Domestic Violence Routine Screening: Implementation Review 2024

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Acronyms

Acronym	Meaning
DVRS	Domestic Violence Routine Screening
NSW	New South Wales
MoH	Ministry of Health, also referred to as 'The Ministry'
PARVAN	Prevention and Response to Violence Abuse and Neglect
ECAV	Education Centre Against Violence, NSW Health
LHD	Local health district. NSW Health has 15 local health districts across NSW
AOD	Alcohol and Other Drugs
MH	Mental Health
TIC	Trauma Informed Care
PD	Policy Directive (refers to the 2023 DVRS policy)

Glossary

Term	Meaning
Women	This report refers to 'women' as the victim-survivors of violence, with acknowledgement that not all people who experience violence are women or identify as women. The use of the term 'women' is not intended to discount the experiences of men or non-binary people who experience fear and intimidation from their partner's use of violence and abuse, or to omit the experience of women who experience violence in same sex or queer relationships. While anyone can experience DV, it remains a gendered issue with women (including transwomen) much more likely to experience violence (NSW Health, 2023; World Health Organisation 2015) and as such, continued use of gendered language is considered important. Continuing to use gendered language in relation to DV recognises that DV cannot be understood in isolation from the norms, social structures and gender roles within wider society, which influence women's vulnerability to violence.
Domestic Violence	There has been much debate about the appropriate terminology to use when discussing violence, commonly used against women in the domestic context. It is recognised that DV occurs in a wider context of gendered crimes and patriarchal systems (Kuskoff & Parsell, 2020). In this report the term Domestic Violence (DV) is used to align with NSW Health Policy, however it is recognized that DV does not capture the experience of all people and in particular Indigenous Australians. This document adopts the NSW Government's shared policy definition: *Domestic and family violence is defined to include any behaviour in an intimate or family relationship that is violent, threatening, coercive or controlling, causing a person to live in fear. It is usually manifested as part of a pattern of controlling or coercive behaviour.* *An intimate relationship refers to people who are (or have been) in an intimate partnership, whether or not the relationship involves or has involved a sexual relationship — i.e. married or engaged to be married, separated, divorced, de facto partners (whether of the same or different sex), couples promised to each other under cultural or religious tradition, or who are dating.* *A family relationship has a broader definition and includes people who are related to one another through blood, marriage or de facto partnerships, adoption and fostering relationships, or sibling and extended family relationships. It includes the full range of kinship ties in Aboriginal and Torres Strait Islander communities, extended family relationships, and of family within communities of people with diverse sexualities, gender identities and those with intersex variations. People living in the same house, people living in the same residential care facility and people reliant on care may also be in a domestic relationship if their relationship exhibits dynamics that may foster coercive and abusive behaviours.*
Mandated settings	Mandated settings refer to those service settings in NSW Health where DVRS is mandated to occur as part of routine care. These settings are Alcohol and other drug services, Maternity Services, Child and Family Health Services and Mental Health Services.
Trauma	A broad definition of trauma is used to encompass the effects of exposure to adversity and life experiences which impact upon psychological wellbeing.
Trauma Informed Care	Trauma-informed care is an approach to care delivery embedded in organisations, services and individuals understanding, recognising and responding to trauma. It aims to mitigate the impacts of trauma, avoid exacerbating trauma, and support safety.
Vicarious trauma	Vicarious trauma refers to a form of trauma, common in healthcare workers, which occurs through direct exposure to people who have experienced trauma or indirectly through exposure to traumatic information or stories. Vicarious trauma leads to symptoms similar to those experienced by direct survivors of trauma.
Victim/Survivor	The term victim/survivor is used to describe women who have lived or living experience of domestic violence, with acknowledgment that some women may identify more with one term or may conceptualise themselves differently.
Z-Card	The Z-card is a wallet sized card that folds out to an A4 Page with basic information on domestic violence and key referral pathways.

Key Messages

Staff from Alcohol and Other Drug Services, Maternity services and VAN clearly identify areas where they **require support or resources** to undertake Domestic Violence Routine Screening more effectively.

DVRS requires **safety and trust** within healthcare relationships to be effective. **Staff require resources** to foster safety and trust and enable them to undertake DVRS within their existing roles. Resources must be **appropriate to the different context** and scope of services and include space, time, access to supervision, training and recognition of the unique ways DV interacts with their work.

The structure and process of DVRS are clear and **when staff access training, they feel equipped** to undertake routine screening. However, **flexibility in how and when screening questions** are asked requires systemic consideration, to ensure staff can prioritise safety for women while still meeting policy requirements. **Data, flagging and reporting systems should support staff** to undertake screening in ways that enable support for women.

Beyond screening, it is essential there are **clear pathways, decision-making tools, and services** to enable intervention. Suggestions from staff include access to **structured decision-making tools** to support safety planning and responses to disclosures**, single point of access** to local services for effective referral and **increased access to interventions** to support a reduction in violence and increase perpetrator accountability.

Additional **systemic and structural changes** are also indicated to ensure DVRS occurs in a context of care that **minimises harm to women** and **supports staff** who engage in conversations around violence daily. Suggestions include **specialised positions** within health to support strategic DVRS implementation, support staff and maintain standards of practice **and integration at all levels** across mandated settings, to ensure responsibility for DVRS is shared. In addition, **ongoing advocacy** for social and political action is needed to **reduce barriers** to women accessing support, including from police and child protection services, as well as **ensuring adequate services** so screening results in positive outcomes and safety for women who need it.

These changes should also occur in a context of **recognition of Aboriginal knowledge**, cultural safety and increased **system-wide shifts towards trauma-informed ways of being**, including acknowledging the existing practices undertaken by Aboriginal Health Workers who work constantly to promote safety and trust with Aboriginal women within mainstream services.

The experiences of staff across Maternity and AOD settings are **unique to each context** but also broadly align with existing knowledge of healthcare workers' experiences of DV screening, suggesting that many of **the known barriers and systemic issues are ongoing** in New South Wales and continued work is needed in implementation efforts. The experiences of staff across Child and Family and Mental Health settings require further consideration, along with increased understanding of the experiences of women.

Executive Summary

This report collates the experiences of staff from across NSW Health who undertake Domestic Violence Routine Screening (DVRS) or support the process of DVRS in other affiliated ways.

Background

The NSW Health Domestic Violence Routine Screening (DVRS) Program is an early identification and intervention strategy to promote awareness of the health impacts of domestic violence, ask questions about women's safety in their relationships and the safety of their children, and respond to disclosures of domestic violence. DVRS is mandated with all women and girls accessing Maternity and Child and Family Services, and women 16 years and over accessing Mental Health, and Alcohol and Other Drug services. Other services outside these four mandated service settings may 'opt in' to delivering DVRS following consultation with the Ministry of Health.

DVRS is an effective way of identifying Domestic Violence in healthcare settings, with routine screening supporting early intervention and normalising conversations about violence with women. In the state of New South Wales, routine screening for Domestic Violence has been in place across Mental Health, Drug and Alcohol, Maternity and Child and Family Health settings for over 20 years. The literature shows that women find screening acceptable across these service streams but they may not always disclose DV through screening for a number of internal and external reasons.

A lot is known about barriers to screening. For staff this may include a lack of access to training and education about DFV, insufficient clinical support on the ground, and lack of confidence to screen and manage disclosures. Service barriers may include a lack of private spaces to safely conduct screening, challenges with finding sufficient time in service workflows to build rapport and ask questions, a lack of established processes for responding to disclosures, inadequate services to refer women to and lack of clarity about how best to respond within the existing service model. Impediments to screening may also include frequent presence of others (eg. family members, partners or friends) at appointments, language barriers, cultural barriers, and fear and stigma about disclosing violence in health settings.

Despite knowledge of the barriers, less is known about optimal practice, staff experiences of the process and how staff's own experiences impact delivery of screening. With DV recognised as a form of trauma, and movements towards Trauma-Informed Care across healthcare, it is important to know how DVRS is being undertaken in ways that are Trauma-Informed, safe and effective. The Ministry of Health collects data on DVRS completion and disclosure rates across the four mandatory services settings. This project shifts focus from compliance with screening, to exploring how to support screening to occur in safe ways.

Policy Directive

This project is an evaluation of the implementation of the 2023 Policy Directive (PD2023_009) 'Domestic Violence Routine Screening'. The policy was released by NSW Health in April 2023 and provides direction to health services and workers to support screening practices which are consistent, accessible and trauma-informed,

and ensure safe and effective responses to disclosures of domestic violence. The policy also establishes a new requirement that all Health workers who deliver screening must attend a four-hour DVRS training, and a new process for services outside mandated settings to seek approval to opt in to DVRS. This implementation review focuses on AOD services and Maternity services, with targeted data collection across an urban and a regional Local Health District. As outlined the DVRS Policy Directive, DVRS occurs across 5 stages:

- Delivering the domestic violence routine screening preamble;
- Asking the screening questions;
- Taking appropriate actions in response to the woman's answers;
- Explaining and offering the domestic violence Z-card;
- and Documenting screening and outcomes in medical records.

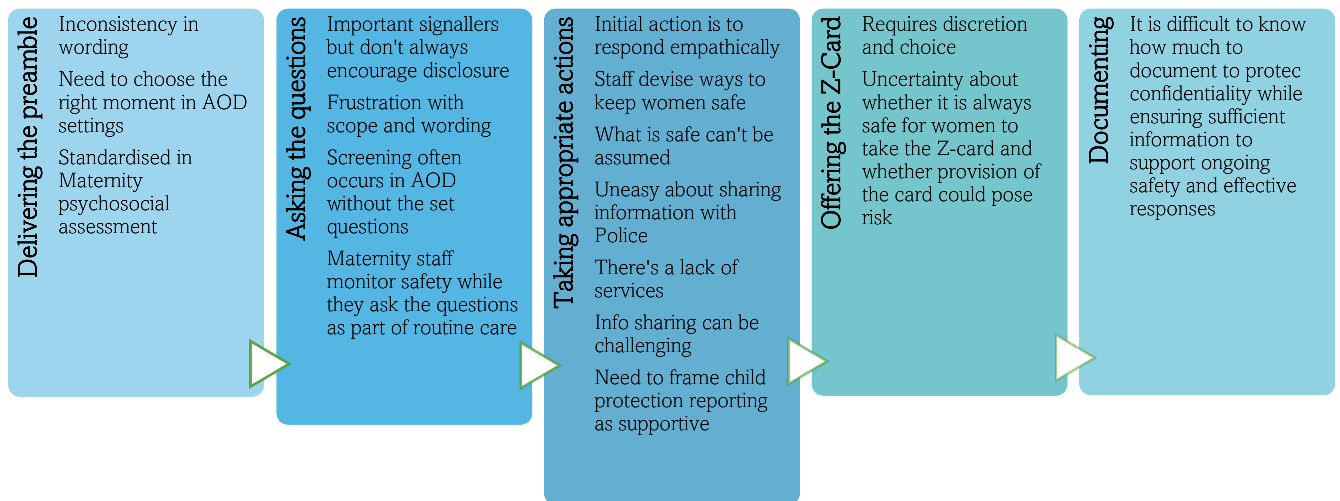
Implementation review

Through targeted focus groups, in-depth interviews and a statewide survey the review identified both shared and distinct experiences of staff across the mandated settings, with implications for practice, policy, education and further evaluation. The findings build upon existing knowledge about barriers to screening by considering the unique experiences of staff across settings and the intersection of trauma-informed approaches with DVRS.

What are the experiences of clinicians in screening and responding to DV in mandated settings?

The findings show there is a need to understand the implementation and practice of DVRS within wider practice. The context across settings includes staff not yet being aware of the new policy, staff not always understanding the purpose of DVRS, staff observing that DV and AOD use can be interwoven and intersecting for many clients, and DVRS being a more clearly defined pathway in Maternity settings due to being embedded within routine structured psychosocial assessment. In addition, staff are under pressure across contexts and being asked to do more with less, with negative impacts upon time and capacity to undertake DVRS effectively. Culture, including mainstream attitudes to DV within Australia, impacts upon women being safe and able to disclose, with knowledge of Aboriginal women's experiences of systemic and community trauma and violence crucial to providing culturally sensitive care. Staff are frustrated by a lack of services to refer women to which undermines the routine screening process.

Across the stages of DVRS, shared and unique experiences were identified for staff in AOD and Maternity settings, including needing to adapt the timing and language of DVRS to meet the needs of clients, working flexibly to support safety, fitting DVRS around clinical demands, frustrations with the wording of the questions, difficulties engaging with police, child protection and other services, a lack of services to support women overall, uncertainty about how to use the Z-Card, and conflicting ideas about how to document for safety.



<u>In what ways are clinicians undertaking screening guided by trauma-informed principles?</u>

Staff are asked to be trauma-informed despite for many staff a lack of consistent access to knowledge or training about trauma and a lack of system wide clarity around what it means to be trauma-informed. Subsequently staff are trying to figure out what it means to be trauma-informed in the context of DVRS, which largely results in attention to the relationship, considering how the dynamics of DV impact disclosure, and emphasising safety and trust. Safety is complex in the context of DV and as result, sometimes staff are engaging in practices to enhance safety based on their own perceptions of their time, skill and capacity to respond to DV disclosures in meaningful ways that support women.

Where previous research has shown a need for cultural sensitivity but less clarity about how to enact it, the Aboriginal Health Workers in this study described specific and careful ways that they adapt DVRS to enhance cultural safety for Aboriginal women, including recognising how the need for indirect questioning and storytelling alters the DVRS process, identifying cues of trust within the relationship, and positioning themselves as advocates for women in advocating with external agencies and systems such as Child Protection and Police.

While it has often been presumed that staff's own lived experiences of DV may impact upon DVRS in ways that negatively impact upon screening and staff wellbeing, the findings highlight how lived experience can enhance empathy, sensitivity and resilience amongst staff undertaking DVRS and enhance confidence in talking about violence with care. However, support is necessary. All staff require support, including opportunities to share, simulate and practice DVRS, access to skilled reflective supervision and time and space for debriefing with colleagues.

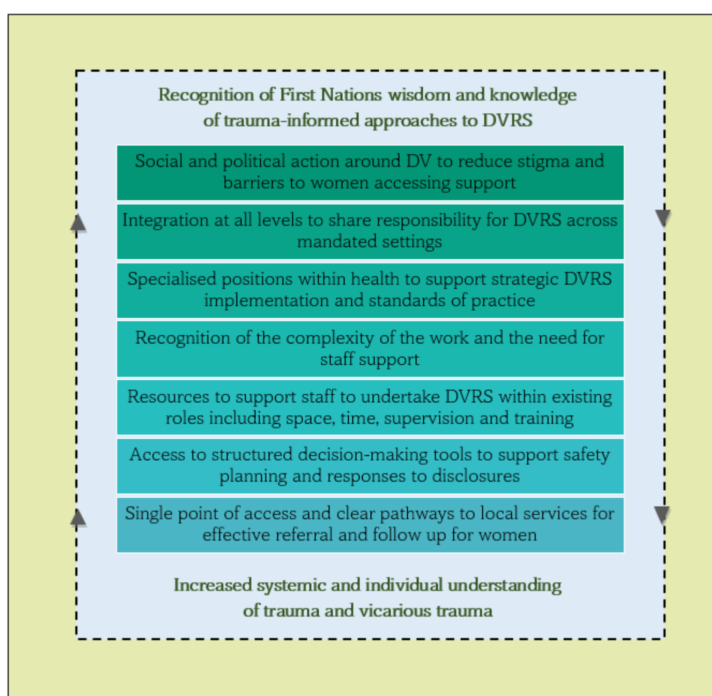
<u>What resources and support needs are identifiable to improve the quality of DVRS across mandated and opt-in screening services?</u>

The NSW Health *Domestic Violence Routine Screening (DVRS) Policy Directive* includes a new requirement for all workers whose role includes DVRS to attend a mandatory 4-hour face-to-face training. Prior to 2023, DVRS training was available but was not mandated across the state so access to this training was variable across LHDs and within mandated settings. The findings show the updated training has recently commenced and staff are finding this beneficial, although the logistics of training the whole workforce are slow and burdensome. In addition to the knowledge-based training, staff want opportunities for skill development and ongoing opportunities to reflect on how to best engage women and respond to DV.

Staff clearly identify a number of things required to undertake DVRS effectively. These include:

- Resources to support staff to undertake DVRS within existing roles, including space, time, supervision, training, and recognition of how DVRS differs across settings
- Access to structured decision-making tools to support safety planning and responses to disclosures
- Single point of access and clear pathways to local services for effective referral and follow up for women
- Specialised positions within health to support strategic DVRS implementation and standards of practice
- Integration at all levels across mandated settings, to share responsibility for DVRS beyond PARVAN and VAN services within LHDs.
- Social and political action around DV to reduce community and service provider assumptions about DV and barriers to women accessing support, including from police; and ensuring adequate services so screening results in positive outcomes and safety for women who need it.

Attention to these areas of resources and support needs should also occur in a context of recognition of Aboriginal knowledge, cultural safety and increased system-wide shifts towards trauma-informed ways of being.



Conclusion

The findings of this project align with the literature on healthcare worker experiences of DV screening, suggesting that many of the barriers and systemic issues are ongoing. The review found that staff are committed to DVRS and engaged in practices to try to respond to DV for their clients. Unique experiences of staff across mandated settings were identified and require ongoing consideration in the context of DVRS expectations and implementation. Staff identified numerous challenges to implementation of the Policy Directive but early implementation data shows interest and engagement, with staff keen to access training and contribute to ongoing practice development. Staff are adapting practice to work towards being trauma-informed within existing contexts, as demonstrated by attention to safety and trust when engaging with women.

Staff identify numerous areas which require support within their roles and LHDs, while emphasising that DVRS occurs in a wider context of attitudes to DV, and more work is needed to ensure services are adequately resourced to respond to women disclosing Domestic Violence within healthcare. While it is not part of this review, it is also noted resourcing is required to support this work within the Ministry of Health, where currently there are no dedicated positions or funds for DVRS. However, as the Policy Directive implementation continues, there are a number of key areas identified that require ongoing support from the Ministry of Health for successful uptake of changes at an LHD, service and clinician level.

Introduction

This project is an evaluation of the implementation of the 2023 Policy Directive (PD2023_009) 'Domestic Violence Routine Screening' The policy was released by NSW Health in April, 2023 and outlines guidance and requirements to support safe implementation of DVRS and response to disclosures of domestic violence (DV). DVRS is mandated in the state of New South Wales (NSW) for all women and girls accessing NSW Health Maternity and Child and Family services, and women 16 years and over accessing Mental Health, and Alcohol and Other Drug services.

In New South Wales (NSW), the NSW Sexual Violence Plan 2022-2027 and the NSW Domestic and Family Violence Plan 2022-2027 provide the NSW Government with strategic direction to prevent and respond to domestic, family and sexual violence. These plans align with the National Plan to End Violence against Women and Children 2022-2032. They also build on the work and reforms already underway in NSW and replace previous whole-of-government strategies to address Domestic and Family Violence and Sexual Violence, which ended in December 2021. At the time of writing this report, there is renewed attention on DV at a government and community level with further funding and actions to be considered.

DVRS is one part of the way the public health system responds to DV. The policy identifies that regardless of whether DVRS is being undertaken, a health worker who suspects any client (regardless of gender) is experiencing DV must ask direct questions about the violence and respond to disclosures. Subsequently, health workers may hear about and respond to DV outside of DVRS. Health workers are expected to respond to all disclosures with respect and empathy and keep safety at the core of the response. This must always include risk assessment and safety planning and may include referrals to specialist services.

Continuous quality improvement of Health's implementation of the DVRS Program is a component of NSW and Commonwealth commitments through the NSW DFV Plan 2022-2027, NSW Health Integrated Prevention and Response to Violence, Abuse and Neglect (IPARVAN) Framework, NSW Health Strategy for Preventing and Responding to DFV 2021-2026, NSW Future Health Strategic Plan 2022-2032, and National Plan to End Violence Against Women and Children.

Health services are complex, with service delivery occurring across diverse settings. In NSW, there are 15 Local Health Districts (LHDs), nine of which cover rural and regional areas. LHDs manage public hospitals and health facilities and provide a range of health care services to defined geographical areas across the state. There are also three specialty networks covering child and paediatric services, justice health and forensic mental health services and public health services. NSW Health, directly or via LHDs also provide grants for the delivery of health services through Non-Government Organisations (NGOs) and Aboriginal Community Controlled Organisations (ACCHOs). Many of these NGO services are not mandated to undertake DVRS.

Much emphasis has been placed on the need for universal screening across healthcare settings, although research exploring how best to deliver screening and what the barriers are to effective screening is relatively limited (Ahmad et al., 2017). Routine screening has been implemented across public health services in NSW since 2003. Screening data for NSW shows varying rates of screening completion and disclosures across LHDs, settings and services. While there remain some issues in effective uptake, healthcare policy and procedures have now moved beyond emphasizing the need for screening, to considering how to best undertake screening in ways that support women.

The 2023 Policy Directive (PD) replaces an older DVRS policy and contains several significant changes. The PD requires a 4-hour training package to be mandatory for all screening clinicians and workers, which is a significant logistic and resource intensive shift for Local Health Districts (LHDs). Historically, DVRS training has been encouraged but optional for health workers and delivered by LHDs, local educators and other organisations and supported by a train the trainer course delivered by the NSW Health Education Centre Against Violence (ECAV). Since the release of the PD, ECAV and LHDs have commenced a 'train the trainer' approach to skill up nominated staff in delivering this DVRS training locally. In line with the Policy, ECAV significantly updated their training with the addition of a 1-day course to prepare staff to facilitate DVRS training in their LHDs. This can be attended online or face-to-face and covers the DVRS PD and use of the tool, as well as preparing staff to deliver the content. The subsequent staff training remains a 4-hour course.

Other key changes in the 2023 policy include updated guidance on: the age of children whose presence screening can occur in, the required verbatim preamble wording, advice on sharing information with NSW Police, the need for initial risk assessment and safety planning when responding to disclosures, and increased guidance and direction on information sharing in line with legislation. It is acknowledged that at the time of this review LHDs are in the early stages of implementing the processes required to support the updated PD, with some systemic delays including the implementation of the mandatory training flag in NSW Health learning systems. The data in this review examines the challenges and possibilities encountered within existing practice across the stages of DVRS, to inform ongoing implementation work. The PD identifies that DVRS involves five phases:

- delivering the domestic violence routine screening preamble;
- asking the screening questions;
- taking appropriate actions in response to the woman's answers;
- explaining and offering the domestic violence Z-card;
- documenting screening and outcomes in medical records.

Overview of the literature

DVRS is known to be an effective way of identifying DV

Across the literature, DVRS has been acknowledged as an effective way to identify DV. Routine screening normalises the process for women, familiarises staff with the process and provides consistency of practice rather than relying on individual clinical decision-making about screening. In places where DVRS isn't mandated, staff only enquire about experiences of violence when they suspect violence (Creedy et al., 2021), leading to targeting of groups and missed opportunities for support. A 2013 Cochrane review (Taft et al., 2013) found mixed evidence about the effects of routine screening, highlighting that while it leads to higher rates of disclosure referrals to specialist services remain very low, service responses are not always co-ordinated and there is minimal evidence of the effect upon violence, mental health or longer-term service engagement (Taft et al., 2013). However, an earlier systematic review (O'Reilly 2010) identified that interventions provided to pregnant women following DVRS, who have experienced DV, reduce the amount of violence experienced.

Rates of completion of DV screening vary significantly, but where DVRS is mandated completion is generally very high (Hegarty et al 2020). High rates of screening are crucial for efficacy. However, defining 'efficacy' is complicated and links to women's' experiences of the process, and the sustained effects upon their safety, wellbeing, and service usage. It is known that many women do not disclose during screening. Women largely report that screening assists with accessing support and fostering environments where DV is recognised and talked about (Gielen et al., 2000), whereas clinicians often presume efficacy to be directly linked to whether the woman leaves the relationship (Gillespie et al., 2023).

Despite high rates of completion, rates of disclosure to DVRS remain low. However, for those who do disclose or those who are considering whether to disclose, the process of screening, disclosure and response is key to the efficacy of DVRS. Screening is one aspect of DV intervention, however it is known to be most effective when undertaken by skilled staff, who have adequate understandings of the dynamics of DV and its impacts upon families, impacts of structural entrapment and the availability of resources; working in supportive environments, who feel confident enough to use their clinical decision making skills to respond sensitively and effectively to disclosures of DV (Hegarty et al., 2021) .

Across Australia DVRS in healthcare settings occurs most commonly in Maternity settings (Soh et al., 2021; Spangaro, 2007). Other settings report inconsistent rates of screening, with Mental Health services and Alcohol and Other Drugs services having much lower screening rates yet higher disclosures (Coyle et al., 2019; Cunningham et al., 2016; Fisher et al., 2020; Spangaro, 2007). Consistent screening in maternity settings is thought to be facilitated by the availability of clear guidelines and policies; managerial support; intersectoral coordination with clear referral options; trained staff with empathetic attitudes toward victim/survivors; initial and ongoing training for health workers; and a supportive and supervised environment (Colombini et al 2017).

Routine screening is an early intervention strategy

Globally, routine screening has been the most widespread domestic violence-related intervention to be introduced in health services (Hunter et al., 2017). It involves asking all women about current or recent experiences of domestic violence using a standardised set of questions, regardless of their presenting issue. Routine screening for domestic violence positions DVRS as a public health issue with health impacts, supporting staff awareness and confidence in talking about DV. In addition, it is a prevention and early intervention strategy, which allows for identification and appropriate intervention. However, DVRS can be complicated by competing priorities during assessment and intervention, mistrust of services and unclear expectations.

Currently routine screening is mandated in NSW in Maternity, Child and Family, Mental Health and Alcohol and Other Drug services. Screening is mandated in these four settings because of sustained or repeated contact with women at critical times in their lives, who may be experiencing violence. In addition, each setting has its own risks and opportunities associated with prevalence and processes. Many women access maternity and child and family health services during the perinatal period. For women experiencing violence, this may be one of the few times they build relationships with healthcare providers and have opportunities to disclose DV and seek support. There is a well-documented increased risk of violence during pregnancy and after birth; pregnancy can be the first time that women are subjected to violence and can also be a time of increased severity of violence (Lévesque et al., 2022). DV during the perinatal period is associated with adverse physical and psychological consequences for women and their children (Howard et al., 2013; Khatoon et al., 2021; Lévesque et al., 2022; Wong et al., 2023). The period after birth and throughout early parenting is also a time of increased risk and engagement with services for women, as well as an opportunity to reduce the impact of violence upon children (Bilukha et al., 2005; Carpenter & Stacks, 2009; Mueller & Tronick, 2020). The prevalence of DV in the lives of women who access AOD or Mental Health services is very high. DV is known to precipitate or exacerbate mental illness (Trevillion et al., 2014), with screening considered essential for identifying DV as a contributing factor to distress or illness (Ferrari et al., 2014). Similarly, the relationship between DV and AOD usage is complex (Macy & Goodbourn, 2012), but evidence suggests that when AOD use is involved, experiences of DV are more severe (Meyer et al., 2023). While screening in these settings is mandated, other settings may 'opt in' to screening, with approval from the Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit in the Ministry of Health.

There are some known differences in screening across the mandated settings. In a recent Australian study (Withiel et al., 2020), Child and Family Health clinicians report that their roles allow time to screen and their focus on family well-being, parenting and child development allows for meaningful screening of women and opportunities to screen safely. However, screening rates remain low due to the presence of partners or other family members, visits being dominated by parenting concerns and decreased staffing. In maternity settings, screening rates in NSW are high as DV questions are woven into the psychosocial assessment undertaken as part of routine antenatal care. However, Australian midwives also report working within oppressive and hierarchical settings where they often feel unable to advocate for women in their care, leading to moral distress (Foster et al., 2022), compassion fatigue, helplessness and fatigue from working in task-oriented ways due to time constraints and workloads (Catling et al., 2017; Catling

& Rossiter, 2020). Exploration of midwives' experiences of DVRS have identified that structures of care could better support relationships and capacity to respond to DV through continuity of care models such as such as midwifery group practice where the same midwife or small group of midwives provide ongoing care to the woman, and through personalised care (Mauri et al., 2015). Midwives identify that their relationship with women is the key factor in effective screening, but this is often compromised through disjointed care pathways and a lack of time for individual engagement. Antenatal screening is considered an optimal time point for supporting women experiencing DV, both due to the potential benefits for women and children, but also due to the healthcare interactions being commonly focused on the woman's health and wellbeing, rather than parenting (Melendez-Torres et al., 2023). Both AOD and MH services are complicated by high rates of involuntary care, and the subsequent power and coercion which can be woven into interactions. Mental Health staff report that knowledge, confidence and expectations to screen are not priorities, as treatment is focused on responding to mental illness and its symptoms (Gillespie et al., 2023). A recent meta-review of DV screening confirms that DV has rarely been incorporated as a priority in mental health services despite the critical role that violence plays in the development and experience of mental health conditions for women (Melendez-Torres et al., 2023). This supports findings from an earlier qualitative meta-synthesis which found that across studies, mental health services were reported to give little consideration to the role of DV in precipitating or exacerbating mental illness, with treatment approaches and stigma impeding responses to disclosures and resulting in inadequate actions to reduce violence (Trevillion et al., 2014). In addition, women seeking help for suicidal ideation and concurrently experiencing DV describe feeling dehumanised in services (Papas et al., 2023; Taylor, 2020). Similarly, in AOD services, there remain limited linkages between models of substance use treatment and understandings of DV, despite people impacted by both DV and substance use typically experiencing more severe symptoms, poorer treatment outcomes, and concurrent other social disadvantages (Armstrong, 2023). The relationship of DV to perinatal and lifetime mental health issues and substance use has led to calls for exploring how all mandated settings can not only screen but realign to address domestic violence and improve health outcomes for women and their children (Howard et al., 2010)

Women find screening acceptable, but may not always disclose

It is difficult to know the impact of screening on how women perceive and experience violence. While studies report high rates of acceptability of screening, there are limited recent Australian studies reporting on women's experiences of DVRS. The initial evaluation of the pilot implementation of routine screening in NSW in the early 2000s, found the overwhelming majority of women (95%) indicated they felt either 'OK' or 'relieved' about being asked questions about DV (NSW Health, 2001). The majority expressed satisfaction with the explanation given for routine questioning, the questions and the information about domestic violence which was provided to them. Spangaro et al (2010) conducted focus groups with women in NSW in 2007/2008 who had been screened in healthcare settings. They found many women who had experienced abuse chose not to disclose due to not feeling comfortable, not being sure if the abuse was serious enough to talk about, or being scared the offender would find out. For women who did disclose, for one-fifth of them it was the first time they had told anyone.

Literature across countries highlights that women's experiences of DVRS vary. While some women appreciate being asked about their experiences, others report feeling uncomfortable, nervous or unwilling to disclose abuse due to fear of implications or judgment. The responses of the clinician are key, as well as the importance of private spaces, enough time and an understanding of possible response pathways. Judgement, shame and fear can deter disclosing (Bacchus et al., 2002). Women who have experienced DV commonly report not disclosing due to uncertainty of what help is available and fears about repercussions (Lindhorst et al., 2008). However, women who experience violence and choose not to disclose have also reported still finding DVRS beneficial in helping them to feel connected, to being able to recognise DV and in creating environments where signalling of acceptability and understanding about DV is normalised (Spangaro et al., 2020). In this way, the benefits of DVRS are hard to measure as they may not correlate to disclosure.

In a recent Australian study in maternity settings, highly clinical interactions and feeling judged about their relationships impeded women's sense of safety to discuss DV (Branjerdporn et al., 2023). Intersectional stigma was also identified as an issue, with a sense that existing vulnerabilities (such as substance use) would impact how clinicians would react to disclosures of DV (Branjerdporn et al., 2023). This aligns to recognition across the literature about the impact of staff attitudes and understandings of DV on screening. It may also reflect implicit biases within services around 'vulnerability' and who is 'at risk' of DV (Broughton et al., 2022). Women in a regional antenatal setting in Queensland similarly reported being 'put off' from screening by a lack of trust, bluntness of clinicians, feeling disrespected and a fear of child protection services being informed (Creedy et al., 2020)

A qualitative study in America found (Dichter et al., 2020) that older women experience parallel experiences to that of younger women including shame and embarrassment about their experiences of DV, a lack of trust in healthcare clinicians, concerns about privacy and safety, and a perception that questions are only asked out of obligation. The authors observe that older women may be 'more private' about disclosing, may feel stigma about experiencing DV at their age or may have more complicated financial and family ties to the perpetrator. Women reported being more comfortable when interactions were warm and friendly, and undertaken by women. Across the literature, trust is identified to play a significant role in women's willingness to disclose. Fear for their own safety and the safety of their children or infants can discourage women from disclosing. Women have reported feeling helpless about DV, sensing clinicians' discomfort or lack of understanding, as well as fear of being disbelieved or making their situation worse (Poreddi et al., 2021). Across healthcare settings awareness of time constraints, lack of privacy, and the absence of a trusting relationship with healthcare providers are repeatedly noted to hinder effective screening.

Women may also face internal barriers to disclosure, such as shame, trauma and a lack of trust or safety in care (J. Spangaro et al., 2016). Culture and associated attitudes towards DV can also impact how women respond to screening questions. For some women, screening is an empowering process that validates experiences and forms a crucial step in accessing support services. Positive experiences with screening are known to encourage women to seek help and support, whereas negative experiences may lead to a reluctance to engage with healthcare providers or other support services in the future.

Concerns about child protection responses impede disclosures

Where DV is disclosed or identified, health workers are required to assess and respond to risk. As mandatory reporters under the *Children and Young Persons (Care and Protection) Act 1998* (NSW), they are also required to address safety, health and wellbeing concerns for children and young people. However, the DVRS policy is clear that responses to disclosures of DV should assist women to continue to care for their children in safer environments where possible, and that reporting of child protection concerns in itself will not assure safety.

While children are present in the lives of many women who access MH, AOD, Maternity and CFH settings, there is limited focus on children and DV in the literature (Hooker et al., 2012). This is despite awareness of the challenges that arise between requirements for mandatory reporting of children at risk and commitments to agency and empowerment around consent for women experiencing DV (Hooker et al., 2012). It has been identified that fear of child protection service involvement impedes women's ability and willingness to disclose DV upon screening (Postmus, 2004).

Many women whose children experience DV support mandatory reporting when notifications are made transparently and collaboratively (Spangaro, 2017). Collaborative and respectful assessment is needed to support any report to child protection services, with a focus on violence rather than the women's capacity to protect their child (Spangaro, 2017). A recent meta-review identified that while child maltreatment often co-occurs with experiences of DV, most countries' protocols are inadequate in ensuring the safety of children is prioritised within DV interventions (Melendez-Torres et al., 2023). A recent qualitative synthesis identified that disclosures are impeded by women's fear of being labelled as bad parents for staying with perpetrators (Papas et al., 2023). For staff, tensions between their desire and need to promote trust, and limited confidentiality due to the need to report children at risk of harm, is a complex problem that can create moral tension (Spangaro et al., 2011)

Staff experience barriers to screening

There is a lot of research about staff experiences of screening, although it is largely from settings where screening is not mandated. Screening is known to not always be effective or sensitive (Durham-Pressley et al., 2018). Barriers to screening in health services have consistently been found to be time constraints, lack of confidence and knowledge, competing priorities, discomfort of clinicians or worry about causing offence, and a lack of services to refer to (Branjerdporn et al., 2023; Sprague et al., 2017). Staff who regularly screen have been reported to have more positive attitudes to screening (Alvarez et al., 2017). In a recent Australian qualitative study of staff in mental health services, all participants described inconsistent or inadequate access to training leading to a lack of confidence and skills in screening and responding adequately to DV (Gillespie et al., 2023).

Across settings there are staff who are skilled, committed and effective in undertaking DVRS. However, the literature also highlights that some staff in mental health services hold attitudes to DV that impede screening, a lack of awareness of basic safety requirements in screening processes and a lack of cultural competency (Gillespie et al 2023; Cleak et al 2020). Some staff in child and family services report being unprepared, not knowing what to say or what resources are available in the community and not being confident assessing danger or safety planning

(Burnett et al., 2021). Some staff in maternity settings report fears of 'opening a can of worms', and conflicts when engaging with both the victim/survivor and the perpetrator (Usanov et al., 2023). Hegarty et al 2020 (Hegarty et al., 2020) found 4 themes illustrating what staff in antenatal settings in Australia require to undertake women-centred DV screening: experience to build confidence, having the support of their team, being clear on their role and expectations and training, mentoring and support in responding. In the same study, systemic supports identified as required included clear policies, sufficient time, access to services, capacity to respond to disclosures, continuity of care, effective documentation and electronic systems, safe and private environments and bilingual responsiveness through bilingual workers and trained interpreters.

It is also important to recognise that DVRS is one intervention within a wide range of service interventions delivered within a broader global context of increased demand, reduced resources and lack of access to supervision. Resourcing, training, timing and supervision challenges related to delivery of DVRS also apply to other aspects of service delivery across settings. DVRS is not the cause or primary cause of workplace stress for staff but occurs in a wider context of a general lack of resources and recognition, minimal clinical supervision and support and compromised workplace safety.

A lot is known about barriers to screening, but less about optimal practice

A lot is known about barriers to screening. The most commonly cited barrier is a lack of training and education about DV, as well as a lack of support, services to refer to or confidence to respond appropriately (Kirk & Bezzant, 2020). Screening is known to be impacted by a lack of private spaces, the presence of support people, a lack of time and adequate services (Alvarez et al., 2017), as well as language barriers, cultural barriers, a lack of skill or empathy on the part of the clinician and fear and stigma (Andreu-Pejó et al., 2022). A lack of processes for responding to disclosures is known to impact upon effective screening, including a lack of available services to refer to and a lack of interventions to enact within existing care (Burnett et al., 2021). Critical literature identifies a need to focus not only on disclosures of DV as a crisis to be managed in the moment, but to ensure any response also includes strengths-focused approaches to supporting women in addressing the long-term effects of violence on multiple aspects of their lives (Broughton et al., 2022). Purpose developed education programs have been positively received by participants, increasing confidence, awareness, knowledge and skills (Kirk & Bezzant, 2020)

Despite a focus on barriers to screening, much less is known about optimal practices for screening or response (Correa et al., 2020). In one American study, women describe listening, eye contact and empathy to enhance rapport as essential, with sincerity and interest also noted to be crucial, as well as explaining possible actions prior to screening to enhance trustworthiness (Correa et al., 2020). Women have also suggested that staff should be gentle, friendly, sensitive and conversational in their enquiries (Branjerdporn et al., 2023). An observational study of DVRS in child welfare services identified predictable ways in which interactions between staff and women about DV went awry (Lindhorst et al., 2008). They found that when frontline workers ask about DV, the majority use ineffective screening strategies that restrict the likelihood that women will disclose DV. These include asking the questions in ways that are easily not answered or experienced as minimising, filling in documentation without asking the

questions in a meaningful way, failing to build rapport prior to asking, or failing to adequately ensure and explain confidentiality. Conversely, more effective interactions are observed to demonstrate sensitivity to the experiences of fear and threat commonly involved in domestic violence. Similarly a meta-review of strategies for DVRS identified that effective identification occurs as "sparking a transformative moment of trust in the patient-clinician relationship" (Melendez-Torres et al., 2023, p1464).

Giving out educational materials is considered important in DVRS as it allows women to consider seeking support later. In New South Wales, staff have historically reported under-distribution of Z-cards due to supply levels and a lack of procedural guidance. It is recognised Z-cards are more used when they are explained, not just included in information packs (Spangaro et al., 2010), however, any written materials must be given safely so women are aware they have them and can make choices about taking them home.

Following screening and positive disclosures, risk and safety assessment are required to evaluate risk of further harm, protective factors and determine actions. Processes of screening and risk assessment are distinct, and risk assessment itself requires skills, knowledge and confidence, including awareness that leaving an abusive relationship may not always be the safest option (Spangaro, 2017). Remaining in a relationship where there is DV may allow women to better monitor risk, protect children and increase safety, as separation is a known time of escalating lethality, systems abuse and harms for children. Less is known about how staff can best support women who are not currently planning to leave an abusive situation.

Staff may have their own personal experiences of DV

Healthcare workers are known to experience DFV at higher rates than the general population in their own lives which may impact upon delivery of DVRS. A 2018 study in Victoria identified a lifetime prevalence rate of 45% amongst female healthcare workers, with 11.5% of responders experiencing DV in the last year (McLindon et al., 2018). This compares to Australian Bureau of Statistics estimates of 27% lifetime exposure to DV amongst Australian women (ABS, 2023). Similar prevalence rates have been reported across studies, with a recent meta-analysis reporting lifetime prevalence rates of 40% for female healthcare workers (Dheensa et al., 2023). There has been little research about how personal experiences of DV impact upon healthcare professionals' ability and confidence in dealing with disclosures (McGregor et al., 2016), although it is presumed to impact (Dheensa et al., 2023). Engagement in DVRS increases staff's overall awareness of dynamics of DV, leading to more willingness to intervene with friends and neighbours experiencing violence (Spangaro et al., 2011). Being aware of staff experiences of DV is crucial in devising approaches to screening implementation, including acknowledging the impact of personal experiences within training and education sessions and ensuring clear pathways of support for staff (Kirk & Bezzant, 2020). There is also a need to understand how patriarchal systems of healthcare may create a context where staff experiences of DV are silenced (McGregor et al., 2016), this includes through staff lived experiences being overtly obscured, minimised or penalised as well as silenced through implication, stigma and discouragement.

The efficacy of DVRS is impacted by cultural norms

The 2023 Policy Directive identifies that DVRS should be undertaken in culturally safe ways, in particular recognising the loss, grief and intergenerational trauma experienced by Aboriginal women due to colonisation and enforced by policies and practices within health facilities in Australia. The need for culturally safe spaces for screening and the expertise of Aboriginal Health workers is also emphasised.

First Nations women, and migrant or refugee women, experience magnified distrust in healthcare providers and systems (Papas et al., 2023), with Aboriginal women reporting concerns about reports to child protection services about DV in families, due to historical and ongoing overrepresentation of Aboriginal children in out-of-home care (Spangaro, 2017). Alongside First Nations women, women from migrant and refugee backgrounds may also be particularly vulnerable to sustained negative effects of DV (Gharfournia & Easteal, 2018), with minimal culturally safe services noted (Gillespie et al., 2023).

The efficacy of DVRS is impacted by cultural norms. For example a study in Pakistan identified that DV is often considered a private family issue, with recommendations that any support be inclusive of the entire extended family (McCauley et al., 2017) and a study based in India identified that worries about losing family support or social standing could lead women to tolerate DV (Purbarrar et al., 2023). Women in Lebanon report challenges in balancing their own wellbeing with family preservation and loyalty, however report that screening within healthcare contexts is acceptable (Usta et al., 2012). It is important to recognise however, that generalisations about cultural beliefs don't equate to cultural sensitivity or humility. A cultural humility approach requires self-reflexivity, recognition of victim/survivors' lived expertise, willingness to sharing power with people accessing care, and awareness of stereotypes, structural racism and stigma (Lekas et al., 2020). Despite widespread recognition of the relationship of culture to DV responses, disclosures and experiences, a recent overview of reviews on DVRS identified a lack of exploration of how culture impacts upon screening, calling for urgent attention to this to inform clinical practice (Melendez-Torres et al., 2023). Healthcare workers report being very aware that culture impacts upon experiences and understanding of DV, including attitudes to screening, but being less sure how to accommodate for this within screening or how to provide culturally safe resources (Usanov et al., 2023). Many concerns identified in research with migrant and refugee communities, such as the need to consider the whole family in service responses or fear of losing family support, are likely relevant across cultures, thus while cultural awareness is indicated, cultural humility or safety is a flexible practice which benefits all.

Domestic Violence is a form of trauma

DV is the most common form of violence experienced by women in Australia, and the impact of DV may lead to interpersonal trauma, impacting upon people's sense of self, safety, and the world. There are links between experiences of DV and trauma diagnoses such as Post Traumatic Stress Disorder (PTSD) and Complex PSTD (CPTSD), documented across studies. Previous experiences of trauma prior to experiences of DV compound the risk of PTSD, and the extent, severity and type of violence correlate to symptom severity. The experiences of women who experience DV were pivotal in Judith Herman's original identification of CPTSD. CPTSD describes the effects

of prolonged and repeated trauma in situations of 'captivity'; Herman (1992) detailed the often unseen 'captivity' that can occur in domestic relationships where physical barriers are replaced with economic, social, psychological, legal subordination and control, as well as dependency, leading to long-term impacts on relationships, self-concept and emotional regulation. Experiencing repeated interpersonal violence as is commonly experienced in DV, can lead to CPSTD (Salter et al., 2020).

Trauma associated with DV can be intersectional. Aboriginal women are 35 times more likely to require hospital care from DV and 10 times more likely to be killed by an abusive partner than non-Aboriginal women, yet they are also less likely to seek help due to persistent systemic racism (Spangaro & Ruane, 2014). People from culturally diverse backgrounds or from gender or sexually diverse communities, are also at increased risk. A review of the prevalence of DV among people experiencing mental health issues estimated that the risk of DV was four times more likely for people who experienced anxiety disorders, and seven times more likely for people experiencing symptoms of PTSD (Trevillion et al., 2012). A recent Australian study identified that 48% of women with serious mental illness have experienced DV and are 3 times more likely to report violence than the general pregnant population (Suparare et al., 2020). Research also consistently demonstrates that women accessing AOD services have extremely high rates of DV, with a recent narrative review identifying rates of between 24-75% (Mehr et al., 2023). A qualitative study in America found that establishing safety and trust in DV screening can be impeded by people's interactions with other systems, with refugee status, cultural or linguistic diversity or other systemic disempowerments all contributing to understandable mistrust and feelings of powerlessness that impede disclosure (Critelli & Yalim, 2020).

Feminist theorists and practitioners who have advocated for DVRS have also been pivotal in advocating and shifting understandings of trauma, repositioning trauma from being a personal deficit to occurring in a context of systemic and social invalidation, exclusion and silencing (Herman, 1992). Feminist theory has contributed to understanding the complexity of trauma occurring in interpersonal relationships and the interwoven nature of power and, in part, contributed to modern diagnostics of trauma (Brown, 2017). The principles of feminist practice overlap with emerging ideas of Trauma-Informed care (Pemberton & Loeb, 2020). While the discourse of 'trauma-informed' has emerged across healthcare in the last 25 years, DV services and advocates have been establishing shelters and crisis services for victim/survivors for decades, built on understandings of trauma and advocating for social awareness and victim/survivor rights, without explicitly using the language of 'trauma-informed' (Maracek, 1999; Funstan, 2019).

Not much is known about whether DVRS is currently undertaken in Trauma-Informed ways

Trauma-informed care (TIC) is a way of delivering care that is underpinned by knowledge about, awareness of, and sensitivity to trauma. Being trauma-informed is a way of approaching care with sensitivity to the possibility of trauma, active efforts to reduce retraumatisation or iatrogenic trauma and consideration of what is required to foster safety within care. The principles of TIC vary across resources but were initially defined as Safety, Choice,

Collaboration, Empowerment and Trustworthiness (Harris & Fallot, 2001). Entwined within these is recognition of aspects of culture, history, identity and gender which can increase the likelihood of trauma, intersect with experiences of trauma or impact upon people's experiences within care and service. Increasingly, services are working towards being trauma informed across settings. In 2023, PARVAN released the Integrated Trauma Informed Care Framework. The framework guides system-wide change to ensure that children, young people, their families and carers, as well as staff within NSW Health, experience trauma-informed, integrated care.

There are increasing calls for DVRS to be undertaken in trauma informed ways, including within the 2023 Policy Directive. Yet very little is known about whether this occurs and in what ways. To be trauma-informed in delivering DVRS requires application of the principles, underpinned by an understanding of trauma and its impacts.

Staff across health services have reported challenges in implementing trauma informed care, including in perinatal, mental health and drug and alcohol settings eg. (Huo et al., 2023; Kirst et al., 2017; Lovell et al., 2022; O'Dwyer et al., 2021; Sperlich et al., 2017). Trauma-informed DVRS requires empathic screening with attention to relationship building between staff and women and efforts to reduce the risk of re-traumatization, as well as offering appropriate interventions (Gillespie et al., 2023). Integrating the principles of trauma-informed care to DV related practices across settings is thought to enable services to better meet the needs of women (Critelli & Yalim, 2020), with trauma-informed principles directly relevant to engaging with victim/survivors, with recognition of intersectionality also crucial (Critelli & Yalim, 2020). Through a trauma-informed approach, staff can recognise the ways in which trauma can impact upon engagement, change and behaviour, while also helping women recognise these experiences, normalise them and support self-regulation (Sullivan et al., 2018). A critical narrative review by Wathen & Mantler (2022) identified that clinicians, organizations, and systems must prioritise viewing the complex and lasting impacts of DV through a trauma informed lens, to ensure opportunities are not missed to provide effective services, and risk causing further harm.

Part of a trauma-informed approach is reducing retraumatisation or iatrogenic harm occurring in care. This requires awareness of the possible harms associated with DVRS such as shame, guilt, loss of safety, distress about disclosure, invalidation, further harm or secondary social disadvantages such as impacts on housing or finances (O'Campo et al., 2011). These harms may not be emphasised in mandatory screening settings as they discourage uptake. Conversely, caution is also needed to ensure that using a trauma informed lens does not embed assumptions about the likely impacts of historical trauma for specific individuals and communities at the expense of considering current trauma, or an excessive focus on discussing or highlighting trauma in interactions, which can trigger shame and disengagement (Armstrong, 2023). At times the intent of interactions can appear to be in tension with focusing on trauma and historical events. For example, in AOD services, staff have expressed concerns that if services are not set up to address trauma in safe and effective ways, talking about trauma may derail recovery (Armstrong, 2023). However, staff are aware that addressing the impacts of trauma is crucial for addressing AOD use. Within trauma informed approaches, there are pushes to focus less on individuals and their trauma experiences, to allow for consideration of wider systemic factors that shape and enable traumatic experiences and present barriers to prevention and care which make it difficult to effectively meet the needs of victim/survivors (Wathen & Mantler,

2022). Wathen & Mantler advocate for ecological approaches to DV policy which are resourced and sustained to address complexity, ideally by being embedded into existing systems of care. However, alongside systemic approaches, clinicians, services and women still require awareness of processes, interactions, interventions and environments and how they may impact upon individuals who have experienced trauma (SAMHSA, 2014). Regardless of organisational approaches, literature in the DV sector identifies the need for individual clinicians to employ the principles of TIC with a particular focus on relational safety and choice (Anyikwa, 2016).

On an individual level TIC requires understanding of the diverse nature of traumatic responses, sensitivity to the need for increased attention on establishing safety and trust within interactions, and attunement to signs that someone is experiencing an interaction as retraumatizing (Isobel, 2021). Where clinicians inappropriately respond to disclosures of DV, this can in itself be retraumatising (Melendez-Torres et al., 2023). For many women, disclosing DV can be an important step to ending abuse, as it breaks isolation (which is commonly a tactic of abuse) and provides opportunities for validation, information, and access to services (Spangaro et al., 2010). The responses of staff are therefore critical. In addition, acknowledging, responding to, and reducing staff experiences of vicarious trauma or re-traumatisation are also key parts of any movement towards trauma informed care.

Approaches to recognising and addressing violence in health services are shifting from focusing purely on interventions for and by individuals, to broader conceptualisations of DV and other forms of gender-based violence as pervasive social problems embedded in structural inequities (Wathen & Mantler, 2022). Policies in Australia have begun to shift towards addressing prevention of DV at social, attitudinal and cultural levels, driven by literature that identifies culture as a primary determinant of DV, and a need for associated structural change to reduce systems and cultural norms which condone violence against women (Kuskoff & Parsell, 2020). As part of shifts towards identifying social, cultural and structural factors which oppress women or sustain rates of DV, there is a push to also shift the responsibility for change away from individual or collective women and to position 'the problem' within the sphere of men who use violence and the cultural structures of masculinity which support this (Kuskoff & Parsell, 2020; Salter, 2016). Within trauma-informed movements there is subsequently suggestions of the need to use the language of 'trauma and violence informed care'. Including the term 'violence' expands the concept from the individual effects to also the precipitating actions, and repositions circumstances of systemic and interpersonal inequities and violence as forefront (Wathen & Mantler, 2022). 'Trauma and Violence Informed care' highlights the responsibility of services and clinicians to hold a socio-ecological perspective of health and wellbeing and deliver equitable care that reduces the burden on individuals to have to advocate for their own needs to be recognised and met. Violence-informed care has been driven by many First Nations groups around the world to counteract western notions of trauma as an individual experience (Cullen et al., 2020). To centralise violence alongside trauma is to recognise the holistic, communal, transgenerational and structural impacts of inequality, social disadvantage and abuse (Cullen et al., 2020). Violence-informed care has also contributed to recognition of the need for services to also focus effort on engaging and working with perpetrators for accountability and responsibility (Scott & Jenney, 2023). Engaging a 'Trauma and Violence Informed' lens in DVRS, allows for people's responses to trauma and violence, which may include substance use or mental health challenges, to be considered predictable consequences

of events, inequities and circumstances. While this review uses the language of 'Trauma-Informed' in line with local policy, the importance of centralising violence is acknowledged.

It is also acknowledged that 'Integration' is important as part of shifts towards being Trauma Informed, in line with the PARVAN Integrated Trauma Informed Care Framework.

The Review

This DVRS implementation review intends to better understand motivations, barriers and enablers to clinicians across settings being able to screen and respond to women in accessible and trauma informed ways through exploring experiences of current practice. Findings will inform how the MoH, ECAV and LHDs can best provide workforce support resources to ensure effective DVRS implementation and response. This report focuses on the experiences of staff and notably does not include the experiences of women being screened, who are acknowledged to likely have diverse and differing experiences of the screening process.

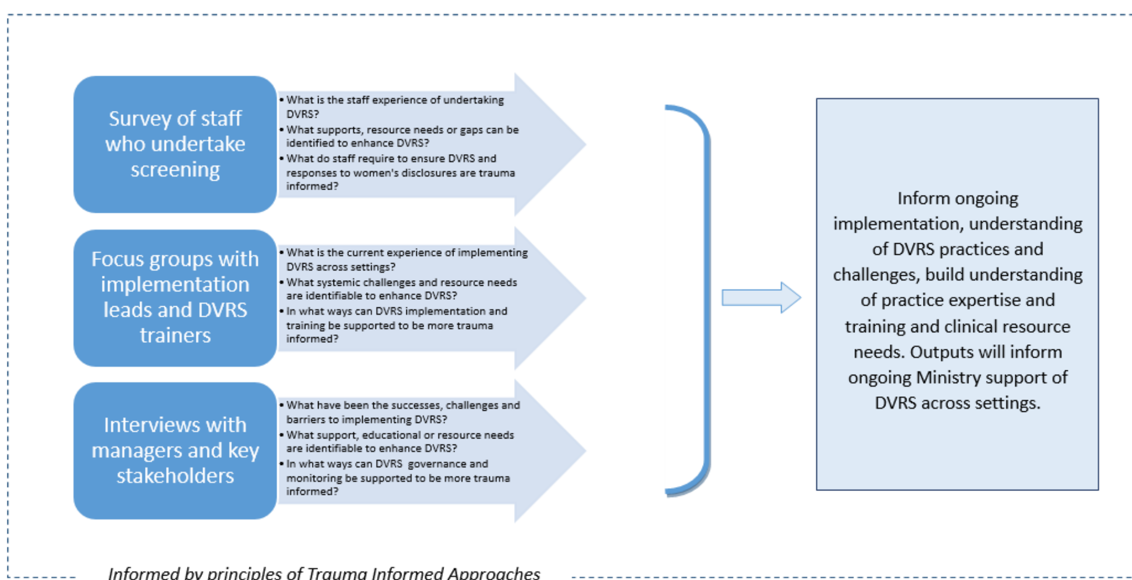
The guiding evaluation questions were:

- What are the experiences of clinicians in screening and responding to DV in mandated settings?
- In what ways are clinicians undertaking screening guided by trauma informed principles?
- What resources and support needs are identifiable to improve the quality of DVRS across mandated services?

Method

A participatory approach was used, engaging with stakeholders across the policy context. A qualitative approach was used to centralise the experiences of individuals, and to facilitate exploration and understanding. A Project Advisory Group was established with representatives from across LHDs and associated services and met regularly throughout the project. Data was collected via consultation with identified LHDs, a purpose-developed statewide staff survey, targeted focus groups and interviews across two exemplar LHDs and two mandated settings.

Figure 1. Evaluation Design



Data sources in participatory approach evaluation are led by asking the question, '*Who should be involved, why and how?*' (UNICEF, 2014, p1).

Table 1: Who should be involved and why?

Data source	Who should be involved, why and how?
Survey	All staff across NSW who undertake mandatory screening in the identified settings should have a chance to contribute to the review. A survey requires minimal clinical time, can be rolled out widely over a short time period and provides an anonymous and voluntary way for staff to participate. Emails via service directors allowed any interested staff to participate.
Focus Groups	To better understand the experiences, challenges and opportunities of current practice, detailed qualitative data was required from a selection of people who undertake screening. Focus Groups allowed for in-depth data, collegial safety and the opportunity to hear shared and differing perspectives from staff in rural/regional and metro sites. Collaboration with LHD leads allowed for purposive sampling of staff who undertake screening.
Interviews	Stakeholders who hold unique autonomous positions (such as educators or managers) bring unique perspectives on the challenges of preparing, mandating and supporting staff to undertake screening. In depth individual interviews provided a private and de-identified space to gather these experiences. Specific roles and individuals were invited to participate by the research team.

Data collection was preceded by a period of exploring current practices, governance and structures of DVRS in the identified settings.

Trauma-informed considerations

The review was undertaken in line with the principles of trauma informed care and in acknowledgment of the high rates of primary, secondary and vicarious trauma in the lives of healthcare workers. Trauma-informed research approaches are an emerging field that recognises the need for both the design and processes of research to be sensitive to trauma, especially when participants are likely to have experienced trauma in their personal or professional lives. Trauma-informed approaches to research build on existing ethical and methodological guidelines to consider why research is being undertaken, who undertakes it, who participates and who may benefit, alongside active consideration of the principles at each stage (Isobel 2021).

In this review, being trauma-informed required attention to how and where data was gathered, how staff experienced the process of interview or focus group and how data was managed and presented. The external researcher mediated the space between the Ministry and participating clinicians, and the Advisory Group also supported processes of LHD engagement to minimise power dynamics influencing LHD participation. Transparent information was provided about the scope and focus of the review. When appropriate, the sharing of traumatic material was discussed as part of data collection, with attention to not silencing participants while still ensuring a safe enough

space for all participants, the researchers and victim/survivors. Care has also been taken in the writing of this report not to identify individual staff members or teams, and to not include identifying or traumatic stories of women's experiences of violence.

While it is desirable to include members of the community impacted by policy in any review of its implementation, a collaborative decision was been made to first work closely with LHDs and clinicians to understand the provider context of the policy framework, before moving to exploring the impacts of DVRS upon women. This approach reduces burden on victim/survivors and focuses the scope of the review upon improving clinical practice within services. Issues of cultural sensitivity and humility were also discussed as part of the consultation about the design of the review and were further discussed with any participating Aboriginal specific service.

Participating sites

Participating sites were identified with the Project Advisory Group, based on the variety of services available and engagement of staff. Participating LHD sites were chosen to include an urban and regional area. The identified LHDs, Southern NSW LHD and South Western Sydney LHD, represent two large and diverse populations with high rates of screening and disclosures. Within these LHDs, Maternity and AOD services were identified as the initial focus as these services have contact with women at varying stages of life, and wide variations in screening compliance and quality.

At both sites, Aboriginal Health Workers and managers were engaged in project planning, with Aboriginal Maternal and Infant Health Services (AMIHS) and Aboriginal Health Workers subsequently proactively engaged in the project. AMIHS support pregnant women, their families and community through delivering culturally safe services. AMIHS are positioned in LHDs across NSW and are funded by NSW Health. AMIHS build on universal maternity services that are available in NSW, through innovative collaborations with Aboriginal Health Workers, Aboriginal midwives and mainstream services to make services more accessible and appropriate for Aboriginal women (Best, 2011). Aboriginal Health Workers are employed across sites and services and provide culturally-sensitive care to Aboriginal people accessing mainstream services, including conducting DVRS.

Initial meetings with managers and service leads in the participating districts and streams were held in February 2024. These meetings sought to introduce the project, introduce how DVRS is occurring in each setting and organise ongoing pathways of engagement. While focus groups and interviews occurred across both sites, the data is presented in a collated format. The purpose of the review was not to compare across LHDs nor monitor compliance with screening, but to use the experiences of two large and diverse LHDs to inform policy and practice. Where specific details were shared about the rural or urban experience these are noted, but otherwise data is not identified in relation to which service, team or LHD it came from. Participants from the sites are detailed in Table 2.

Data from all sources was thematically analysed, triangulated and synthesised to form a nuanced understanding of the challenges, possibilities, achievements and gaps in current DVRS practice. An inductive approach was used involving immersion in the data and determining patterns across the data and synthesis of findings in the context of

wider literature and the project design. Survey responses were incorporated in the findings, including those from other settings outside of AOD and Maternity. Findings were discussed with the project group to generate Key Messages, with actions to be subsequently developed by the Ministry of Health.

Table 2: Participants from across sites

Source	Recruitment	Participants
Interviews	Undertaken with staff identified initially through service leads as holding positions related to DVRS or supporting DVRS training or processes. This also included staff who undertake screening in autonomous or specialty roles. Emails were sent through LHD leads by the external researcher, offering opportunities to participate. Interviews were held face to face and via zoom during March and April 2024.	12 individual in-depth interviews 6 in SNSWLHD, 5 in SWSLHD, 1 with ECAV 6 maternity staff, including social workers, AIMHS workers and senior midwives 4 VAN staff and 1 ECAV educator 1 AOD manager
Focus groups	Focus Groups were arranged at key sites across LHDs where the most staff who screen would be likely to attend. Staff were invited by local managers and executive to attend. Guidance was sought from individual services about who should be invited. Focus groups were held face to face and via zoom during March and April 2024.	4 held in SWSLHD 4 held in SNSWLHD 5 in AOD services, 2 in Maternity, 1 with trainers Between 3-16 participants at each group with a total of 67 participants Variety of professions including Midwives, Doctors, Social Workers, Nurses, Educators, Aboriginal Health Workers and AOD workers.
Survey	The survey was established in REDCAP with the link disseminated through existing committees and Ministry relationships with LHD and stream leads. The survey was open for 6 weeks through March and April 2024.	126 staff members responded from across Maternity (22.4%), AOD (32%), Mental Health (9.6%), Child and Family Health (26.4%), VAN (5.6%), and Other health settings (5, 4.0%) 85% undertook DVRS in their roles with the other supporting DVRS rollout in other ways. 78% were familiar with the 2023 policy framework.

Southern NSW (SNSWLHD)

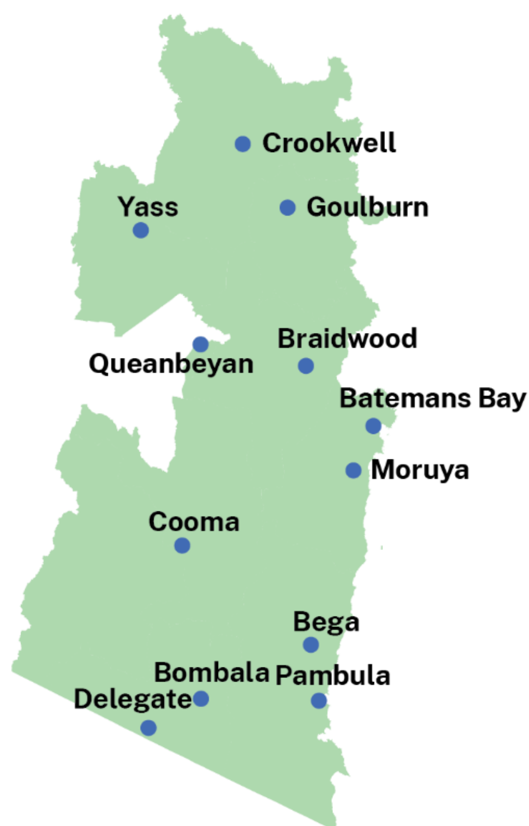


image from https://www.health.nsw.gov.au/lhd/Pages/snswlhd.aspx

SNSWLHD services the communities across south-east NSW, on the land of the Gundungurra, Ngambri, Ngarigo, Ngunnawal and Yuin peoples, covering 44,534 square metres across the South Coast, Southern Tablelands, Great Dividing Range, and Snowy Mountains. In 2019 the estimated population was 211,122 residents projected to increase to 211,617 by 2031.

Southern NSW has antenatal services across 5 hospitals (Bega, Cooma, Moruya, Queanbeayan and Goulburn). Queanbeayan has the highest birth rate in the district. There is a large Aboriginal population in SNSWLHD who receive care through AMIHS alongside mainstream services. AMIHS are based at Moruya and Queanbeayan, close to the hospital. AMIHS is staffed by two Aboriginal midwives and 1 Aboriginal health worker. Senior managers report a passionate workforce with high rates of DVRS completion by midwives. Managers observe that the process is largely driven by following the tasks and documentation in e-maternity (the online documentation system) which assists with consistency and clear expectations but can lead to a de-personalised approach. There are also challenges to creating safety due to the presence of partners in the clinic.

SNSWLHD AOD services are spread across the district, with community-based teams at Eurobodalla, Bega, Goulbourn and Queanbeyan, as well as Consultation Liaison in-reach to the general hospitals, partnerships with mental health services and a MERIT program. Referrals come through other services or the centralised access line.

AOD services senior managers report high rates of DVRS but acknowledge that at times the rates may not reflect the quality of screening due to DVRS not being prioritised in services over recent years, and the complexity of client relationships. DVRS usually occurs as part of structured and comprehensive assessment processes within community teams, with ad-hoc screening occurring in specialist teams. All teams have Clinical Lead positions and small workforces. Historically AOD services were part of Mental Health services, but they separated and have developed local team cultures and practices. There is funding for the Substance Use in Pregnancy and Parenting Service (SUPPS) in SNSWLHD, but this has not yet been rolled out.

DVRS in SNSWLHD is supported locally by the Domestic and Family Violence lead. SNSWLHD identified the importance of holding focus groups across inland and coastal sites. Staff in SNSW describe a spread-out health service covering rural areas and serving a diverse population, including high rates of socioeconomic disadvantage and limited services. Many of the staff live and work within their communities.

South Western Sydney (SWSLHD)

Image from: https://www.health.nsw.gov.au/lhd/Pages/swslhd.aspx

SWSLHD services a diverse and large population across the lands of the Darug, Dharawal and Gundungurra peoples, in the Bankstown, Fairfield, Liverpool, Campbelltown and Bowral areas of South Western Sydney, including rural areas of Wollondilly and Wingecarribee. SWSLHD is the largest and fastest growing District in metropolitan Sydney, serving a socially, economically, culturally and linguistically diverse population of over 1 million people.

Stakeholders identified that in maternity services there are very high rates of DV, but these are largely not identified through DVRS. Local data reportedly suggests that approximately 6000 women are screened each quarter, with comparatively high rates of disclosure. SWSLHD has 5 maternity hospitals in Campbelltown, Liverpool, Bowral, Fairfield and Bankstown. Within the hospitals there are Aboriginal midwives or Aboriginal liaison workers who work as part of mainstream services. There are also embedded Young Parents midwives, Substance Use in Pregnancy midwives and other specialised streams. DVRS is undertaken by midwives as part of psychosocial assessment at booking in. When DV is identified, referrals are made via Safe Start to antenatal social work who provide intervention.

The majority of clients enter AOD services in SWSLHD through the centralised intake service. They have community counselling teams across sites, an inpatient withdrawal management unit (15 beds) at Fairfield Hospital, Opioid Treatment Programs at Liverpool, Bankstown and Campbelltown led by medical and nursing staff, allied health streams including court diversion, Merit and counselling services, Harm reduction services as part of district services and specialised streams including Quit for new life and a Blood Borne Virus team. Enhancement funding has led to expansion of their community youth service and establishment of an Aboriginal Health team. A new Dual Diagnosis team is also being established which will be located across inpatient and community and linked with NGO services in the community. DVRS in AOD at SWSLHD occurs at intake and assessment.

Staff in SWSLHD describe a very large, multicultural population, high rates of trauma and refugee populations, known very high rates of DV, severity of DV, and associated child protection reports. Managers also describe very high staff turnover that occurred during and after COVID-19 as South Western Sydney experienced long periods of lockdown. Staff describe that many members of the local community may not access private services and require well-established and visible public services.

What are the experiences of clinicians in screening and responding to Domestic Violence in mandated settings?

Findings are presented across the stages of DVRS with all sources of data triangulated to form an overview of staff experiences. Unique aspects of DVRS in AOD and Maternity settings are reported separately. LHDs, teams and locations are not identified and where necessary, roles are generalised to ensure the confidentiality of the participants. Illustrative quotes are used throughout to ensure the findings elevate the voices of the staff and stay close to their intended meaning. Throughout this project, staff engaged enthusiastically and earnestly in conversations about DVRS. The focus groups, interviews and survey data reveal complex understandings and practices occurring across DVRS in New South Wales. Staff describe awareness of the importance of asking about and responding to DV within their work and appear committed to undertaking DVRS. The completion of DVRS occurs despite very large and diverse workforces of many thousands of staff members undertaking it, without the

consistent provision of training until recently, and in context of their own attitudes, beliefs and experiences of violence.

Staff across services, contexts and geographical areas express differing and conflicting understandings of the intent and expectations of DVRS, alongside consistent commitments to try to support women in ways that support safety for both the screener and the screened. Existing knowledge and gaps in knowledge about how they do this are articulated and DVRS is widely acknowledged to exist in a broader context of role expectations, attitudes, knowledge, capacity and service availability.

Acknowledging Aboriginal knowledge of trauma informed ways of being

In gathering the data to inform this work, the knowledge and wisdom that Aboriginal clinicians and workers held about the challenges and possibilities of navigating screening for violence within mainstream health services became apparent. While this knowledge is woven throughout the findings, it is also important to front-end these findings with overt acknowledgment of the longstanding knowledge of trauma and resilience held within Aboriginal communities in Australia, and the work being done daily by Aboriginal health workers, midwives and clinicians working across LHDS and services to support women and families, including in situations of domestic violence.

Contextualising DVRS in practice

Staff across LHDs and services describe, and display, complexity and nuance embedded in DVRS practice. This relates to the power dynamics inherent in healthcare, their own understandings of DV and its dynamics, and practicalities of service delivery. Staff are familiar with DVRS and undertake it routinely. While some services experience numerous challenges around DVRS, others report it to be well-established and identify minimal difficulties.

"It's done most of the time…our rates are quite high for screening and everyone kinda knows it needs to be done and are doing it …we're doing it, doing it well and documenting it" AOD Manager

Awareness of the new policy has largely not yet reached frontline staff

At the time of data collection for this review, the DVRS policy is in the early stages of being rolled out across the LHDs. While VAN staff are very engaged with new policy and describe in detail the implementation plans and steps, changes have not yet filtered down to clinical teams. Many staff are unaware of the policy and have no familiarity with any changes associated with its rollout. Subsequently, the experiences documented herein inform a baseline understanding of DVRS practice prior to the PD, with some pockets of change observable where training has been commenced or implementation strategically commenced.

"Is there a new policy?... I better look that up!" Midwife

Staff in VAN services describe the policy as very helpful and well-received. VAN staff identify that they were keen for clear articulation of updated practice expectations, including to support staff to respond to disclosures. While VAN staff acknowledge some challenges in implementation of even minor changes in LHDs generally, they have largely found the policy guidance clear and helpful. Challenges from a VAN perspective remain largely around

implementation, engaging the large workforces in even small shifts and the practicalities of rolling out mandatory training.

"So DVRS is a great opportunity for us to upskill workers across the 4 mandated areas, but also to use that momentum to upskill workers in other areas as well… It is sort of like starting afresh with the new policy" VAN worker

Staff aren't always clear on the purpose of DVRS

Staff across AOD and maternity display varying understandings of the purpose of DVRS, not always understanding its connection to keeping women safe. Some feel it serves a data collection purpose for the Ministry of Health and is not expected to alter outcomes for individual women, while others want DVRS to facilitate opportunities for direct support and crisis response for women. These differing understandings of the intent of DVRS impact staff investment in the process. A lack of investment in DVRS does not represent a lack of understanding of the importance of asking about DV and providing support, but rather a resistance to mandated screening at set time points. For example, some staff in AOD settings retrospectively complete the DVRS based on information known about their clients, to ensure data accurately represents their client population and because they ask questions about DV without having the tool available.

Some staff express confusion about who they should screen and who they shouldn't. While staff are clear that they are required to screen women and do so routinely, many raise questions about why men or non-binary people aren't required to be screened. In AOD services, some staff report only screening women they are concerned for, whereas in maternity, the questions are asked of all women. Many staff feel that current DVRS is limiting in its focus on women and intimate relationships, but are also unsure if that is purposeful. This leads staff to question whether the scope should be expanded to diverse relationships, including family violence, and to screening across genders. This topic was passionately debated at a number of focus groups, with staff who had attended recent DVRS training seemingly best able to justify the focus to their peers.

Many staff see DVRS as a moment in time that can facilitate support, especially in maternity settings. Staff understand the importance of mandated screening and largely do not question its merits, but identify a need for wider attention on the actions and services required to support women over time and to support staff in their work with women. At times staff express frustration at the focus on DVRS, including in this review, as they identify a need for support throughout their engagement with clients, regardless of initial assessment, and a need for increased services to refer women to. Staff are frustrated by a focus on screening if there are limited supports or services able to be provided.

"Everyone gets screened when they come into the health system, and it's not a bad thing to do at the beginning, but really the effort for me should be focused more on how we engage clients during their treatment for supporting with DV and looking out for signs, because DVRS is only a tiny part of the picture." AOD worker

Whether DVRS is intending to seek out 'the truth' from women, was raised across services. While some staff adapt DVRS practices to try to extricate accurate responses from women, others understand that women may not be

prepared to answer fully for a myriad of reasons. Staff broadly describe understanding of the dynamics of DV and how it can impede women from being able to disclose.

Domestic Violence often intersects with AOD use

In AOD services, while the demographics of clients vary across LHDs and teams, DV is widely seen to be perpetrated at high rates against women accessing AOD services. Many AOD services have high rates of male clients but can also identify the disproportionate rates of DV for women. Staff spoke in detail about the intersection of violence with drug use, including drug use as a way to manage trauma symptoms and violence related distress, drug use implicated in violence, additional barriers to women leaving relationships where the perpetrator may control drug accessibility and usage, and the relationship between current and lifetime experiences of violence for many clients. Staff express compassion and awareness of the intersection and acknowledged that many of their clients frequently experience violence from intimate partners and others in their lives. Staff describe it being not possible to provide AOD care and not recognise the role that DV plays. However, they describe they are largely aware of DV through sustained relationships and provide long-term support to people who they know DV is an issue for, rather than hearing about DV through DVRS.

"When you're thinking about domestic violence and drug use, you have to understand that they're totally interwoven together…you can't treat one without the other. So many of our women are taking drugs because a partner introduced them to them… people are taking drugs because their partner makes them. And drugs become part of the relationship, or there's threats associated with drug use…Threats if they stop. The drugs play a role in their relationship, there's coercion around using drugs and about stopping using drugs… Or people take drugs to cope with the violence or to stay awake if they are living on the street because of violence. If you sleep on the street, it's not safe…Taking drugs may be the only way they can sleep or stay awake to keep safe… So we simply can't treat drug use, and not do something about the domestic violence. Otherwise, we're essentially taking away a coping strategy, or a part of the system, and leaving the person more at risk". AOD worker

AOD staff also explained that it is not uncommon for them to be providing care to both victims and perpetrators of DV concurrently. This can complicate undertaking DVRS but more importantly, advocacy, responses and actions. Staff manage this situation by being led by the needs of the client and trying to prioritise safety. Staff requested more support around how to work with perpetrators and dyads and were notably non-judgemental in how they reflect on all their clients' experiences.

"I had a situation recently where I wanted to ask the partner to leave so I could ask the questions but I wasn't sure if I was able to… is that even legal? I wasn't even sure. We did ask him to leave, and they both weren't happy about it. Sometimes it is just hard to know." AOD Worker

AOD staff identify a critical lack of services to refer clients to. Drug or alcohol use means their clients are often ineligible for the few services that do exist. Not being able to refer women to shelters or support services due to requirements of abstinence can impede staff seeking disclosures from women through DVRS.

AOD staff in some services articulated serious concerns for their own safety when DV is disclosed. These concerns were evidenced by being able to describe numerous occasions of staff having been threatened or stalked by perpetrators of violence due to DV dynamics and following disclosures. They describe having their own safety in the forefront of their mind when working with some clients and having experiences of violence perpetrated upon them as staff. For other teams this is not a concern.

"It's the vicarious trauma as well, like, not just vicarious trauma, actual trauma. We've had staff be threatened. We've had people be followed. We're talking about really strategic violent people. No wonder the women are scared. We're also scared"
AOD Manager

In AOD services across both LHDs, DVRS occurs at assessment. In some services it is a mandated field in electronic assessment documentation and clinicians report not being able to complete the assessment without undertaking DVRS, whereas in other services it can be skipped until a later time if needed. In services where it is a mandated field, this can be frustrating as safety can't always be established to undertake it, whereas in services where it isn't mandated there are also frustrations about it being easily missed. Staff identify that data documenting compliance with DVRS would not articulate this complexity. Questions about DV are also built into other forms, including the comprehensive drug health assessment which means women are potentially being asked repeatedly. Across services the consensus amongst staff is largely that while DV is relatively common amongst clients of the AOD services, this is commonly disclosed throughout the relationship rather than through DVRS, even if it is retrospectively recorded in the DVRS tool. While conversations about DV are common in AOD services, formal DVRS is not commonly repeated after initial assessment.

The pathway in general maternity care is more clearly defined

Maternity is identified by VAN staff to 'carry DVRS screening performance', with 96% of women screened across LHDs and this compliance lifting the statistics for all services. In maternity services across LHDs, DVRS is a component of booking in appointments scheduled for all women during mid pregnancy. DVRS is part of the structured psychosocial assessment undertaken by midwives and Aboriginal Health Workers, where other childhood, life and current adversities are also asked about. Midwives describe that high rates of completion in maternity are likely because it is a mandatory field in the electronic system, and their documentation can't be completed until it is filled. In addition, psychosocial assessments are usually completed in front of a computer, ensuring DVRS can be undertaken in full. However, midwives report that disclosures are not common.

Midwives openly describe the rote nature of screening, as they all ask the same questions and generally the structure is followed exactly. Although midwives are aware of guidance about re-screening, this is largely not done and due to a lack of continuity models, they often don't know if DVRS is revisited later or retrospectively completed. Midwives identify that while DV may be present in clients' lives, women may not disclose this during the assessment process out of fear and a lack of trust due to short engagement and child protection implications. Midwives describe times where they suspect violence to be present in women's lives, regardless of response to DVRS, but they also

understand the reluctance women feel to disclose this. At times, midwives report feeling glad that more disclosures don't occur due to a lack of time to respond adequately.

"Every woman that I work with wants the best for her baby. It can take time to build up that trust. Sometimes it takes months to build up that trust. So we might ask on assessment. But really, we don't find out about it until much later". Substance Use in Pregnancy Midwife

Referral pathways are largely clear for midwives as they routinely refer any woman with identified vulnerabilities either directly to Social Work or via Safe Start intake processes. Midwives describe that they aren't always sure what happens after that but they assume women get support. While they identify issues with availability of Social Workers, particularly in rural areas or after hours, meaning that at times they are left trying to figure out a plan, their concerns about what to do if a woman discloses are notably less than AOD staff, as their internal pathways are clear. Aboriginal Midwives and other continuity midwives, as well as antenatal social workers, however, are often left trying to navigate services for women and their children and face obstacles.

Midwives generally report limited knowledge about DV and often feel that they need to support women with more subtle forms of control and coercion, as well as more commonly recognised and understood forms of violence, but feel ill-equipped to do so. For midwives who do identify skills and knowledge in this area, this may be gained from their own interest, or lives, or seeking out knowledge outside of their paid time.

Staff are being asked to do more, with less, and this impacts DVRS

Both maternity and AOD staff report changes in their roles over time which have impacted upon practices such as DVRS. These include increasing client loads, increasing client complexity, less community-based services and excessive paperwork and documentation requirements. Amongst these changes, staff expressed feeling the client relationship has been de-prioritised in services, alongside a focus on reporting and data collection rather than meaningful engagement.

"Sometimes we do get focused on 'this document has to be done at this time'. And obviously, we need to capture the information we need to capture. But assessment is an ongoing process. So sometimes we do get, I know, people get stuck in, 'I just have to get all these forms done'. And you might miss the cues or what the client is trying to tell you because you're on to the next thing. Yeah. people don't intuitively have a lot of the time. We need permission for that idea that you can take time." AOD worker

AOD staff describe changes in their service structures that have impacted the relationships they can develop with clients, with dosing outsourced to pharmacies, short-term or spread-out contact and increasing client complexity. These changes have occurred due to increasing client loads, changing approaches to delivering care during COVID-19 and pressures within health services.

"Our relationship with clients has changed. It changed ages ago, but it changed again during COVID, because we started doing stuff on the phone, and we still do stuff on the phone. But then we don't know who else is in the room. We don't know what it is safe to talk about. But also it changed because of a whole lot of other factors. The drugs that we give people to

manage withdrawals are different now, people might just come in once a week instead of daily, or they might go to the chemist instead. So when we say 'case management', we might actually just be talking about a really brief interaction every three months when they come to see the doctor" AOD worker

At times these changes made some clinicians feel helpless when working with clients experiencing DV, with staff expressing frustrations about the lack of pathways and the time required to identify appropriate supports.

"We're holding so much more work. So when you ask staff for one extra thing, we have so many clients that it actually ends up being a huge burden. We absolutely know that a lot of our clients have violence. A lot of our clients have really significant violence and it's been a part of their lives for a really long time. But what are we meant to do about that? …, if there's not a safe service to refer them to, or we're going to ring the local refuge and they are not going to have anything available, then we're going to be in a really difficult situation. It's also about time, there's only so many hours in the day, and we want to respond in ways that are safe and put things in place for people". AOD manager

DVRS is largely undertaken by midwives in maternity settings. Midwives describe how their roles have evolved, particularly those working in the mainstream antenatal clinics in the hospitals. They may see a woman at booking in, and then not again. They have busy clinics and limited time to engage with each woman. They are also increasingly working in inclusive ways where partners are included in care, which while important, complicates DVRS. Midwives agree that continuity models of care are essential in circumstances of DV, although these are not widely available.

"Midwives are under enormous pressure. We need less pressures on clinicians so that they can screen properly, effectively and complete the processes. So much more is asked of clinicians every day that they struggle to complete the tasks properly. Can be very hard for us to be patient, take time to explore their answers & situations when we are on tight schedules. So it's even harder for us to complete [mandatory reports], complete reports, put in referrals and activate support services". Maternity Worker (via survey)

Midwives describe having limited time to build up trust with women during booking in appointments, and time to follow up concerns after appointments. Midwives describe recognising that while DVRS provides an opportunity to support women, that at times they don't feel like the 'best' people to offer such support. This relates to their lack of time, their engagement with the partner, their mandatory reporting requirements and their lack of knowledge of how to support. Midwives detail examples of staying back for numerous hours after their shifts have ended to follow up on referrals and notifications from psychosocial assessments.

"Staff are exhausted and trying to do the best they can with no help or supports. This then impacts on the care they can deliver to the vulnerable". Maternity Worker (via survey)

The importance of culture

Community attitudes to domestic violence impact upon DVRS

Staff describe ongoing stigma towards, and assumptions about, women in DV relationships across the community, with frustrations at prevailing attitudes about 'why women don't just leave'. Staff feel they are often educating others

and challenging judgemental attitudes, including amongst other services and support structures. Staff describe increasing awareness of non-physical forms of violence and coercive control, including financial abuse and emotional abuse, but often women are not aware of these and staff play a role in educating women about forms of violence, alongside DVRS.

"It's a lot to be expected to explain Domestic Violence to someone...like to help them see that that is what is happening. Like how would I know how to do that?" Midwife

Acknowledging diverse families and ways of being

Staff work with families from diverse cultural backgrounds which impacts directly on experiences of DV and acceptability of DVRS. In particular, staff across AOD and Maternity observe that for culturally diverse families, it can be hard to ensure safety with interpreters as people may not trust, there may be conflicts of interest and at times there just aren't interpreters available. With some cultural groups, different constructs of families mean women may never be seen alone and DVRS becomes very challenging. Staff also describe working with many women who experience family violence not perpetrated by their partners. In culturally diverse communities, women may be living with extended family members and take on various family roles, which can also be complicated by violence. Staff describe finding it difficult to respond to DV in the context of their own fears or uncertainty about disrupting cultural norms.

Similarly, staff express concern that families from sexuality and gender diverse contexts may be incidentally excluded from DVRS due to the expectation that only women are screened. This despite DVRS being not the only requirement around identifying and responding to DV for Health workers, with the policy guiding that where indicators of DV or suspicions are present, all staff are to ask direct questions about safety within relationships, regardless of gender.

"For me, being part of the LGBTQ community, I think [not screening all genders] just increases stigma and puts more barriers in for people, maybe male same-sex relationships or non-binary people, to be able to report these things because it's kind of like.. we all know that the main percentage is female in heterosexual relationships, but you can't forget about this other group". AOD Worker

Supporting Aboriginal women requires knowledge of Aboriginal cultures

In working with Aboriginal woman, the importance of DVRS is recognised, alongside adjustments to ensure safety. Differences between Aboriginal ways of being and non-Aboriginal ways of being are clearly delineated by Aboriginal Health Workers. The importance of spending time building safety and trust in the relationship is emphasised, alongside a weaving of the questions into interactions in a non-confrontational way. This can require staff memorising the questions and holding them in mind, attempting to identify cues of safety.

"I've gotta be very, very careful [with DVRS]…I can't just put forward a piece of paper or open my laptop and go 'I'm gonna screen you'…. I would lose them straight away" Aboriginal Health Worker

These differences in approach to DVRS are contextualised to reflect the roles of families and communities within Aboriginal culture and how this can influence responses to Domestic Violence.

"White people are more in silos…little family silo structures. And you know, it's not like that with Aboriginal communities. Families are more extended… someone could have like 20 or 30 Aunties or Uncles. So, thinking about all those systems around that woman and lot more. It can be really supportive, but in DV it can also be really complicated. White people's views may be more narrow, for example 'you should just leave, put up some cameras and go stay with someone else..'. Whereas in Aboriginal communities, people may protect the perpetrator and that can be hard to understand… there's lots of stuff going on behind the door with that family that you wouldn't know about" Aboriginal Health Worker

For some Aboriginal Health Workers, working in woman-centred, family-centred and community-centred ways means that they identified less barriers to screening than those experienced in mainstream services, but for others, the lack of services or the structural racism inherent in existing services is a crucial barrier to effective screening. Aboriginal Health Workers view their role in DVRS as advocating, trying to offer support and where necessary offering guidance. At times this approach means deviating from policy and also working more closely with family members if possible.

"People may stay away when things are really bad, but we have to be clear of what our job is and keep letting them know we are on their side. Most of the time we're just trying to get them to lead their care, but also just kind of guiding, really guiding and recommending. We say that we recommend these things, but you don't have to actually do it." Aboriginal Health Worker

To undertake DVRS in culturally safe ways with Aboriginal women requires input from Aboriginal Health Workers and knowledge of local communities and ways of being. Without this, DVRS is ineffective and potentially harmful. However, there are staff working in Aboriginal health roles who are not Aboriginal and don't have access to Aboriginal Health Workers.

"If you're looking at Aboriginal women, you would be making sure you're involving an Aboriginal worker to be able to give you some family history or background history. Like ideally an Aboriginal Health Worker is doing the question asking, and if that's not possible, then an Aboriginal Health Worker is, you know, educating or supporting a non-Aboriginal person to know how to do it in a way that's culturally appropriate. And sometimes it's simply not appropriate for them to even ask the question if it's not coming from an Aboriginal worker". Aboriginal Health Manager

In what ways are clinicians undertaking screening guided by trauma-informed principles?

There is a lack of system-wide clarity around what it means to be trauma-informed

When staff speak of what it means to be trauma-informed, perspectives differ. Some workers are highly articulate about the meaning, intent and practices of trauma-informed ways of being but frequently others may not be. Many

workers report that practicing in a trauma-informed way feels more like the work they thought they would be doing in healthcare.

"This is what all midwifery should be" Midwife

"Thinking about trauma is part of medicine. Part of my kind of medicine" AOD doctor

Staff across maternity, AOD and VAN services identify that the language of 'trauma-informed' is being used in services but what this means in practice is less clear. There is some scepticism of 'trauma-informed' being a throwaway term or something enacted without intentionality, and confusion about how TIC can intersect with ideas of harm-minimisation or team-based care.

"I think we use the word trauma informed lens, and I hear that around. But what does that really mean? How are we able to respond to trauma? A lot of our clients have had trauma their whole lives, you're talking about developmental trauma, attachment trauma, trauma that's playing out in their relationships, it's interwoven with their drug use. It's beyond the scope of our service to be able to respond to that. We might think about trauma in the context of trying to understand what why people react the way they do. But whose job is it to actually do anything?" AOD Doctor

"'[we need to talk about] what does it actually look like [to be trauma-informed]?..When you walk into a room, tell me what is trauma informed about the way you go into a room?...it's like that intentionality… I make sure the person can choose the chair they want and make sure the lights are on down the hallway because I want people to have light as they walk down the hall...You know, those are trauma informed actions that are conscious and evidenced"' VAN Worker

Staff have differing levels of understanding of what trauma-informed means. While some describe high levels of understanding and reflect on how trauma impacts upon care and engagement, they also notice inconsistency in this awareness amongst teams, a lack of understanding in the community, and in services like the Police. Even within teams, staff have different interest levels, with no baseline assumed knowledge about trauma.

"I guess the concept of trauma informed care being new to people still horrifies me. I don't understand how it can possibly be a new concept. But it feels like it's a new concept every single day". Maternity Manager

Staff are also conscious of the difference between awareness of trauma, and their limitations in responding to lifelong forms of trauma, known to be correlated to experiences of violence. They report awareness of the relationship of trauma to adult health outcomes but even in contexts where trauma is directly relevant to care they feel they are not adequately staffed, supported or resourced to respond directly to trauma.

"The clients that we're looking after have had lifelong [trauma] So we can be aware of that. And we can understand that in the same way we can be aware and understand the dynamics of domestic violence. But we don't have the capacity to respond to it" AOD Manager

It is not clear how knowledge of trauma informs DVRS implementation

Staff describe awareness of DV as a form of trauma, which requires DVRS to be delivered in trauma-informed ways. Yet, beyond their own practice, staff also struggle to identify how increasing knowledge of trauma has resulted in changes to how things are done in health or how knowledge about trauma may be meaningfully reflected in DVRS.

While increased knowledge about trauma supports more engagement and openness about how traumatic experiences may have lasting impacts for clients and workers, and more awareness of the responsibility of health services to be safe and accessible, health systems may also struggle to shift existing practice and to address fear, shame and lack of confidence in responding to trauma.

"I think DV is being more recognised now that people are more being able to identify it and, I think too like people are starting to use, I suppose trauma language and informal language around things. I've seen that there is that has been an improvement in people recognising that people may not disclose DV for various reasons, so people are thinking, people are reflecting and asking the questions more carefully as well. People have more understanding of the impacts of trauma, particularly in childhood and the links between adverse childhood events and mental health issues. These conversations didn't used to be happening but now they are, even around very medical model staff." VAN worker

"To be trauma informed requires a wider lens than just the trauma of DV- how about the trauma of systems responses, and racism, and the police and DCJ, and communities. Women will refuse to go to the police because of past experiences- and then what do we do?" Maternity Worker

To be trauma informed requires modelling of practices and processes. Staff reflect on the ways the DVRS policy needs to be implemented in ways that are trauma-informed and that staff can model and learn from. This requires awareness that beyond asking staff to provide DVRS in trauma-informed ways, there must be systemic multi-level commitment to embedding trauma-informed approaches, including in staff training. For example, the training should role model what it feels like to experience trauma-informed ways of practice, despite this taking significant time, re-thinking and effort.

"one of the things that worries me about the domestic violence routine screening training is that it's a very traditionally designed, traditionally delivered training slide deck with, you know, slide after slide. At an almost unremitting pace. And that's really not a trauma informed care environment… So if I was going to design this training, I would be starting with things like what do you already know? What have you already heard about DVRS? …empowering the people in the room to be equal partners in the way the DVRS training is rolled out. But I see it's the opposite of that. It's like, it's old school. You've got 4 hours. Just get it done…. there's a big discrepancy between the concepts and the process and it comes across in the micro- how will we know if you are ok to continue with the session, if you want to leave how can we support you to do that, it requires lots of setting up the space and interaction as trauma informed. That is what we want staff to do, so are we doing it for them?" VAN Worker

Systemic trauma-informed ways of being also relate to the approach to implementing a policy, the expectations of the policy in relation to mandated practices and the inclusion of support staff in the roll-out.

"And so if you think about trauma informed care, how are we being trauma informed for the workforce to set them up to step into that space?" VAN Worker

There are plenty of examples of trauma-informed DVRS hidden within interactions

Despite the limitations and challenges that staff describe around DVRS, they also describe and display ways that they are inherently and overtly trauma-informed within all aspects of how they undertake DVRS. This includes paying deep attention to cues of safety, choice and trustworthiness, being transparent about their roles and boundaries and respecting women's agency and choices. Staff describe how they alter environments to feel safer, and advocate for structural changes such as continuity of care, longer appointments and a focus on empowering women. Staff describe or allude to building safety for women while also promoting agency, advocating for women and even when it is tricky, attempting to align themselves to the woman. Other examples include being conscious of power and trying not to position themselves as better than or having power over, while figuring out together with women what is possible. Staff describe being very transparent and trustworthy about how systems work, including when information gets shared and with who. Staff also reflect on how the dynamics of DV impact the screening process, potentially triggering shame and defensiveness. They are conscious of how trauma impacts women and how it may also impact screening. One worker described a woman who was experiencing DV and wasn't able to speak.

"it took time and kindness to build even basic safety to talk at all. 'Would you like water?' 'Would you like tea?' I had to give options for even simple questions" Maternity Worker

Often without needing to refer to practice as explicitly 'trauma-informed', Aboriginal health workers and clinicians describe detailed ways that the work that they do within Aboriginal communities is, and has to be, trauma-informed. For those who identify with the language of 'trauma-informed', there is no other option if the work is to be effective.

"In my community you don't do anything that's not trauma-informed…you just don't. You couldn't" Aboriginal Health Worker

Many Aboriginal Health Workers speak openly about First Nations peoples' inherent knowledge of trauma and violence, including their own lived experiences which inform their knowledge, understanding and sensitivity. At times, experiences of violence are woven into their personal and professional lives, particularly in rural communities. Aboriginal Health Workers in these contexts navigate dual roles and responsibilities.

"A lot of our knowledge that we have is not taught in university. It just comes from…just trying to understand how to keep our family safe as they come through our services" Aboriginal Health Worker

These experiences reflect the principles of many Aboriginal led services, including AMIHS, which were set up based on principles of how to work with community, with respect for community woven into the work. While this could be seen to complicate expectations around DVRS, instead staff speak of ways of communicating that ensure DVRS is undertaken in ways that model these principles.

"So people know when they come in to an Aboriginal service that they aren't going to be met with any malice or judgement". Aboriginal Health Worker

Across services, building trust is identified as crucial for enhancing safety and being 'trauma-informed'. Trust relates to building trust in relationships, even brief ones, being trustworthy in one's own practice and building trust with local communities. Trust can be compromised by trauma, coercion, history, culture and the nature of care and treatment. Trust is also essential for conversations about trauma or DV. Staff in AOD services in particular detail how the timing of DVRS is crucial for building trust. Meaningful conversations about DV should be raised at times where the woman will feel some safety and trust, with conversations about trauma usually woven into other aspects of care rather than undertaken upon assessment or routine screening.

"Today at the clinic for example... some of the people were a bit sketchy... I think they're irritated when they come because they know we've got to ask them for a urine. We ask them if they used any substance in the last month…So it's really difficult with some clients to build some sort of rapport, because [DVRS] is quite a personal question. And sometimes asking in a clinic setting, when you have a clipboard in the middle of a teeny room. it's actually I think, hard to get to get that sort of safety and trust" AOD Worker

Staff bring their own experiences to this work, but that can be protective

Many staff throughout this review shared their own experiences of living with Domestic Violence and reflected on how this informs their practice around DVRS. Staff commonly disclosed their own lived experience of violence or of living adjacent to violence when reflecting on how they learnt to undertake DVRS in safe ways While those without experiences of violence may express concern that lived experience of violence could make their colleagues more cynical about DVRS or at risk of vicarious trauma, those with lived experience largely describe how their own experiences have made it easier for them to have conversations about violence with women, to recognise women's inherent coping resources, and to understand the ways that women respond to DVRS.

"People who have had a lived experience aren't scared of [DVRS]. Because generally, we're out the other side of DV, and it's just a thing, it's a thing that happened. It's not a thing that you did. it's quite a different, different experience once you come out the other side" AOD Worker

"Well, I've just lived it. And if you've lived it, you aren't scared to ask" Maternity Worker

Staff with lived experience of violence may be more confident in their ability to respond to disclosures, to ask in ways that minimise shame, and to cope with the stories that they hear from women. Staff describe how their own lived experience informs their knowledge of pathways, enhances empathy for why it's hard to talk about DV, to recognise how quickly women might disengage from services once the topic is discussed and the importance of gentleness, body language and respect.

"I think unless you have lived experience it is very easy to be oblivious of what making a disclosure looks like for victims". Clinical Nurse Consultant (via Survey)

Despite this, other staff are concerned about how their colleagues with lived experience are impacted by the work.

"At times people work outside their scope to try to help because of their own experiences. They want to save people. Let's be honest, a lot of staff have experienced DV.. how is this addressed in the workforce?" Maternity Worker

The possibility of health staff being perpetrators of DV was raised by a few staff members with curiosity about how this may impact upon DVRS.

'I imagine that these would be hard questions to ask if someone has experienced DV. They would also be hard to ask in an unbiased manner if one were still in a relationship where they were the victim, or indeed the perpetrator of DV or coercive control" AOD Worker

Staff with lived experience also express concerns for their colleagues who had not had exposure to violence in their lives and are suddenly exposed to traumatic material through DVRS without structures of debrief, support or supervision. Lived experience was described as both sensitising and desensitising staff to violence in ways that they described as protective.

"Like you know, I had this discussion with somebody before where they've gone 'oh I've seen this horrible incident where this person slapped another person …' and for them it really traumatized them for like a long time, whereas I was just like, 'oh, OK'…. which is sad because I'm desensitized to domestic violence. Whereas for some people, it's so confronting, and you forget that if you didn't or if you don't see that and that's not normal behaviour. Sadly, for a lot of people it is normal behaviour to see and you don't realize the difference until you find someone who doesn't see that." Aboriginal Health Worker

Some staff also only realise they are experiencing DV when screening others for it, due to the complexity of DV dynamics. This is not necessarily a negative outcome but awareness of this possibility was suggested to indicate a need for inbuilt support.

People's own experiences absolutely impact…People may have no understanding of DV so really miss the cues. For others, they may suddenly realise that they are experiencing DV themselves…it could be quite challenging for staff who you know for themselves didn't actually think 'ohh my God, I'm in domestic violence myself'." Maternity Worker

All staff need support

A part of being trauma-informed relates directly to supporting staff and workforces who are engaging with DVRS. Staff question what is done to support them alongside expectations of mandatory screening and holding stories of DV when adequate services may not be available. Some services and individuals report supportive structures or access to reflective clinical supervision which helps them with their work but the vast majority report a lack of formal supports. Teams with supportive cultures recognise the importance of individuals supporting each other, with some services imagining that other areas are 'better at this' or more supported than they are.

"I'm sure mental health and drug health services are geared up a little bit more for that kind of trauma than we are?" Midwife

"AOD is kinda funny. Even Mental Health gets more information than we do. We never hear about stuff" AOD Worker

Staff identify a lack of supports for staff in relation to DVRS and more generally. While staff are aware of Employee Assistance Programs, experiences of these have been mixed and they all require staff to reach out and ask for help. Staff identify a need for more structural support which occurs in the course of work. Throughout the focus groups for this review, staff reflect that they benefit even from the chance to speak about DVRS and their work through this

data collection. Many describe that they rarely hear how their colleagues approach DVRS or stop and think about how the work affects them. Instead, they are used to coping.

"It's actually just really helpful to have this conversation, to hear how the other people in my team think about and ask the questions. We've never talked about that" AOD Worker

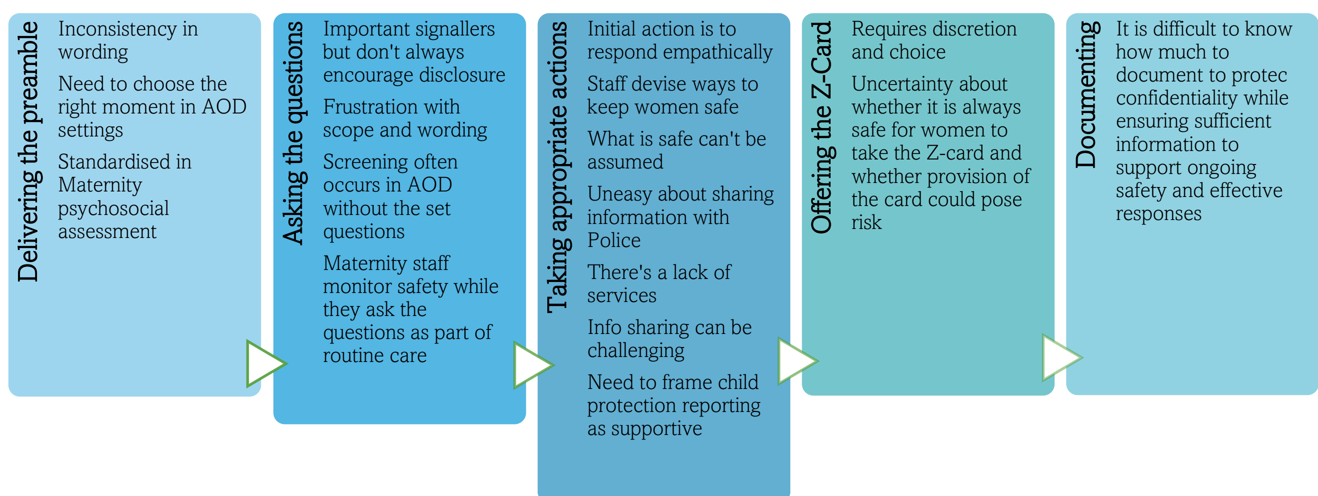
While some staff find opportunities to debrief with their colleagues or managers, others identify barriers to doing so, including workload, inappropriate shared spaces, lack of experienced supervisors, and team culture. For those who do access supervision, this is seen to be a supportive place to discuss experiences associated with DVRS. Staff without access to supervision attempt to discuss this as part of handovers, meetings or informally outside of work with trusted supports. The issue of a lack of support and supervision was recognised to be systemic and to extend beyond DVRS. DVRS was one example of the complexity of the work undertaken and the impacts upon workers.

"some of the stories, that women, you know, tell us are quite awful, tremendous, traumatic, and even hearing it is traumatic. And sometimes I think that we need to debrief with each other…so we might pull, you know, a colleague aside and say, 'Okay, I just need to just say, this is what I heard today', and, you know, talk it through. We've got some staff here that work in the clinic who have been midwives for 20 or 30 years. And if they have previously had a traumatic event that happened in their work life, sometimes the screening can be a trigger and it can bring up past emotions and thoughts about an event that happened 20 years ago. But yeah… we don't even have a tearoom to have those kind of conversations in. The environment where we have lunch is not conducive to having those types of conversations. And so yeah, so that's why we wouldn't do it. We wouldn't discuss any, any stories or anything that we've heard with our women in that area." Midwife

The stages of DVRS

The following section describes staff experiences and reflections across the stages of DVRS as they are articulated in the Policy.

Figure 2: Overview of staff experiences



Delivering the Preamble

There is inconsistency in the use of the exact wording of the preamble

Staff across services and LHDs are aware of the scripted preamble to DVRS and find the wording largely acceptable. Practices vary across teams and individuals in relation to reading the preamble, memorising the preamble or adapting the preamble to their clients. Staff were often quite cautious when describing how they modify the preamble but articulated clear reasons and justifications for doing so. These reasons largely related to not having the computer in front of them or feeling the wording needed to be adapted to suit their specific populations. The preamble was identified by staff to be important in ensuring equity in how questions are delivered, reducing stigma and normalising the topic to minimise shame. Despite more certainty about the policy expectations, VAN staff also reported contradictory understandings of the translation of the preamble into practice:

"I hear people say things like, 'well, I just tell them, you know, my own preamble because it's more natural', but actually the preamble is part of the tool. There is a standard way to deliver it which is part of the intervention and its standard for a reason… And when somebody says I'll just do it myself or I do what I think is the right thing to say, I think we're letting women down because they might not get enough information to make an informed decision…. The preamble for the DVRS is a form of consent" VAN worker

"Yes, we have a script. We do have the preamble. But sitting there, reading it from a card with a woman- that feels very impersonal…I tell staff to learn it and then you use your own way of working with people to ask the questions… you can ask those questions in your own way and get the same thing.. then it sounds like someone's genuinely asking because they actually care, rather than they just reading a script because they have to." VAN worker

You have to choose the right moment for the preamble in AOD settings

Staff in AOD experience challenges around timing of introducing the preamble to DVRS. Many assessment processes are unstructured, undertaken without a computer present and rely upon staff identifying a 'good time to ask'. Staff are also conscious of the power dynamics at play in AOD services and reasons why people may find even the introduction of DVRS uncomfortable. At the point of assessment, clients maybe experiencing a wide range of anxieties and concerns. At times this could lead staff to feel that DVRS was an intrusion indicated due to substance use, rather than an approach prompted by the evidence of perpetration of violence against women who use substances.

"I just find it's really, it's got to be the right time to do it…I think we ask them enough questions when they come in. Even today, we've had clients where you ask the same old questions again and you know what's in there and it hasn't changed. I think our clients feel it's just another thing… Another sort of invasion into their life that's under the spotlight because of their [drug] use or their previous use, I suppose" AOD

In services where staff don't have the computer with them, they follow the preamble as best as they can, remember it and describe often using introductory sentences to make the conversation feel more normalised.

The preamble is standardised in maternity settings

In midwifery, the preamble is largely read off the screen verbatim, as part of psychosocial screening. Midwives describe that DVRS is approached in a standardised way. That is, the questions are on the computer screen as part of the assessment and often introduced as 'next I need to ask you some questions about…'. However, this is possible because the screening relationship has already been established and a number of difficult topics already discussed.

"Because it's sort of like, at the end of the part [of the assessment] where we sort of tell them, you know, the next couple of questions, do get a little bit sensitive... anything you don't want to answer, That's okay. And before we get to that she's already told us about, like her sexual health and all that kind of stuff… kind of opened up already and got into that uncomfortable stuff that you don't particularly …want to share with people. Yes. And she's already sort of in that conversation where she's open. You've already asked sort of those sensitive, uncomfortable questions. So we've kind of already broken that ice." Midwife

Delivering the preamble in midwifery settings is challenged by structural and contextual limitations, largely to do with a lack of private spaces and women bringing partners or family members to appointments. Midwives spoke in depth about the tensions of including partners in antenatal care as part of family inclusive practice, while also requiring time alone with women to ask the screening questions. Practices differ around this, with one hospital recently deciding partners were welcome at all visits to promote shared responsibility and inclusion in care, while other hospitals ask women to come alone to their booking-in appointment. Some midwives directly ask partners to leave for a period of time while the screening questions are asked, but all also recognise the difficulties this can cause and some midwives spoke about aggression from partners in the clinic when asked to leave. Midwives are also aware of how the dynamics of DV can mean that perpetrators of DV are less likely to let their partner attend an appointment alone. They are also conscious of partners secretly recording appointments and other ways that DV can result in intrusive and controlling behaviours which compromise women's safety and capacity to disclose. In practice, midwives describe numerous tricky dynamics that they often navigate in order to ask the DVRS questions. Strategies include positioning psychosocial screening as "women's business" and implying to partners that questions will focus on intimate bodily related things rather than relationships, or asking partners to complete some other administrative tasks at the hospital while they ask the questions. If screening can't be completed then it is delayed until a later visit, although a lack of continuity models means it is subsequently often missed.

"We integrate it into our booking visit but will often defer if another person is present with the woman. eMaternity doesn't remind you it's been deferred until the woman births or has an antenatal admission so unfortunately, many deferred screens are not followed up." Maternity Worker (via survey)

Midwives working in mainstream maternity services report commencing the preamble once they get to that stage of the psychosocial assessment, whereas Aboriginal midwives and health workers use more discretion about when DVRS is introduced and rely on intuition and cultural knowledge. DVRS is positioned within AMIHS as an opportunity to gather support for women, with overt acknowledgement of the potential for the questions to trigger people's mistrust of services.

"We kind of just gauge whether or not it's a good time to do it… We just kind of make that call whether or not it's appropriate at the time to be asking those questions. Based on a feeling…whether or not we feel like the woman will be open with us or, like, just based on their emotional availability at that time, we can generally tell when somebody's not having a good time, 'cause they'll burst into tears or, you know, their body language and stuff." AMIHS worker

Asking the questions

The questions are really important signallers but don't always encourage disclosures

Staff describe that the DVRS questions are important in normalising a conversation about specific forms of violence. Staff identify the importance of being specific in questioning about DV as many clients may not realise they are experiencing violence or may not be able to articulate their experiences without prompting. Despite the importance of the questions, staff across settings also recognise that many women do not disclose during DVRS. Staff from both maternity and AOD believe this occurs because of the dynamics associated with DVRS, fear about what may happen if they disclose, and fearing there are no services or pathways that will help them.

"Sometimes they have the belief and the assumption that I can't trust anyone with this information. And so don't disclose it, because nothing's going to change. And you know, this is my life. And so then they won't disclose it. Because they believe that we, you know, we can't help them" Midwife

Staff understand there are lots of reasons why women don't disclose DV during DVRS, and also identify the role they may play in this by exhibiting signs of reluctance or a lack of intentional engagement.

"We don't really want people to disclose actually, because we don't have time or aren't the best service to respond" Midwife

Staff experience frustrations with the scope and wording of the current questions

Staff describe feeling that the wording of the questions, while useful as a guide, don't adequately cover all clients or aspects of DV they would like to screen for. A frequent topic of discussion is the increased awareness around coercive control. While some forms of control could be covered through the second question about feeling scared of a partner, staff across settings shared examples of clients who weren't being physically hurt and weren't scared of their partners but experienced financial, psychological or emotional control. The wording of the questions was seen to be limiting at best and to reinforce dangerous assumptions about DV at worst by minimising the risks associated with non-physical forms of DV.

"What about all the other types of domestic violence that we hear about so much? We're not even addressing that. …and don't get me wrong, I don't want to start to open up a can of worms because I don't have enough time in my day. But also we all know that domestic violence isn't just physical, it's about manipulation, coercion, all that…, which we don't even approach in that in the screening." Midwife

The questions about children's exposure to DV are also experienced as inadequate. While some staff describe using the questions as prompts to educate about the impacts of DV on children, even when they don't witness or aren't directly physically hurt by it, this is an additional intervention offered primarily by experienced social workers rather than all screeners.

"of course, [the children have] been hurt and witnessed violence at some level. If they're in the household, they're feeling that, even if they're feeling tension here in yelling, they're having that ripple effect… so 'hurt or witness' like I'm not sure that's the right question there…a lot of time women say 'No. They are sleeping. Or they're in the other room' " AOD Worker

While the importance of DVRS is emphasised by all AMIHS staff, staff who identified as Aboriginal themselves describe needing to alter the wording of the questions to suit their community. They describe that the language of the questions is unacceptable or offensive to many Aboriginal people and so they use different approaches to get the same information. The required communication approach is described as non-judgemental, friendly and non-authoritative.

"I just wouldn't say 'has he hit punch scratched' or whatever, we adapt our communication to the family. I might say something like, "oh, you guys had any Blues lately?" or, you know, …"have you had to call the police on him?" or if we know the family do have a domestic violence relationship, we might even say "I heard you had a blue the other day. What happened? Are you OK? Did you wanna talk about it?" Sometimes we would know community background already or we might have seen something, or someone might have said. 'Ohh I heard such and such had a fight and the police were called'. So then we'd go in with like "I heard this happened. Is that true? Are you ok?" And then the conversation would go from there". Aboriginal Health Worker

DV may be identified in the course of AOD care, rather than through DVRS

Staff across AOD settings describe that they ask about DV in numerous ways throughout care and many also see DVRS as a process somewhat detached from this. They routinely ask the DVRS questions when completing an assessment but commonly find this to be challenging due to the nature and context of intake assessments. Challenges largely relate to a lack of time to build trust due to the timing of the questions, the nature of the relationship between clients and services, and the complexity of many clients' lives. Challenges also related to the privacy of spaces if they are seeing clients in busy clinic environments or if their engagement is mandated, for example through court ordered programs. Clients' reluctance to disclose during DVRS also contributes to staff reluctance to ask the questions. However, staff uncertainty about how they will respond to a disclosure can also lead to reluctance to ask the questions in ways that elicit a full answer.

"So, I suppose it's the way we've worded the things and the way we ask... recognizing that like how you ask it, it's one kind of thing, but it links to then do we have the services to refer to if you do get people saying yes? So, what's the point? What's the purpose? When there's no agencies, no other services. This in the country. Not to mention that the assessment is 26 pages long" AOD Worker

Other staff see the benefit of the set questions to ensure staff don't avoid the topic of DV because of the discomfort it can create. Staff describe how with all the content that needs to addressed on assessment, there are commonly topics that staff may consciously or unconsciously avoid if they are uncomfortable or too personal, including sexual history, social history or DV. The less structured approach to care delivery than maternity is identified to also lead to potentially missed screening.

"we have a lot of things to cover and these questions are tricky, if it wasn't a set thing, I can imagine people might avoid the topic.. like we do sex" AOD Doctor

AOD staff describe 'feeling' that they know which of their clients is experiencing DV, as this is usually revealed throughout the relationship, rather than 'discovered' via DVRS. Many describe that for some clients they feel that it is 'impossible' not to be aware of DV in the context of AOD care as they may present with injuries, interact with the police or the service may support the perpetrator also, noting this does not mean staff will always know if a client is experiencing or perpetrating DV. Staff across services have varying ways they may ask about DVRS if they don't use the exact questions. These largely focused on responding to cues from the person, asking more generally about issues that would be helpful to discuss and asking about safety. At times, staff later enter this data into the DVRS tool to meet reporting requirements but they may not formally ask again using the structured approach.

"I ask all of my patients on a regular basis whether their home is safe or not. And I think that's…my way I do things. I don't ask them, I talk with them. Are you safe? Are you safe until you see me next? Are they safe? Is their home safe? is there anything else I can help them with? If you ask people set questions, you're gonna get set answers." AOD worker

Maternity staff monitor safety by managing their own cues and being responsive to women

Amongst the standardised process of asking the questions, midwives describe often having their eyes on the computer screen and feeling there can be a lack of engagement due to the context and in-depth psychosocial assessment being done. Midwives describe in detail ways that they may try to establish safety while asking the questions, including through ensuring no one else is in the room, pausing to make eye contact and using a gentle tone of voice. Some midwives have memorised the questions so they can ask them in a more conversational way, while some also adapt the wording to suit their own style of speech. Many staff undertaking DVRS across the perinatal period express worries about women disclosing and their capacity to respond.

"I feel like we are given lots of education around screening however this doesn't remove the anxiety of asking the questions… Even though we are just screening them…it's a bit like opening Pandora's box and not knowing whether you'll be able to contain the answer and support the woman" Child and Family Health Worker (via survey)

Midwives describe prioritising cues of safety and trust in the relationship and then trying to assess in the moment which questions are appropriate to ask. Many describe never having been taught this skill and not discussing it with colleagues, instead learning in the context of care from repeat experiences of women engaging or disengaging. Some identify that the questions themselves are lacking in nuance for their clients but most feel they flow appropriately in the context of all the personal questions being asked. Midwives in the broader context of their work, which includes asking many personal questions and responding to sensitive issues for women separate to DVRS, may often rely on skills gained through practice of establishing safety and rapport and reading cues from women. At times relying on these skills may mean midwives feel either unprepared for situations or overly confident about their ability to detect DV. Midwives are aware many women do not answer the questions 'truthfully' and they attribute this to concerns about child protection, hope for the future, a lack of understanding of DV, wariness of services, fear of the perpetrator and the rushed nature of the appointment.

“The questions are great for screening…But it's easy to get around it. And it's easy for them to just tell you what you want to hear. And in your limited time you say ‘okay, yep, no worries’”. Midwife

One midwife described feeling shocked to discover that a woman had not disclosed ‘really awful’ DV from her during DVRS and this made her question how many clients do not feel able to disclose it. Another midwife spoke from her own lived experience of DV and reflected on how this informs the way she understands how difficult it can be to identify DV, challenging her colleagues’ certainty about being able to ‘sense’ which women were impacted.

“I have four children and I have been in a domestic violence relationship. And I did lie every single pregnancy and I knew how to fill out that [depression screening tool] and make sure that I looked like I was not anxious….my worry was if I if I was honest and told them... I would have lost that baby. What happens if they take my kids from me or if I leave and they got left with him? …I was so worried that I would lose my children. I know now that it doesn't necessarily work quite like that... But when you're in that mind-frame… you are manipulated… you overthink everything. So, your own perceptions of the way things are may not necessarily be correct. … It’s hard for women to turn around and say, ‘hey, yeah, I'm in a DV situation’. They feel dumb. Why are they in that situation? Why can't they get themselves out? That's how you feel… that someone's going to judge you for it… it's really hard to just sit there and not feel like you're a failure. And you're told constantly, you're a failure...I have been hurt by my partner and I am bringing a newborn baby into the situation...you can become very good at fobbing it off and just having a poker face… you learn to manipulate things so that you're protecting yourself and your baby. And it's not about protecting your partner… You are just trying to survive and protect your kids. I think I feel that I'm good at seeing other people in that situation, I can pick up pretty quick on the cues. Now, if I hadn't been that situation, I probably wouldn't have”. Midwife

Barriers to disclosure in antenatal contexts can be very strong, with staff reflecting on how when they or their colleagues better understand barries and actively build safety and rapport, they can screen more safely and effectively.

For midwives working in continuity roles, they describe often becoming aware of violence throughout the pregnancy, even if women initially screen negative on booking in. They attribute this to needing to build a relationship to be safe to ask the questions in a way for people to disclose and that this requires them to first ‘get a sense’ of the person. Simultaneously, women are building a sense of the type of support they can gain from their continuity midwives, which leads them to disclose more than they may have initially when they were wary of the intent. Similarly, in AMIHS, midwives and health workers report that the questions are largely accepted by women and expected in the course of care, however trust and safety are well established prior to asking.

“I’ve never had an issue with anyone about asking- but my role is well known and respected in the community” Aboriginal Health Worker

Taking appropriate actions

The initial action is to respond empathically

Staff feel largely confident in their capacity to respond empathically to disclosures of DV. They describe the importance of ensuring women feel heard and respected if DV is disclosed and they recognise the importance of this 'window of opportunity' to initiate support. Many staff have limited experiences of unexpected positive disclosures on DVRS and as result can only surmise how they may respond. Continuity midwives, antenatal social workers, AOD workers and Aboriginal Health Workers all reflect on ways they have responded in the past to disclosures of DV, regardless of when they occur. Some staff recognise the importance of taking appropriate actions but are also quite confused about what these might be, beyond immediate responses. Some staff report uncertainty about local pathways. They also report a lack of time and lack of services to refer to, and some hopelessness about what is available or possible which impacts directly on DVRS.

In maternity settings, midwives largely see their role as responding empathically and referring to Social Work. Excluding in some rural areas or speciality services, midwives are rarely involved in the response beyond the initial referral, which means they are less concerned and stressed about what is possible or likely. Midwives describe times where they are unable to refer to Social Work, and the burden of responsibility is significant. Maternity staff report not always being clear on the expectations of their roles when women disclose DV but are not in immediate danger. One midwife who had recently moved into a more autonomous role has been shocked to see the challenges and complexities in trying to support women after positive DRVS. This experience has made her think differently about all the times she had "just referred to Social Work" in the past.

"I don't actually know what services are around, we refer to Social Work and then that's it, I don't know what happens next." Midwife

Staff describe concern that how they respond to disclosures may impact upon ongoing service engagement for women. They are aware that once women disclose, they may not return.

"So yeah, it's just being sympathetic, caring and holding that space for those women to build that trust because she may have disclosed things to you, but she may disengage from you because she feels that she's now at at risk of DCJ coming in, taking her kids, or forcing her to get out of that house. And then what is life going to look like for her if she did so? It's a bigger issue I think." Midwife

When women do not disclose but staff suspect DV, pathways are less clear. Staff in roles that support ongoing contact, including AMIHS services, revisit the topic at later stages of care or let women know that they can talk about it anytime if they want to. Staff are careful not to push women to disclose, as a mechanism of maintaining safety.

"Like, how far do I, you know, go pushing this, when she said, leave it?...I did [a DVRS] lately... partner is part of a bikie gang, you know, and it was hard for me to be in that position…like, you put yourself in her shoes… you don't want to say too much just in case. You know, there's a lot involved, and you have to be cautious about her safety." Midwife

“I've never had a woman disclose to me about domestic violence… Maybe they don’t disclose it… because I don't know what they can do… I don't know how they can get help. If they were to say, ‘Yes’, I think I would have to figure that out… because the only thing I would know is to call the social worker. Like that's all I would know what to do. If they had never disclosed to anyone that they had been experiencing DV, they're probably not going to tell someone like me. Like, I just can't see them saying yes. So I don't know what I would do”. Midwife

In AOD settings, staff report not be shocked by people reporting DV. They recognise that many of their clients have experienced violence from partners, are currently living with violence or that violence from partners or others is a recurrent part of their lives. Staff reluctance to deliver DVRS in a way that is optimal to support disclosures may not always reflect discomfort with talking about DV, but discomfort about when and how to ask and uncertainty about what services are available if the woman does disclose.

“And also, this could be about, sometimes I might not be the best person for this person. So having a really strong referral base that's relevant, and up to date, and resources available, because often times, we're not the right fit” AOD worker

Staff have to devise ways to keep women safe using their existing resources

Following initial disclosures, staff prioritise safety. Due to a lack of services, staff consider how they can respond in ways that support women’s agency and strengths and require minimal external support. After hours or on weekends when hospital Social Workers are less available, midwives experience tension about what to offer and have to develop plans for safety that they feel unprepared for. Occasionally they will escort women to Emergency Departments so they can link into extended Social Work services.

Staff across settings largely describe having no formal knowledge about how to assess risk or safety plan. Some staff are aware of tools that they had been trained in historically but question why these aren’t widely accessible to all staff. Subsequently staff, particularly in autonomous midwifery roles or in AOD services, apply skills from other aspects of their roles to DV safety and risk planning. This involves identifying acute risk of harm and giving women numbers to call if needed. Where possible, staff may also support women to identify what they think they need.

“What are your resources? You’re a resourceful person, what have you been doing thus far to stay safe? How can we help you build resources? I think empowering them because, because domestic violence is all about disempowering them. So, they're in control. They've been easier to control…Yeah, it's about empowering.” AOD Worker

Staff identify a lack of clarity about pathways of response for women experiencing DV. They feel they have to figure out what services exist or what services might be appropriate. They aren’t always sure if they have put enough in place for women and they carry a burden of worry about not doing enough. Across LHDs, staff can identify some local or statewide support services but no set pathways to guide their response. A lack of familiarity with the policy also means that staff often aren’t sure what is expected of them.

“When a woman does disclose, a worker (let alone the woman herself) needs to be able to sit with risk as options are limited- for example it is almost impossible to arrange for escape to alternate housing due to the severe lack of affordable housing and

support services such as refuges or housing case management services are overwhelmed. There is little practical support." AOD Worker (via survey)

Having to devise plans within their existing resources leaves staff feeling unsupported and frustrated. Staff describe wanting to engage more with women about their experiences but feeling helpless about what purpose this serves.

"I think the frustration is yes, you can identify [DV] and it's good to do all the screening…but where do you go with it? You don't feel supported after that. Like ... we're here working, working busy clinics, what do we do with them? What I'm really saying is that, yes, I don't as a clinician, I do not feel supported with information that we get from clients. I would happily sit with clients and chat to them, that's why I came into this work. But there's time restrictions. Yeah, you have don't have time to build up rapport. You know, you've got to take this and take that and write that." AOD worker

What is safe can't be assumed

Staff identify that the response to DV is commonly assumed to be encouraging or supporting women to leave perpetrators, however in practice the response is often more complex. Many women are not ready or able to leave their relationships and some may not want to. If women do want or plan to leave, staff feel limited in their capacity to find them safe places to go.

"Aboriginal women can feel unsafe in refuges, so we are essentially pushing them from one unsafe environment to another… Aboriginal women are wary of services because they don't get heard, believed or listened to." Aboriginal Health Worker

While the solution of supporting women to leave DV once it is identified can seem simple, the reality is often much more nuanced. Staff describe that this links to needing to be clear on why screening is being undertaken and what a 'good' outcome is.

"For someone to get up and leave while they're pregnant, knowing that they're not going to be able to work, they've got to then find a safe place for themselves and all… a lot of these times these relationships, while they might not be beneficial, that's their comfort zone as well, you are not going to get out when your life's about to change and move away from all your supports. I think it's great to offer them that sort of support. But it's at the wrong time. And I know that we don't really have an option, because that's when you see them, but providing them with what they can do, how they can be helped, rather than 'you really need to go'…it's about offering them options, not so much telling them. Somehow you have to help them manage their life, while they're in that position as well." Midwife

Staff describe that women may not feel safe and may not be safe in leaving DV situations. Threats from the perpetrators and other community members are common, while women may also be at risk of homelessness, financial hardship or violence from other sources. In addition, many women have had negative experiences in services which impact upon their trust in the possibilities of seeking help to be safe. In AOD particularly, staff report being unsure how best to support when clients want to stay in relationships with DV perpetrators.

"a lot of times they do stay together… They do live together, So what can we do to improve those relationships? Is there more we could be doing?" AOD worker

Both AOD and maternity staff describe ways that they work with women to promote safety after disclosures, including helping women to identify things that keep them safe and trying to establish plans for follow up.

"I will talk through the power and control wheels with women. And we'll talk through what they already do to keep themselves safe. Because they've already got a list of things that they're doing". Midwife

Staff describe that sometimes undertaking DVRS can make people less safe, especially in rural areas or when working with Aboriginal women or women from some cultural backgrounds. This is attributed to large, widespread family relationships and the risks associated with family or community knowing that services are aware about violence.

"You think you are helping people be safe but sometimes you aren't" Aboriginal Health Worker

Staff are very uneasy about sharing information with police

Not all staff interact with police about DV, but for those who do, there is a lot of apprehension. In AOD services, staff describe that their interactions with police largely relate to existing Apprehended Violence Orders or court orders, and it is not common for them to contact police about DV. Senior midwives have contact with police through Safety Action Meetings but largely social workers engage directly with police. Maternity staff working in autonomous roles, particularly in rural areas, occasionally had to contact police directly about women's safety while Aboriginal Health Workers describe advocating for women with police and report significant challenges in interacting with police about DV.

"Quite often I will have to support the woman to go to the police station to make a statement because when they've gone on their own they've completely been dismissed by the police officer who they've spoken to…The first point of call if you're at risk- call the police. If you're not safe, call the police. But women don't want to call the police, so it's again, that's another big system that needs to be looked at." Aboriginal Health Worker

Aboriginal Health Workers describe that DV is taken 'more seriously' when they accompany women to make statements to police which they attribute in part to stigma and judgement but also a lack of understanding about DV. Staff describe that sometimes police don't help because they see women keep presenting and don't leave the relationship and they think that means they don't want help or there is no point in trying to help. Staff describe having to educate police about the risks when they minimise women's concerns and identify that the pathways to reporting DV to police need significant work. In some regional and rural areas, there is just one Domestic Violence Liaison Officer, meaning if that person is not on shift, nobody may have any understanding of the risks of DV. While many staff expressed frustrations with how police respond to DV, Aboriginal Health Workers spoke in the most detail about these concerns and their deep frustrations with the police response to DV.

"To be honest, I don't know where to start…I don't know what to do with that space and I don't actually have time" Aboriginal Health Worker

VAN staff identify that changes to the policy around when to share information with police have brought additional challenges that have not yet been addressed, primarily to do with a lack of staff confidence in knowing when to

report. While the changes in the PD place greater emphasis on assessing risk and prioritising the woman's views as part of clinical judgement, this can be interpreted as relying on staff being able to assess risk and make a clinical judgement about concerns. Staff openly describe being very uneasy about when to share information with Police if the woman does not consent, as they don't feel skilled in assessing safety. VAN staff identify that even in areas of health where discourses of safety and practices of safety planning are well-established, such as mental health services, staff may show resistance and fear to safety planning for DV.

"One part of the new DV policy is about sharing information with police. I think that needs to be really sort of brought out, as people are seeking more guidance on that… it's not exactly clear yet…. I mean for someone who has worked in the sector for a long time, I think you know about how you can ask those questions and use your own professional judgment to elevate it if it needs to be, but not everyone feels confident to do that, of course. [people say] 'She asked me not to ring the police'. So then you know, someone's coming into [services] with [serious DV inflicted injuries]. but.. she's begging... 'Please don't ring the police' and they're saying, 'but she's an adult. I don't have to ring the police'. Ok, its not mandatory….But think of the risk if we let her leave here and go back to him." VAN worker

ECAV and VAN staff articulate the importance of the changes in policy in the context of safety, including that sharing information with Police without consent must be based on the level of threat the woman is experiencing and how her safety may be supported; and that sharing information with Police without consent carries its own risks, including disengagement from Health services, and must be carefully considered This focus on ensuring an assessment-based reason to share information without a woman's consent is different from the previous policy approach. There is widespread awareness that this change requires support for staff in decision making.

"we were reporting to police sometimes without them knowing and then police had to.. follow up and then they would turn up on the doorstep, the victim wouldn't be aware they were coming, the perpetrator wouldn't be aware they were coming, and the violence would escalate, so now there's much more nuanced approach we've taken into account the views of the woman and the professional judgment." Educator

Across services, staff are of the belief that sharing information with Police about DV is often of minimal benefit to women. Staff also identify that at times women will present to health services seeking protection, rather than attending police stations.

"It takes a lot for the police to actually follow up properly. And it takes a lot before it may progress.. for example, on to jail time. Mostly they just think 'that's their business'. ...I've found that a couple of times, and I think it needs to change." AOD worker

"we've had women turn up here with their suitcases that screened no to DV" Midwife

Staff also describe that some reluctance to engage with police is about desiring access to more therapeutic interventions, both to support women who stay in violent relationships and to facilitate support to men who perpetrate violence.

"At times [our response] feels quite punitive. We call the police...we don't offer any other intervention…and nobody does anything about resolving the DV issue with the man" AOD worker

"All the knowledge and skills in the world won't help if there's no services"

Staff strongly and consistently identify a lack of appropriate services to refer to if women disclose DV. Staff feel angry and distressed by a focus on screening without the required support to ensure women get appropriate and timely support. Across all services and settings staff identify difficulties in identifying and accessing services. Staff describe refuges which are full, confusing service criteria, limited practical support and services which change frequently due to cut funding. Staff describe spending hours on the phone waiting to speak to services and being reluctant to encourage women to reach out when the pathway is so challenging.

"It would be so helpful to just know what resources are around. It's exhausting trying to contact services and having to wait, finding services have changed and gone…Not sure if your client will fit the criteria anyway. So, what do we say to people when we ask about violence? 'Tell us if you have violence and then maybe we will try to figure something out… but probably not'" AOD worker

"That's the problem with it.. it's nice to have all this screening, but you've really got nowhere to go" Midwife

In rural areas, services are particularly limited. Staff express frustration at the lack of services, but also the lack of access to any emergency funds to help women get out of town or access services in other towns. Rural maternity staff describe that experiences of DV during pregnancy are of great concern to them, but they feel 'hopeless' about the availability of services to provide adequate support to women. Where services do exist, these commonly have inequitable distribution and staff are unsure about accessing them. For example, there is a Domestic Violence service within Health in one part of SWSLHD that many staff are aware of and appreciative of. Staff involved in the delivery of this service describe that the majority of referrals aren't from DVRS and rarely from health at all, and referrals largely come from Non-Government Organisations, self-referral, or government services. Health and VAN staff acknowledge this service is incredibly important but would also like to see similar services embedded across all parts of the LHD and other LHDs, and made much more visible to staff.

"There are no services to refer to and it's actually horrible, and that's one of the things I find really frustrating as a social worker… you know, you think 'ohh we just support women and keep kids safe and it's all happy pathways of resolving these issues' and.. and… it doesn't work that way because we need the services." Maternity Social Worker

Staff identify that services need to be easily accessible for women as the window of opportunity for them to seek help may require fast action, and women are often wary of contacting multiple services due to fears of not being believed or heard. AOD and Maternity staff describe sitting with women to make phone calls to services, driving women to services and helping women navigate internal and external barriers. This work often feels like it is out of the scope of their intended roles. Aboriginal Health Workers in particular describe how their roles can end up systems-navigating and translating, being a point of contact and providing practical support to women, on top of existing and visible parts of their roles.

"DVRS can be a really sad exercise because you identify DV and you want to help but where are the resources and services? There are resources about DV but not many services that will help. All the knowledge and skills in the world won't help if there's no services" Aboriginal Health Worker

Information sharing processes have their own challenges

Information sharing about DV is not something most staff are engaged in. Staff describe ways they communicate internally amongst their teams about DV, for example identifying clients on patient lists using codes or using aliases when necessary. When staff do engage with other services through Safety Action Meetings (SAM), these are noted to have their own benefits and challenges. While SAMs are an important source of information and action, some SAMs extend over many hours and Health staff attending SAMs must review Health records for people listed on the SAM agenda, which is resource-intensive. VAN staff note the significant staff time required to conduct audits of Health information for SAMs, with limited resourcing. The Macarthur region in SWSLHD for example, have the highest rates reported rates of DV across the state, with workers in Macarthur identifying that the SAM takes a full working day to facilitate.

"From our perspective, I think what would be really helpful would be where we've got this level of emphasis on DVRS would be to have something similar on our safety action meeting space as well… On top of that one day every fortnight [to facilitate the SAM] we have, you know, countless hours of file audits and things that people are doing on top of their day jobs and staying back to do and you know, like there's a lot of people holding up this process through their shared goodwill, not because as a system it's being facilitated" Macarthur worker

Beyond formal processes of information sharing, staff describe worries about the intersection of DV with critical unmet needs for women. Staff particularly emphasise the inadequate supplies of housing for women trying to escape DV. Temporary housing options are also very scarce. Many temporary housing options are not available to AOD clients due to substance use.

"I mean, one of the things is homelessness and the lack of housing. Women have a choice of camping in the bush, where child protection are gonna come and remove your kids anyway, or you stay in the violent home because that's the house for your children and you just don't say anything and you try to keep DCJ off your back." Maternity worker

"I have worked with people who were in a DV situation and they were really reluctant to leave and go to a shelter because a lot of shelters are zero tolerance… So then that means that they cannot drink…there are curfews.. They cannot use drugs… so they stay in violence and it's really hard. Add to the complexity of leaving a DV relationship that the only places to go you would have to stop your main coping mechanisms.. it's too much, so they are forced to stay." AOD worker

Staff attempt to frame child protection reporting as supportive

Staff describe that women are terrified of child protection services, particularly in maternity settings. Staff observe shame, fear and stigma associated with child protection service involvement and lack of openness to any report being made for the purposes of seeking support. For many women, disclosures of DV will not occur during pregnancy due to the risk being too high that their children will be removed. Staff try to frame notifications to child protection services as opportunities for support for women, but are also sceptical about the possibilities of what

support is available. Child protection services are noted by staff to be lacking in trauma awareness and sensitivity. *"Women stay in DV to avoid being homeless and [child protection] getting involved. At least that way they can have their children"*. Midwife

In Aboriginal communities in particular there is fear that any talking about DV will result in child protection services getting involved due to systemic racism. Aboriginal Health Workers describe at times having to excuse themselves from decisions or conversations about reporting, so they aren't reporting their own mob and to balance their mandatory reporting requirements and their commitment to their communities. When reporting is required, staff try to support women to view child protection services as supportive.

"It has to happen sometimes, and in that case, the role becomes that we look at other things that we can support, like we look how we can support that family if these things are arising, to have a plan for [child protection services] when they do kick in. So we've been able to say to our mums... 'work with us, we will support you through any of the [child protection] stuff'. Like we will offer to attend those appointments with them to be that contact person and liaison between [child protection services] and our families just to keep everything level and to keep our mums feeling safe in our families." Aboriginal Health Worker

Mainstream midwives describe that they are more likely to report concerns to statutory child protection services, although across services who performs this task differs. Senior midwives may refer directly, whereas junior midwives usually seek support from Social Work. As midwives' shifts are often spent in back-to-back appointments, all consultation including completion of the Mandatory Reporter Guide, speaking with the CWU and reporting to the helpline if required, has to be undertaken at the end of their clinics. This means that they may be on the phone for hours and are required to re-tell the story a few times. Midwives describe that this often occurs out of their paid hours but is necessary to ensure reports are made.

"You speak to somebody and then they put you through to somebody else, then you have to tell the story again. It's just so time consuming…it's outrageous actually" Midwife

AOD staff describe that many of their clients have had their children removed previously by child protection services, so they do not often need to make notifications to child protection services as a result of DVRS, except in Substance Use in Pregnancy and Parenting services where collaboration with Child Protection Services is a key part of the work.

"I'm not sure how often we get to that stage [of reporting to child protection services] through the screening process…it kind of wouldn't be appropriate as you haven't got the information at that stage really to give a good report anyway…unless there were really significant risks maybe you'd call the child wellbeing unit and share information and do the Mandatory Reporting Guide, but you'd mostly try to work with the client and get more information and see how you can best support them." AOD Manager

Aboriginal Health Workers describe DVRS as an opportunity to flag things antenatally and put things in place with mums to reduce likelihood of child protection services getting involved. Through this lens, they work hard to build trust with women and while being open about their mandatory reporting requirements, also try to distance themselves from child protection services. This can also mean advocating for women, and sometimes that results

in conflict with child protection services or the police to get the best outcome for women. Aboriginal Health Workers describe awareness of mandatory reporting obligations but are also careful to only report when they consider that the risk of significant harm threshold is met, to avoid systemic over-responses.

"It's about what you do with that information when you've got it and how you share information with the client as well. You need to be transparent with the process and be clear if you have worries and need to mandatory report. Which requires learning ways to have those conversations without losing that engagement…. There are women who could require a mandatory report every time they come in, but that can also compromise their safety. Women learn how to answer the questions to avoid that, but we also have to ask carefully" Aboriginal Health Manager

Offering the Z-card

Giving the Z-card safely requires discretion and choice

The PD is clear that all women should be offered a Z-card, and have its contents explained, regardless of their answers to DVRS and staff should check whether the woman feels safe to take the information with them, to minimise risk of the card being seen by perpetrators and increasing risk to women. However, staff across settings have differing opinions about the Z-Card and how best to use it to support women safely. Many staff do offer it to all women and find a small percentage take it. In some Maternity settings the Z-card is incorporated in packs of flyers and information given during booking-in. In AOD, usage is more ad hoc.

Ways that staff across settings have adapted their practice to enhance safety and minimise shame for women who may not disclose but could still benefit include suggesting that women take it 'in case a friend needs it' or 'store it somewhere in case you ever need it'. Many staff adapt how they speak about the Z-card depending on the woman. At times staff practices contradict the policy requirements.

"I'll say, have a good read, then don't throw it away. Because you might have a girlfriend, you can pass it on to them. Sometimes I say "throw it down on the coffee table, so your husband can see it".. but other times I tell them… "you can pop it in your bra so your partner doesn't know you've got it". " Midwife

Some staff expressed concern that the Z-card may compromise the safety of women if taken home. In some services, staff have been told to stop offering it at all or have decided it isn't helpful based on women's responses, while others are being careful about ensuring women have a choice in taking it or not.

"You've got make sure that they're not going to be punished for that if the partner finds it. So I ask them, Is it okay for you to take this?" AOD worker

Staff also describe concerns about whether the services are up to date and culturally appropriate and whether women will require support to access them.

"Women need support to call those kind of numbers, if they've been living with DV they so often are scared, they don't know the right thing to say, they are scared of saying the wrong thing". Maternity worker

Documenting screening and outcomes

It is difficult to know how much to document

Staff are concerned about safety in documentation related to DV, including the risks of files being read by people linked to the perpetrator. AOD, Maternity, VAN and Aboriginal Health Workers are all concerned about who can access files and how this may result in more violence for women.

"When people are having babies, there is a lot of contact with different services so it isn't always possible to identify who everyone is that has accessed files, people's families and communities can be big and there is no way to be sure that people's files are private. We have to trust the system but in DV, people do extreme things". Maternity Social Worker

Staff manage their concerns in varying ways. While many staff confidently describe that they document everything women tell them for safety, others conversely document as little as possible, also for safety. Staff are aware of the importance of disclosures of DV being documented in case women present elsewhere or 'something happens' and accept that they have to try to 'trust the system'. Specific examples to manage documentation include the use of verbatim quotes and avoiding assumptions, simplifying through acronyms and brief notes, using non-specific headings as signallers, and keeping information factual with no detailed stories or examples.

"I tell them at the start that anyone in NSW Health can access their notes, it's part of letting them know that you're going to have to document what they're saying to you and also letting them know that if the perpetrator, or the perpetrator's mum or auntie or friend works in NSW Health, they could read their notes. And I make a judgement about how much to write". Maternity Worker

Staff largely feel they have to figure out for themselves how much to document, in order to feel they have recorded the interaction, but not compromised the woman.

"You need more information in there and you need the quotes, and the language is really important. So it kind of contradicts our medical notes and what they would normally be…. It's tricky because you are thinking what if the client reads this, what if this gets subpoenaed for court, what if somehow the perpetrator gets access to this…we don't get taught this, we just have to figure out what to document" AOD Worker

What resources and support needs are identifiable to improve the quality of DVRS across mandated services?

Training is underway and beneficial, but more is needed

Most staff are not yet trained but would like to be

At the time of this review, most staff reported that they have not yet received any DVRS training. Pockets of staff and teams have attended the new train-the-trainer training or have received training from local trainers, but the vast majority have had no training in many years, if at all. Some staff describe having worked for 30 years or more in

maternity or AOD settings and never receiving DV-related training. Prior to the new policy, staff with an interest in DV could apply to do training but there was no requirement to do so and some staff report wanting training but not being able to access it. Managers, VAN staff and educators are aware of the obstacles to accessing training, including vacancies, delayed recruitment to key positions, delays waiting for the new policy, problems with the 'flag' in the electronic learning management system, and the slow process of training the trainers. But they also recognise that 'in the meantime' staff have been expected to maintain DVRS compliance despite no training and to fill gaps and 'make do'.

Many staff identify a need for theoretical and baseline education about DV and then specific skills-based training on DVRS for mandated screeners. Staff express interest in understanding emerging ideas about DV, having a better understanding of what helps in DV and also knowledge of how to talk about DV with women outside of DVRS. This is in addition to knowledge of how to do DVRS and subsequently how to respond to disclosures.

"We don't have baseline courses, but we're all expected within health to be responding to domestic violence to some degree, just like child protection... Like to me it would make sense that you have a mandated domestic violence baseline education that everyone in health has, and then you go up a layer for the people doing DVRS, with expectation that they access their four-hour DVRS training, before they can start screening. At the moment we're assuming that all of those roles in mental health, drug health, child, family health, and antenatal maternity, just have this baseline and if not, you do a crash course in four-hours and off you go and start screening and then hope that you've got a social worker that you can refer to… there's a missing step." VAN worker

Throughout the review, staff and teams repeatedly endorsed the need for training, even in teams where they felt well supported and prepared for DVRS. Staff also desire training in being trauma-informed as they report being expected to 'do it', without consideration of what it means in practice.

"We need mandatory training for clinicians in trauma informed care & therapeutic relationship skills for the ability to ask questions in a more sensitive nature. Clinicians do not have counselling skills and this would be very beneficial". Maternity Worker (via survey)

Attending the training is beneficial for knowledge and awareness

There are some staff and teams who have recently had training, either as trainers or participants, and all spoke positively about it. Staff speak highly of the content, delivery, and opportunity to reflect on their practice. Even staff who report having existing knowledge of DV prior to training and can't identify what they learned from it, notably answered questions about DVRS with greater ease and were able to explain things to their colleagues when questions arose in focus groups.

Staff who have not yet attended the training are wary of what it might look like and what it might include. Staff want 'good training', 'localised training', 'meaningful and engaging training' and 'opportunities for refreshers'. Staff who have attended the 'train the trainer' sessions found the training also informative about local services and staff, for some they had not previously known who to contact for support in their LHD. In rural areas, staff value the online options, as much training is often inaccessible.

“we've just done the train the trainer. And prior to that, I always had a question of why is it only asked to women. Yeah. But now I know why”. AOD Worker

Trainers who have commenced rolling out local sessions in their LHDs report that many of the concerns they had initially have been unfounded, with training going smoothly and they have felt well prepared. ECAV describe that the 8-hour train the trainer training goes through the 4-hour mandatory module with additional tips and tricks for delivery to support trainers.

“we talk about how you might respond and we give tips and tricks. But there's just, even in the four-hour training, there's just not enough time. Even in the 8 hours… you still have questions…Tips and tricks include for example, “ok so you know, here is the gender based violence slide and quite often it will be at this point that you will hear “why aren’t men being screened” and here are some possible responses to that” ECAV Educator

The logistics of training whole workforces are significant

Despite staff enthusiasm for training and positive feedback about the training sessions, the logistics of training the whole workforce to meet the requirements of the Policy Directive are significant. Identifying and releasing enough staff to attend the train the trainer days is difficult, with subsequent obstacles in the logistics of organising, scheduling, evaluating and record keeping of training. Staff across LHDs describe that this is requiring significant time and resources from staff on top of existing roles.

“[It’s] very resource heavy because we are running services, we're not educators. And as much as we're passionate about this area, to then kind of be, go and train a four-hour training module to staff, that's a big chunk of work, which is important, but we're not really resourced to have, I guess…. It takes managers away or team leaders away from their job to do something which is really important, but again, it's just …there's more and more and more trying to fit into your role”. AOD Manager

In LHDs where the train the trainer program has been underway for longer, VAN have established ongoing supports to aid the trainers in their roles. VAN staff meet with the trainers every 6 weeks and support their practice by ordering resources and supporting skill building. VAN staff describe that a lot of work has gone into supporting the trainers beyond the initial ECAV course as the trainers may be dealing with staff who may be reluctant to change and who have done things the same way for a long time. VAN staff acknowledge it is a big ask to train an entire workforce through existing resources. Many staff who have been trained as trainers report not being prepared for what their subsequent obligations would be.

“We did the train the trainer last week, we did it because we were interested. But I don't really know what the expectation is. I don't think until I did the train the trainer, I really realized the implications of domestic violence routine screening, I've never really thought about it.” Midwife

Staff describe the training as dense and ‘very knowledge based’. Following the training they have additional concerns about how they will be able to train their colleagues and answer questions. Many staff feel it is beyond their roles to have to train the workforce and address all the resistance and questions that may arise. In addition, they have not

been allocated any time away from other tasks to roll out training. They question the efficacy and sustainability of the model.

"It doesn't really feel like it's a midwifery role…especially when it when it comes down to it a lot of its impacted by mental health…it'd be beneficial to have someone that is in that sort of area, that has a broader understanding of why these things sort of come about, that would be more beneficial for a training role." Midwife

Training also needs to be practical and ongoing

Alongside the logistics of the training rollout, staff also report that training about DVRS needs to be supported by opportunities to develop skills to support the knowledge, as well as ongoing opportunities for knowledge updates and practice. Staff who have been trained report wanting more detailed knowledge about how to work with clients with DV, as well as ways to support staff to practice how they word the preamble, questions, and response.

"I think the training needs to go much further. Like it is really good training as they do cover a lot… but it needs to be followed by more in-depth training…because you're holding these clients with the comorbidities and including…domestic violence, how do you work with the client? And often the perpetrator?" AOD Worker

Staff desire regular booster sessions and much more in-depth skills based training around empathising and engaging with women. Staff also request opportunities to discuss what is possible within the policy directive and critically reflect on practice.

"And I think that kind of training, other than 'this is just how you ask the questions' and it's always the same people who train it, who don't really understand it, who have never lived it or if they've lived it, you know, they're very clinical…It's like we have to go by this policy and this is what you have to do and say so then they deliver it like that… Needs to be more of a discussion about, well, how do you guys deliver it? What do you think is appropriate? and what can we do within the parameters of this policy? Maternity Worker

VAN staff identify a need for simulation components of training so that staff aren't practising DVRS on women, but instead having opportunities to try out their skills in simulation spaces. This idea is supported by clinicians who recognise they never get to hear how others ask the questions. While there is support for this in some LHDs, and efforts underway, it is unclear whose role this is to lead.

"Ideally, we need SIM training but at least we need staff to be saying the words out loud, becoming familiar, critiquing each other, talking about what they are uncomfortable with or comfortable with, what are you worried about, what answer might you get to that, where might you need support in your practice?... In nursing you don't go and inject a person, until you've injected like 200 oranges … or whatever is you inject right? But the DVRS, it's not like that… you're practicing on the live real person…You haven't even spoken it to a colleague…. in the DVRS there is like, OK, so we've trained you in the knowledge, now go out and practice on women." VAN Worker

Staff across settings agree that ongoing support for staff who deliver the training and for those who undertake screening is essential, along with opportunities to refine skills in supporting women beyond screening.

"ECAV need to think about the training model- It's one thing to provide training and to capacity build others to deliver the training. But I think that there needs to be… like a communities of practice type model where perhaps two maybe three times a year you know those trainers come together to have a look at and discuss, perhaps themes or elements of the training that might need to be reviewed, but a space where they're going to have ongoing support around these packages and the delivery and also the support for staff in that space as well. I'm not talking about the individual staff member who might have, you know, some history and some challenges. but it is more around in ongoing support system to help the integrity of that package stay at the level that it needs to stay in." VAN Worker

How will we know if training is effective?

While considerable effort is underway to support the rollout of mandatory training and the train the trainer model, questions are raised about how the efficacy of the approach will be monitored. Training all staff will occupy much of the implementation time and resources of the policy directive and VAN staff in particular want to be sure the training will benefit women who experience DV.

VAN staff identify that staff commonly misunderstand the intent of DVRS training prior to attending and imagine it will focus on broader responses to DV, when it is primarily focused on effective delivery of DVRS in line with policy requirements. While it is hoped that the training will help with consistency or practice around DVRS, this will take time and will also be difficult to assess.

Evaluation is not built into the local 4-hour training sessions to assess how staff feel their knowledge, skills or confidence have improved or what staff need to maintain their skills, with LHDs considering how to build this in. Staff identify that a difficult link needs to be made between training the workforce and the experiences of women being screened.

"Because I think it's one thing to have it written in the policy and you know, kind of go, here's the expectation. But it's another thing to develop staff confidence in delivering it… Confidence and assertiveness in asking the questions in a very gentle cared for way and then the confidence and capacity to be like 'OK then I've gotta do something with this information' and that that also is inclusive of things like documentation as well." Van Worker

Staff identify other resources and supports required for DVRS to be effective

Throughout the data collection for this review, staff were asked what would be beneficial for them to undertake DVRS more effectively across maternity and AOD settings, and in ways that are trauma-informed. Staff identified a number of things they feel would support them in the ongoing implementation of DVRS in the context of the new Policy Directive.

Staff want recognition of the complexity of the work that they do and the need for support

Staff feel the complexity of the work they do to support women, provide care, meet expectations and keep themselves and others safe is sometimes invisible and under-recognised. Staff emphasised that decisions not to screen women do not always equate to poor practice and that focusing on completion of screening does not reflect

the complexity of trust, safety, and engagement, as well as safety planning and responses. Staff across settings describe difficult roles with complex communities, and speak about their work with passion and care. They want support and access to skilled supervision to ensure wellbeing. They value the chance to contribute to decisions that will impact their work and to advocate for staff wellbeing, alongside better care for clients. DVRS is not the primary source of staff feeling unsupported or overwhelmed, but is an example of expectations not being matched with structural support. Staff want recognition that while they value DVRS and are committed to it, undertaking it is also asking a lot of staff and occurs in contexts of many competing demands.

"I think it would be helpful for the ministry to know what it's like working in drug health services, the sort of things that we face on a day to day basis, the sort of threats and violence that we are exposed to as staff. Is there any wonder that we're nervous about asking people too many questions about violence at home? You ask the questions. But beyond that, it's a bit of skill, it's a bit of luck. We do the best that we can with what we have". AOD Worker

"It's all very well to suggest that we have a trauma informed lens. But I don't know if you know quite how many things we're having to do and hold, things have got infinitely more complex. And you're asking us essentially, to look at the whole situation differently without any additional support. There's like a million things that pile up, right? Like, yes, DVRs, may be just four minutes extra per client. But when you're talking about 500 clients, and in the context of everything else we have to do, it's actually a huge piece of work" AOD Manager

Alongside the challenges and concerns that staff raised about DVRS, they also highlighted good work being done and emphasised the investment and time that goes into DVRS in services.

"we are experienced clinicians and conduct this assessment with dignity and respect and provide take-away information for clients. We are mindful of privacy and client's permission to discuss or not. In my service we are proactive with responding to DV and conduct weekly risk assessment for clients who identify or disclose DV." AOD Worker (via survey)

Staff want the resources required to do their jobs well across their unique settings

Staff are frustrated by the lack of resources to do their jobs in ways that feel effective and meaningful. Lack of resources and worker frustrations relate to roles and settings as a whole, with DVRS one part of the picture Resources include adequate staffing, reasonable workloads, supervision, access to medical and allied health services, physical spaces to meet with clients that are private and welcoming, and access to education sessions and opportunities. Many staff report doing multiple roles or lacking time to offer even basic care. Staff in rural areas report feeling isolated in their roles and under-resourced compared to city areas, while staff in urban areas also report severe understaffing and a lack of systemic support.

"Honestly, it's kind of hard to know what we need. We have minimal resources, we have never had training, where do you start? We are all busy...we have a lot of priorities. We are doing what we can." AOD Worker

"There is a real issue with space in the clinic. When having very personal conversations we often have to ask other colleagues to leave the room and sometimes we are meeting clients in staff areas. Social Work don't have protected space so they are

often meeting women in tea rooms or big education spaces which feels inappropriate and lacking in safety." Maternity Worker

"We need more money to support services like ours" Aboriginal Health Worker

In regard to responding to DV, resources refer to things required to ensure they can support women who do disclose. For example, emergency funds, baby supplies, emergency accommodation and transport. Staff feel that once they have screened women, they need access to pragmatic forms of help such as money, phones or accommodation. The experience of undertaking DVRS differs across each of the mandated settings and resources must be adapted to the unique contexts of services.

"There has to be a location where we can just access things, or even a bucket of funds. This woman's presented we need to get this, this and this immediately, and the worst thing about it is in health they'll just discharge a woman with no follow up plan with no idea of how she's gonna go get home. Or where home is or where the perpetrator is...we need buckets of funds so we can at least pay for two or three nights accommodation for those emergency type situations… I know this asking for money is always a thing that never happens, but if there was a bucket of funds…" Aboriginal Health Worker

"Transport is a big factor in regional areas. If we are thinking about safety for women- how do they get to safe spaces, how do they stay connected if they are living somewhere else. [Existing housing services] have been awful. …It is awful having to put women through that, you know, like the processes that is expected of them and these women can be pregnant and you're expecting them to be running around and getting all these paperwork for housing. And they don't have cars. Public transport is absolutely appalling. It creates such anxiety for these women and then puts the pressure on us as service to provide that transport for these women to all these places to get all their information". Aboriginal Health Worker

Staff want specialised positions for Domestic Violence within Health

Beyond recognising the work they already do, and the resources required to do their roles better, staff also identify a need for specialist DV positions. Specialist positions would be a point of contact for staff undertaking screening, support training delivery, oversee strategic planning of the policy implementation, ensure fidelity and standards of practice and coordinate DVRS. While these roles currently have largely been taken up by existing VAN staff, both VAN and other clinicians call for permanent staff to drive the portfolio. Alongside this, teams and workers identify a need for staff within their teams with specialist knowledge and skills in DVRS and response.

"We need a social worker, we don't have any social workers in in drug health. How is this a nursing role? How is it possible that we're meant to know everything about domestic violence and housing and pathways? Without any time allocated for that? We have our clients booked throughout the day, there's eight hours in the day. And if somebody tells us they are experiencing domestic violence, that's going to require a whole lot of time to respond in safe and appropriate ways. Where does that time come from?" AOD Worker

"we need an actual role… someone to help with this stuff. How are we supposed to manage?" Midwife

With the shift towards mandatory training, VAN staff are in a bind of wanting this policy, having pushed for this policy, seeing the importance of this policy, but having to take on a huge task within existing busy roles. VAN staff

identify that LHDs need support with implementation scaffolding and planning. Currently relying on people doing it strategically within existing roles leads to wide variations in practice and further delays in training roll out.

"I think in a climate where there are so many different programs…. I just know that we're not on equal footing in the way that we see this work… particularly when they're competing against many other demands every single day. And those demands, particularly in the hospital setting, as an example, are very clinically based or medically based". VAN Worker

Staff want access to structured decision-making tools to support safety planning and clear pathways to local services

Staff express concern about having to determine risk for women and establish immediate safety plans. Staff want structured tools to guide decision making after women disclose DV, similar to resources available for child protection decision-making. Decision making tools would assist in responding directly to the woman but also in determining what steps to take.

"We have only vague processes of what to offer/do when women disclose, it would be very beneficial to have set pathway". Maternity Worker

I was just thinking of a cheat sheet, you know, how you know what to do…what to do in a specific situation…If the client says this, what do you do? If whatever happens, What do you do? That would be good. I think sometimes it's about knowing what will I do with that information? And that being really clear. And I think people have varying degrees of understanding about that for lots of different reasons. Maybe you're new to service? Or maybe you you're new in your career, or maybe it's just a competency in general, and maybe other factors that can impact at the time, but sometimes I think it's those kind of things as well. It's wondering about what exactly do I do when it's not black and white" Maternity Worker

Staff want to know quickly and easily what services are available in their local area and which service would benefit their client. Staff speak of trawling the internet or outdated resource lists, spending hours on the phone to services or trying to find a colleague to ask. Many staff identify a need for a centralised portal of services or even a service that could take on the role of finding appropriate services for women if they were referred following DVRS.

"And there's a lot, like they just need one kind of updated source of information where there's not 101 of them and where it can go to a referral service that says, OK, well, these are the identified people in your area". Maternity Worker

"services come and go and availability of services comes and goes very quickly and having a centralized area like an app or something that we could all go into and go right, it's up to date. AOD Worker

Staff want to see integration at all levels to share responsibility for DVRS across mandated settings

Staff identify the responsibility for DVRS should be shared amongst health and seen as core business across the mandated streams from the Ministry downwards. Currently VAN feel they are 'driving' the portfolio into the mandated streams but they would prefer that there is already existing leadership and buy in from executive within mandated streams in LHDs as well as across the portfolios of the Ministry, such that their roles can focus on implementation support rather than educating executives in the policy requirements.

"The first time [Mental Health/AOD/Maternity/CFHN executives] hear about the requirements for their services shouldn't be from me" VAN worker

"I think we tend to still work in siloes you know, drug and alcohol, mental health, DV, ok there's DV you refer to a DV service, there's drug use, refer to Drug health, whereas we need to put more emphasis on how we can work with this client with their complex issue" AOD Manager

Staff want clarity about how to accommodate diverse family structures, cultures and genders, while still protecting women

Staff would like guidance on how to ensure that DVRS isn't discriminatory against people in same-sex relationships or people of diverse genders, while still ensuring it still protects women. In addition, staff want to know how to adapt DVRS for cultural sensitivity and inclusivity.

Staff want to better accommodate Aboriginal knowledge and First Nations' understandings of family beyond intimate partnerships.

'I believe we need further training about DV in context of LGBTQIA relationships and trauma-informed, appropriate support for such clients'. AOD worker (via survey)

Staff want social and political action to ensure identifying women, supports women

Staff want to ensure that screening women for DV equates to support for women and to do this, they are clear about the social and political action required. Social and political change includes ensuring there are services to refer to, that women are heard and kept safe when seeking police input, that child protection referrals result in support for women, that there are appropriate and safe housing and refuge options that don't discriminate against women based on culture or coping strategies, and that community attitudes and understanding of Domestic Violence minimise stigma and are aware of dynamics of DV and power and control. Without these structures, staff experience moral tensions about screening women, without places to send them for support.

We need the police and the courts to take this seriously. Then there may be a chance. Without that, I pity all women that disclose and think they will be appropriately supported in a rural community. It's devastating. Clinical Nurse Consultant (via survey)

"There is a lack of specialist services in the communities for supporting our consumers who are living in a situation that is unsafe due to domestic and family violence. There are not enough specialist clinicians available in our remote communities to offer counselling, let-alone accommodation available for emergency housing. Even Emergency Services (both Police and Ambulance) have restricted access due to availability in those remote areas". Mental Health Worker (via survey)

As part of social awareness, staff want women to have access to resources so that they are aware of the many forms of Domestic Violence, as well as what pathways of support might be so that they can make decisions about disclosure. Staff want places to send women for help and to do so with a sense of hope and empowerment, not just as a crisis response but to achieve this, staff also need hope and empowerment.

"Maybe they need a pamphlet for when they sit in here [in the clinic], like, what is domestic violence, how you can get help … so they can see themselves telling someone and you know, what the pathway of getting help would actually look like? I guess if they can perceive themselves getting the help, then maybe they would ask for help…If they can see that there's positives that come out of making changes. Yeah. And that support might be available and not that it's not necessarily doom and gloom to leave and yeah, its hard leaving. But the benefits outweigh and you can get through it. It's not the end." Midwife

"Why would they disclose if it is just going to mean more scrutiny?... I wonder if there is a way that we could highlight what supports are available if people do disclose" Maternity Worker

Staff worry about focusing just on screening without a dual focus on follow up services and responses. They describe asking women on entry to multiple different services about DV, but they also want to know what is helping and how to keep women safe.

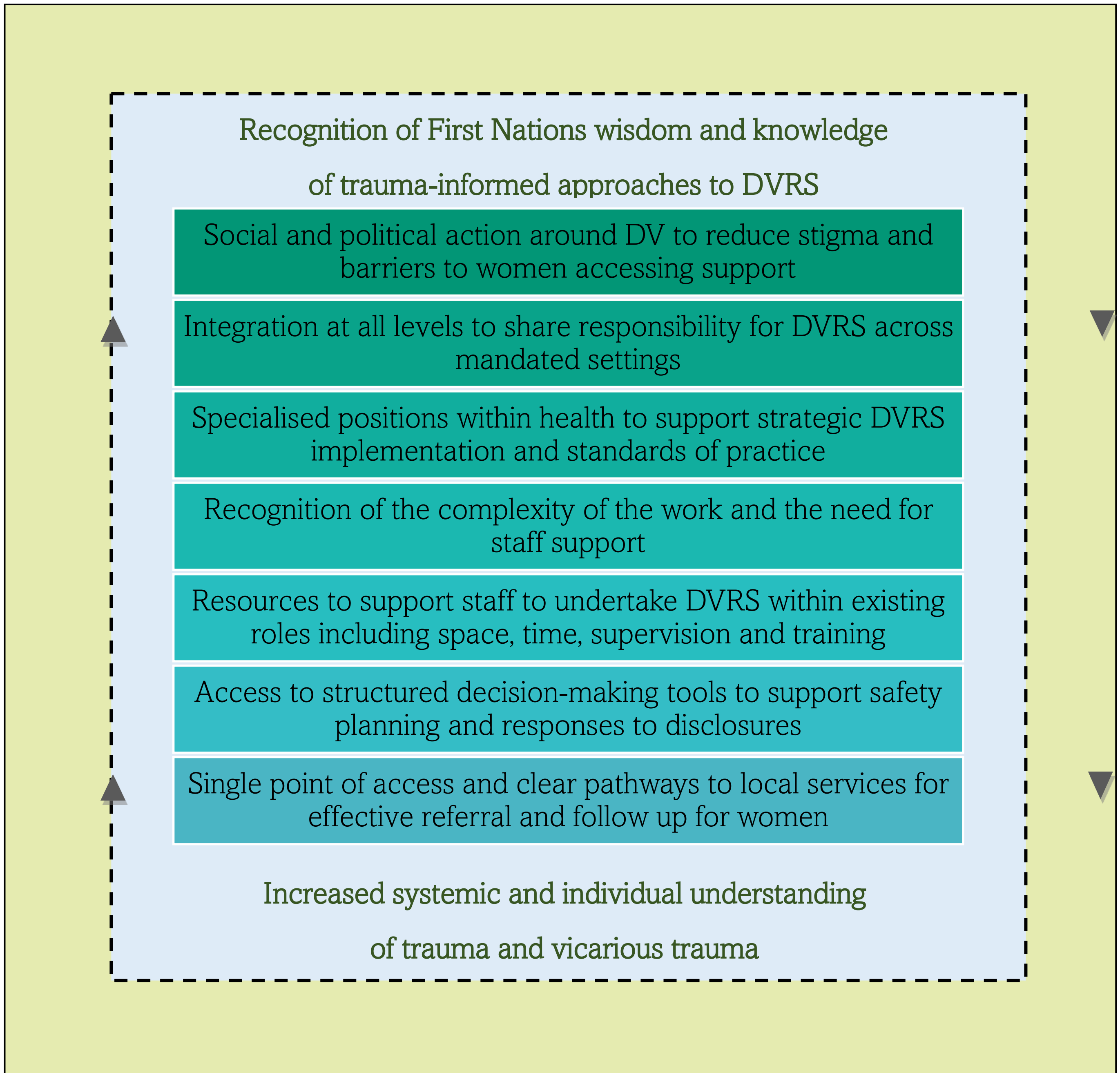
"I'd be really upset if what came out of this [review] was more focus on that form. Like that is one moment in time but if you are just going to make a whole lot more questions and a new form, that takes away from what is really important. The relationship. And how are we going to ask in ways that are relaxed and safe. And then what? It's not the form that's an issue" AOD Worker

Conclusion

The findings of this project align with the literature around healthcare workers experiences of DV screening, suggesting that many of the barriers and systemic issues are ongoing. Similarly, work to support implementation of DVRS and associated policies is ongoing with many initiatives underway to improve practice and outcomes. The review found that staff are committed to DVRS and engaged in practices to try to respond to DV for their clients. Unique experiences of staff across mandated settings were identified and require ongoing consideration in the context of DVRS expectations and implementation. Staff identified numerous challenges to implementation of the Policy Directive but early implementation data shows interest and engagement, with staff keen to access training and contribute to ongoing practice development. Staff are adapting practice to work towards being trauma-informed within existing contexts, as demonstrated by attention to safety and trust when engaging with women.

Staff identify numerous areas of support that they require within their roles and LHDs, while emphasising that DVRS occurs in a wider context of attitudes to DV, that women must be able to access support and services following disclosure, and that more work is needed to ensure services are adequately resourced to respond to disclosures of Domestic Violence within healthcare. While it is not part of this review, it is also noted that resourcing is required to support this work at the Ministry level, where currently there are no dedicated positions or funds for DVRS. However, as the Policy Directive implementation continues, there are a number of key areas identified that require ongoing support from the Ministry of Health and LHDs for successful uptake of changes at an LHD, service and clinician level.

Figure 3: Resource needs of the workforce



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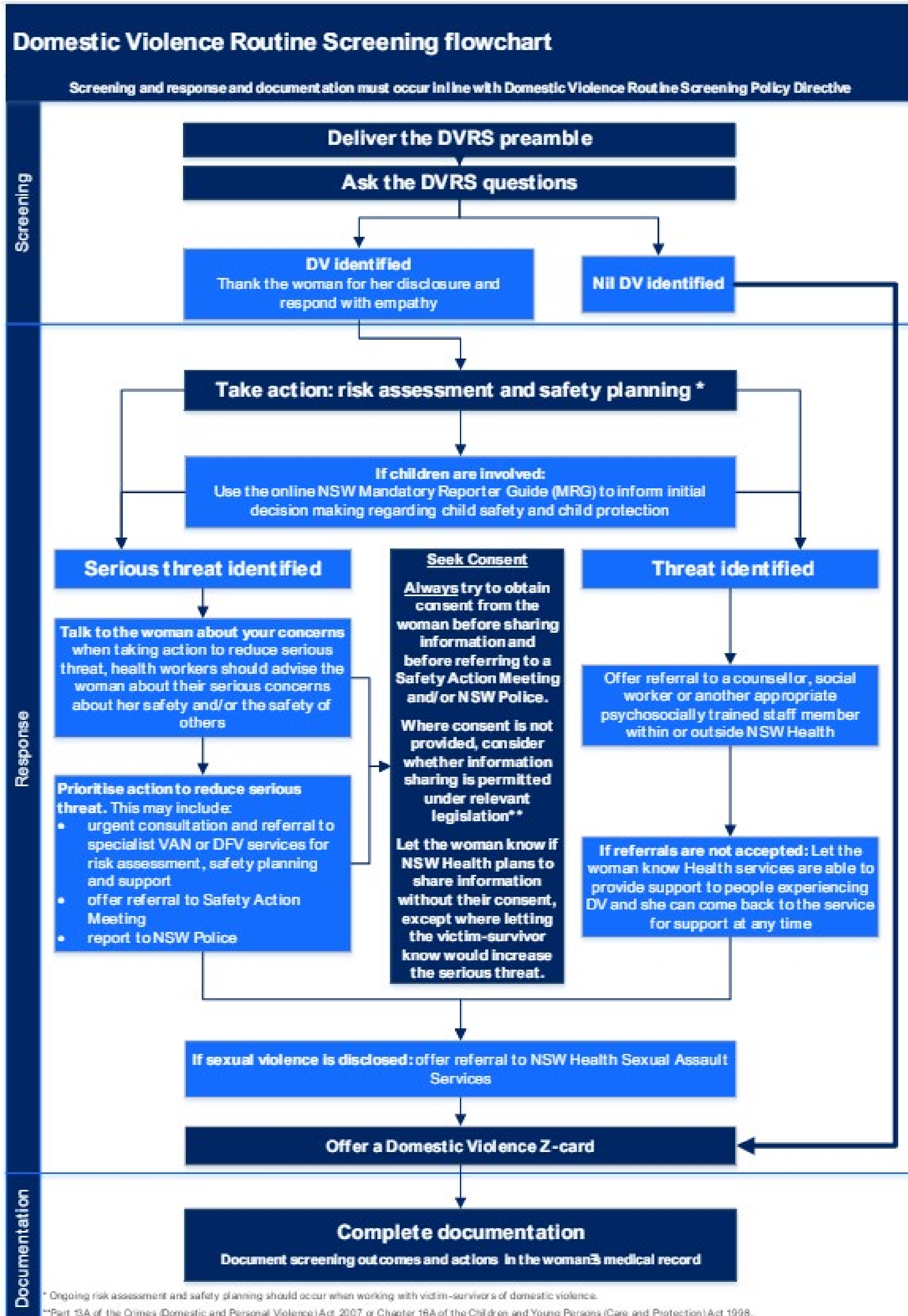
Domestic violence routine screening flowchart



Staff survey

DVRS implementation review

This survey is for staff of NSW Health who undertake mandatory Domestic Violence screening in their work, or staff involved in DVRS training or management.

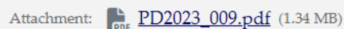
If this relates to you, please complete the survey below.

This survey asks about your experiences with undertaking or supporting processes of Domestic Violence Routine Screening (DVRS) in your workplace. Please answer the questions that are relevant to your role.

The purpose of the survey is to explore the implementation of the 2023 Policy Directive for DVRS which guides mandatory screening of all women and girls accessing maternity and child and family services, and women 16 years and over accessing mental health, and alcohol and other drug services.

The survey will inform ongoing policy implementation support by the NSW Ministry of Health, PARVAN Unit. No individual or service will be identified in any report produced.

The policy is attached here for your information.


Attachment: PD2023_009.pdf (1.34 MB)

1) Prior to commencing this survey, were you familiar with the 2023 DVRS policy directive?

2) What setting do you mainly work in?

3) Please provide additional information about your role or position (optional)

Expand

4) How long have you worked in this setting?

Optional

5) Do you currently..

Please choose the answer that best describes your current role in the LHD

Thinking about your own practice in working with women who access your service, across each of the stages of DVRS (pictured) please provide specific examples or suggestions in relation to the questions below:

6) What do you think is working well in DVRS in your setting?

Expand

DVRS refers to Domestic Violence Routine Screening.

7) What challenges do you face in undertaking or supporting DVRS?

Expand

8) In what ways is DVRS undertaken in ways that are trauma informed (or not)?

Expand

'Trauma informed' refers to the delivery of DVRS in ways sensitive to the effects of trauma upon women accessing services

9) In your workplace, are there clear and accessible pathways and processes of response to disclosures of DV on DVRS?

Expand

10) What helps or hinders effective DVRS generally at a team, service or systemic level?

Expand

11) What support do you need to undertake (or support others to undertake) DVRS in ways that are more trauma informed?

Expand

12) Do you imagine your colleagues in other mandated settings experience similar challenges and successes to you? (why/why not?)

13) In what ways do you think staff's own experiences, attitudes or values may impact upon DVRS (positively or negatively)?

Expand

14) Are there specific training or resource needs you can identify that would benefit you or your colleagues?

Expand

15) Please add any other comments or feedback you have in relation to DVRS

Expand

To discuss this project, please contact Zia.Tayebjee@health.nsw.gov.au (Senior Project Officer) or Sophie.Isobel@sydney.edu.au (External Researcher).

If you require support regarding your experiences of working with people experiencing Domestic and Family Violence, you can contact your local Employee Assistance Program via your staff intranet page, or the NSW Domestic Violence line on 1800 656463.

Submit

Focus Group Guide

The purpose of this project is to explore the implementation of the 2023 Policy Directive for DVRS which guides mandatory screening of all women and girls accessing maternity and child and family services, and women 16 years and over accessing mental health, and alcohol and other drug services.

- Has the introduction of the policy had any impact upon your work?
- Reflecting on your experiences, what has been working well across the phases of DVRS in your setting?
- what are the challenges you and your colleagues or your staff face in undertaking DVRS in your setting?
- In what ways has knowledge of trauma informed approaches impacted upon DVRS?
- In what ways do you think staff's own experiences, attitudes or values may impact upon DVRS (positively or negatively)?
- Do you imagine your colleagues in other mandated settings experience similar challenges and successes to you? (why/why not?)
- What support do you need to be able to better undertake DVRS in ways that feels safe and effective for you and for the women you screen?
- Are their specific training needs you can identify that would benefit you or your colleagues?
- Is there anything else you want to use this opportunity to say?

Prompt for stages of Preamble, Asking the questions, Taking appropriate actions, Giving the Z card, Documenting (sample prompts below):

Preamble

- Do you feel you can make women feel safe enough prior to screening? How do you know when people are feeling safe enough to screen?
- What choice is possible?
- What examples do you have of things that help or hinder your approach in preamble through a trauma informed lens? (individual, service, system)

Asking the screening questions

- what works and what doesn't work for you and for the women in how you ask the screening questions? (Probe for environmental, interpersonal and procedural)
- Do you feel you can make women feel safe enough during screening?
- What choice is possible?
- What examples do you have of things that help or hinder your approach in screening through a trauma informed lens? (individual, service, system)

Taking appropriate actions

- what works and what doesn't work for you and for the women in how you ask the screening questions? (Probe for environmental, interpersonal and procedural)
- Do you feel you can make women feel safe enough when responding to screening?
- What choice is possible?
- Are there clear and accessible pathways and processes of response and referral in your setting if women disclose DV?
- What examples do you have of things that help or hinder your approach in taking action through a trauma informed lens? (individual, service, system)

Giving the Z-card

- what works and what doesn't work for you and for the women in how you ask the screening questions? (Probe for environmental, interpersonal and procedural)
- Do you feel you can make women feel safe enough when giving out written resources?
- What choice is possible?
- In what ways is the Z-card fit for purpose (or not)?
- What examples do you have of things that help or hinder your approach in giving the card through a trauma informed lens? (individual, service, system)

Documenting

- what works and what doesn't work for you and for the women in how you document the screening outcome and actions?
- What examples do you have of things that help or hinder your documentation through a trauma informed lens? (individual, service, system)

Other

- How did you learn to do DVRS (prompt for training attended)
- In what ways do you think staff's own experiences, attitudes or values may impact upon DVRS (positively or negatively)?
- Do you imagine your colleagues in other mandated settings experience similar challenges and successes to you? (why/why not?)
- What support do you need to be able to better undertake DVRS in ways that feels safe and effective for you and for the women you screen?
- Are their specific training needs you can identify that would benefit you or your colleagues?
- Is there anything else you want to use this opportunity to say?

Interview guide for stakeholders and managers

- Can you overview your role in relation to DVRS in your LHD?
- How long have you been in this role?
- We are reviewing the implementation of the 2023 policy framework for DVRS across mandated settings in NSW. Are you aware of the policy? Has it impacted upon your work or that of your colleagues (if so, how?)
- Can you explain current processes for access to training and support for DVRS in your setting?
- What has been working well across the phases of DVRS in your setting?
- what are the challenges you and your colleagues or your staff face in undertaking DVRS in your setting?
- In what ways has knowledge of trauma informed approaches impacted upon DVRS?
- In what ways do you think staff's own experiences, attitudes or values may impact upon DVRS (positively or negatively)?
- What support do you need to be able to better undertake DVRS in ways that feels safe and effective for you and for the women you screen?
- Are their specific training needs you can identify that would benefit you or your colleagues?
- Is there anything else you want to use this opportunity to say?