken seriously. I was glad to have what felt like an impartial and objective assessment of my situation."*
- *"I thought it really opened my eyes and confirmed the situation (made me more aware)"*
- *"The relationship assessment was affirming, and made me feel 'backed up.' The action plans were relevant and useful"*

To date, over 400 women have signed up to the I-DECIDE trial, and over 250 women have completed the baseline measures and been accrued into the study. We intend to follow up these women at 6 and 12 months. I-DECIDE will be fully evaluated by mid-late 2016 and could be made available for use by the general public by the end of 2016.

Technology for Perpetrators

We have received funding from the Australian Primary Care Research Institute to explore effective ways to intervene early with men who have used violence in relationships. As part of this project, which will run until early 2016, we will be exploring men's views on the potential for a website or app to form part of an early response to FV. Given that men often do not attend health settings, even when they are unwell or stressed, and do not often talk with other men about their relationships, other avenues for engagement

need to be explored. We will be running several discussion groups with men who are currently attending, or who have recently completed, a men's behaviour change program. We are trying to determine whether a website or app might encourage men to assess their relationships and their behaviours, and prompt them to seek help if they are using violence. We hope that the men involved in this project will be able to suggest appropriate language and tone, possible ways to raise awareness about the website/app, and ways to get men to take action after using the website/app.

Preliminary data from discussion groups suggests that the idea of addressing men's violence against women through a website/app might be useful. For example, one man commented:

- *"If you have an application where you can look and find the right people to contact…[information about] the triggers that set blokes off…If they've got stuff going on and they don't realise it's affecting them, they can read about it and go, 'Hang on, this is affecting me.'"*

It is important, however, that a website or app do more than just provide information about healthy relationships. Another participant in our discussion groups pointed out:

- *"Knowledge is not enough… it's like alcoholism. I'm well aware about what drinking does to you, but it's not enough to stop me."*

Technology Recommendations

- Victorian government to enhance the community hub of resources at DVRCV to include I-DECIDE for women experiencing family violence
- Disseminate I-DECIDE through government/sector/community/police channels
- Provide funding to translate technological interventions into multiple languages or simplified/pictorial formats (for CALD populations)
- Provide funding to develop technological interventions for Aboriginal and Torres Strait Islander people
- 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
- Provide funding to partner with Universities to develop and evaluate technology to address the needs of children witnessing family violence in the home

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Using Technology to Address Family Violence

Relevant to terms of reference: 1, 9 and 10

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Melbourne Research Alliance to End Violence Against Women and their Children

Briefing Paper No. 3

Coordinated Service Responses

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Coordinated Service Responses

Relevant to terms of reference: 1, 3, and 8

Introduction

This briefing paper is relevant to points 1, 3, and 8 in the Terms of Reference. In this paper we put forward best practice for service coordination to identify and protect those at risk of family violence (FV)(1b) and support for victims of family violence to address the impacts, particularly on women and children (1c). We recommend ways that service efforts can be better coordinated (3 and 8). Additionally, the paper addresses questions 4, 9, 10, and 11 from the Issues Paper.

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 (AOD) and mental health are multidirectional.[1,2] 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[3-6], as well as a growing focus on trauma-informed care.

Mental Health, Drug & Alcohol, and Family Violence/Child Protection

The prevalence of substance use and co-morbid mental health issues like depression, anxiety, self-destructiveness, post-traumatic stress disorder (PTSD) and suicidal behaviour is documented as higher in women who have experienced family violence.[7] It is not surprising then that family violence and alcohol and other drug (AOD) specific services ultimately end up providing care for the same women.[8] While simultaneously targeting substance misuse and family violence is more effective than addressing either as a single issue,[9] it is surprising is 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.[10-12] Partnerships that coordinate interventions would improve outcomes for women and children yet these remain underdeveloped.[13,14]

Mental Health, Sexual Violence and Trauma-Informed Care

In Australia, one in five women have experienced SV, mostly perpetrated by someone they know, and often an intimate partner[15]. There is a strong association between sexual violence and mental health problems for these women [16]. Mental health and sexual violence services often have a shared client group[24], and ideally, women would have a pathway to safety and wellbeing no matter which service they approach first, i.e. "No Wrong Door" [17]. However, although nationally and at various state levels there is policy/guideline work around trauma-informed care and practice [19,20], gender sensitivity [21], connection of services [22] and family violence sector reform, [23] 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.[24] 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 FV sector as sexual violence is a common component of FV, and because the majority of SV against women is perpetrated by an intimate partner.

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We have 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.

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.

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.

Recommendations

- Policy directions support more than dual diagnosis in mental health but incorporates a third axis of family violence and sexual violence
- Ensure training of mental health and AOD professionals in family violence
- Ensure that trauma informed services are the norm in mental health and AOD services
- Databases record underlying family violence and data sharing across services is facilitated in order to support trauma-informed care
- Support for services to integrate more effectively to provide trauma-informed care to women experiencing multiple issues such as mental health and sexual violence and/or AOD misuse

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Melbourne Research Alliance to End Violence Against Women and their Children

Briefing Paper No. 4

Research Recommendations

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Research Recommendations

Relevant to terms of reference: 4

Introduction

This briefing paper is relevant to point 4 in the Terms of Reference. In this paper we put forward recommendations for research and evaluation of strategies, frameworks, policies, programs and services put in place to stop family violence. Additionally, the paper addresses questions 4 and 5 from the Issues Paper.

Research remains critical to the prevention, early identification, and response to family violence. In the recent *Violence Against Women and Girls* series published in *The Lancet*,[1-6] several research priorities were outlined which apply to the Victorian context.

Research Recommendations

- Community longitudinal studies - Although data is clear on the range of health effects of family violence, most of this (with the exception of child abuse[7]) is mostly based on cross-sectional surveys. There is an urgent need for a community longitudinal study on family violence to advance our understanding of the health effects and potential for intervention. The Personal Safety Survey[8] is cross sectional. The National Mental Health study[9] also has measures of violence which are limited. The Women's Health Australia study[10] is longitudinal but until recently contained limited measures of partner violence. The Composite Abuse Scale[11] (developed by Kelsey Hegarty) was recently added as a comprehensive gold standard. However there is a need for a focused violence study, which allows greater exploration of different types of violence (e.g controlling and coercive behaviours) and samples of particular groups that are often not captured in population based surveys (e.g. Indigenous women, women who live in prisons, women with disabilities, women from culturally and linguistically diverse backgrounds and transgender women.

- Randomised controlled trials of early interventions (through primary care, community and technology) with both quantitative and qualitative outcomes - There is a need to expand the evidence base on secondary prevention/early intervention research as there are limited trials globally, particularly in the health setting and through the use of technology. Kelsey Hegarty is on two Cochrane reviews which are being updated (unpublished presently) but due to come out this year. The first is on screening in health settings[12] and the second is on advocacy interventions[13]. Both have a limited pool of studies from which to make recommendations. Similarly the WHO guidelines group recommendations[14] were also limited by the lack of an evidence base.

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- Primary prevention evaluations are urgently needed - More research on primary prevention is essential as most research in high income countries is focused on response. We need studies conducted in multiple sites, with larger sample sizes and longer follow up periods to test economic interventions, and workplace interventions. There is some evidence around school based respectful relationships[15], but we have failed to trial economic interventions in high income countries.[6]
- Perpetrator research across the spectrum of drivers, prevalence, and interventions.
- Sexual violence research within the context of partner violence across the spectrum of prevalence, effects and interventions
- Child interventions and mother child interventions are needed to be conducted in Australia as these show the most promise.
- Technological interventions, similar to mhealth and ehealth should be a priority
- 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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