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Safer Families

International Domestic Violence and Health Conference

20 - 21 November 2018

Always was, always will be Aboriginal land.

Abstract Book

Children and Mothers in Mind – retrieving the mother-child relationship

Dr Margaret Kertesz[1], Ms Larissa Fogden[1]
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Introduction

This presentation discusses a program aiming to support families in the aftermath of family violence.

Context and Aim

Family violence not only threatens a mother's safety, but attacks her relationship with her children by undermining her confidence and isolating her from support networks. However, there is evidence that strengthening the mother-child relationship after separation from a perpetrator of violence can mitigate the long-term effects of exposure to violence for both mothers and their children.
Mothers in Mind (MiM), an evidence-based, manualised program originally developed in Canada for mothers and their young children, was piloted in the Victorian context by the Children's Protection Society in 2016-2017.

Method

It was evaluated by University of Melbourne researchers, using pre- and post- psychometric measures and semi-structured interviews with mothers and facilitators.

Findings

Findings from the MiM evaluation suggest that participation in this program increased mothers' confidence in their ability to parent effectively and increased mothers' feelings of connectedness with their children.

Innovative contribution to policy, practice and/or research

The Children's Protection Society has further developed the program, now called Children and Mothers in Mind (CMiM), to better meet the needs of families after violence, by adding further groupwork for mothers and children separately, and also a casework component to support families with the many other life challenges they face after leaving violent situations. CMiM provides an opportunity for mothers to connect with other women in similar circumstances and with skilled professionals. It also allows them to relearn and practise ways of being a parent in a safe and supported environment away from the control of the perpetrator. Evaluation of the CMiM program is now underway, further exploring the sector-wide implications of this program, and investigating its potential to build a bridge between family violence services and family services.

Improving service responses for family violence and brain injury

Dr Suzy Goldsmith[1], Ms Erin Davis[2], Mr Matt Addison[3], Dr Michele Lonsdale[4], Professor Belinda Gabbe[5], Dr Darshini Ayton[5]

[1]Brain Injury Australia, Australia, [2]Domestic Violence Victoria, Australia, [3]No to Violence, Australia, [4]Centre for Excellence in Child and Family Welfare, Australia, [5]Monash University, Parkville, Australia

Introduction

Responding to the Victorian Royal Commission into Family Violence, Australia's first evidence-based study of family violence and brain injury was led by Brain Injury Australia with consortium partners Monash University, Domestic Violence Victoria, No to Violence and the Centre for Excellence in Child and Family Welfare, funded by the Victorian Department of Health and Human Services.

Context and Aim

Brain injury worsens the impacts and avoidable costs of family violence for families and for the wider community. Death, permanent disability or temporary disability result in lost opportunities for economic and social participation, independence and quality of life. For victims, brain injury is a serious, yet often unacknowledged outcome of family violence, impacting on safety and recovery. 'Challenging behaviours' resulting from brain injury are associated with perpetration.

Method

The incidence and prevalence of family violence-related brain injury was estimated from Victorian hospital data. An international literature review provided further context. Current service responses to brain injury were explored via interviews with practitioners working in the integrated family violence system. Stakeholder consultation guided the research and informed the recommendations.

Findings

The study identified a strong association between brain injury and family violence:
for victims, 40% of those attending Victorian hospitals sustained a brain injury; and for perpetrators, the rate of brain injury was twice that of comparable non-violent populations. Gaps in service responses hamper effective rehabilitation, recovery and support.

Innovative contribution to policy, practice and/or research

Recommendations focus on practice innovation to close service gaps at the same time developing novel insights for use in policy and research. They comprise: improved screening, information resources and integrated services for people at increased risk of perpetrating or becoming a victim of family violence due to their brain injury, as well as for people with a brain injury resulting from family violence.

Support for Fathers Project

Mr Dom Alford[1]
[1]*Relationships Australia, Australia*

Support for Fathers is a national project coordinated by Relationships Australia that aims to support young men and fathers in their role as parents and partners, and in turn increase men's involvement in gender equity and reduce family violence.

The project is funded by Department of Social Services (DSS) and comes under the National Plan to Prevent Violence against Women and their Children 2010-2022.

We aim for young men and fathers to:

- Be part of the change and contribute to a reduction in violence against women and their children
- Better understand the importance of their role as parents and partners
- Have access to evidence-based tools, strategies and knowledge
- Improve their confidence as both parents and partners
- Develop, maintain and role-model healthy and respectful relationships with family members.

Support for Fathers will result in the development of:

- Resources for young men and fathers
- A Professionals' Toolkit for service providers working with young men and fathers.

Timeline:
Throughout 2018, the Support for Fathers project will travel around Australia to consult with services, fathers and families.

The final outcomes from these national consultations will be presented in November 2018 at the Safer Families Conference.

In 2019, the resources and toolkit that will be developed as part of the project will be shared with the community and training will be offered to service providers.

Cloaked in Strength - Aboriginal mothers' experiences, family violence through cultural practice

Ms Shawana Andrews[1]
[1]*Uom, Parkville, Victoria, Australia*

Introduction

Family violence is a systemic Australian issue but it is evident that Indigenous women are particularly vulnerable to violence. Male perpetrated family violence features significantly as a reason for the over-representation of Indigenous babies and children in out of home care and in the lives of Indigenous women who are disproportionately over-represented in the legal, health and welfare systems as victims and survivors of family violence.
Context and Aim (why this is important)
This project aims to re-claim Aboriginal mothers' experiences of family violence and to explore the role of cultural practice as a tool of engagement, resilience and resistance.

Method

Beginning with a review of the literature pertaining to family violence, feminist approaches and trauma, the project will engage Aboriginal mothers living in Melbourne through yarning interviews and a series of possum skin cloak workshops to consider their stories of family violence.

Findings

The findings are currently being developed and analysed and will be offered during this presentation as preliminary findings.

Innovative contribution to policy, practice and/or research

The Cloaked in Strength project aims to articulate an Indigenous epistemological understanding of Aboriginal women's experiences of violence. Drawing on cultural practice as a community-identified protective factor but one that is under-researched, the project aims to contribute to the understanding of violence through Aboriginal women's voices.

The project offers new insights and knowledges into the phenomenon of family violence with particular reference to the role of cultural practice as a factor of resilience. Using an Indigenous feminist standpoint this project aims to engage possum skin cloak making and other Aboriginal cultural practices to give agency and voice to Aboriginal women of Melbourne. It will also serve to contribute to the restoration of possum skin cloak making as a process of strengthening Aboriginal women's sovereign cultural identity and cultural continuity.

The impact of intimate partner violence on severe maternal morbidity.

Dr Beatriz Ayala Quintanilla[1], Professor Susan McDonald[1], Dr Wendy Pollock[1], Professor Angela Taft[1]
[1]*La Trobe University, Melbourne, Australia*

Introduction

Preventing and reducing violence against women (VAW) and maternal mortality are Sustainable Development Goals. For one maternal death there are many women affected by severe maternal morbidity (SMM) requiring management in the intensive care unit (ICU). These women represent the most critically ill obstetric patients of the maternal morbidity spectrum and could complement the review of maternal mortality.

Context

VAW has been associated with all-cause maternal deaths, and since many women (30%) endure violence usually exerted by their intimate partners (IPV) and this abuse can be severe during pregnancy, it is important to determine whether it impacts SMM.

Aim

To investigate the influence of IPV on severe maternal morbidity.

Method

Prospective case-control study undertaken in a hospital in Peru. Sample size of 109 cases (obstetric admissions to ICU) and 109 controls (obstetric patients not admitted to ICU). Data collected through interviews and from the medical records. VAW was evaluated by using the World Health Organization (WHO) instrument. Binary logistic regression model assessed any association between IPV and SMM.

Findings

Overall IPV rate before pregnancy was 60.6% and during pregnancy 43.6%. Emotional violence showed the highest rate (60.6% vs. 43.6%), followed by physical violence (8.3% vs. 5.0%) and sexual violence (3.7% vs. 0.5%) before and during pregnancy, respectively. IPV rate was significantly higher ($p < 0.05$) before pregnancy (72.5% vs 48.6%) and during pregnancy (58.7% vs. 28.4%) in SMM cases than the controls. There were not no statistically significant differences in socio-demographic characteristics between SMM cases and controls.

Innovative contribution

Women affected by severe maternal morbidity may have a greater burden of IPV before and during pregnancy. IPV may be consider as a risk factor leading to severe maternal morbidity in the ICU. Thus, non-biological factors (IPV) should be taken into account to improve the mother-baby dyad health.

Longitudinal evaluation of a domestic violence training program for midwives

A/Prof Kathleen Baird[1,2], Professor Debra Creedy[1], Dr Armonrat Saito[1], Ms Jennifer Eustace[1]
[1]School of Nursing and Midwifery, Griffith University, Meadowbrook, Australia, [2]Women Newborn & Children's Services, Gold Coast University Hospital, Gold Coast, Australia

Background:
In Australia, 36% of women who experienced violence by a partner reported that this occurred when they were pregnant.1 Around seventeen percent of women experience domestic violence (DV) for the first time during pregnancy. Routine enquiry about domestic violence during pregnancy is now accepted as best practice. Training is essential to improve knowledge and practice. Yet very few studies have undertaken a comprehensive evaluation of training impact over time.

Aim:
This presentation will provide an overview of an evaluation of the longitudinal impact of a domestic violence training and support program to promote midwives' routine antenatal enquiry for domestic violence using a mixed methods design.
Method: Data sources included (1) surveys of midwives at 6 months post-training, (2) interviews with key stakeholders at 12 months, (3) chart audit data of screening, risk, and disclosure rates (for 16 months). Measures included midwives' knowledge and preparation for routine antenatal enquiry, and perceptions of organisational barriers to routine enquiry.

Findings:
Forty (out of 83) participant surveys could be matched and responses compared to baseline and post-training scores. Wilcoxon signed-rank test identified that all 6-month follow-up scores were significantly higher than those at baseline. Level of preparedness increased from 42.3 to 51.05 ($Z = 4.88$, $p < .001$); and knowledge scores increased from a mean of 21.15 to 24.65 ($Z = 4.9$, $p < .001$). Most participants (>90%) reported improved confidence to undertake routine inquiry. A chart audit of screening rates for 16 months post-training revealed of the 6671 women presenting for antenatal care, nearly 90% were screened. Disclosure of domestic violence was low (< 2%) with most women at risk or experiencing violence declining referral.

Contribution to Policy & Practice:
Training, support processes, and referral pathways contributed to midwives' sustained preparedness and knowledge to conduct routine enquiry and support women disclosing domestic violence.

Findings from the 2017 Queensland Domestic Violence Death Review Board

Associate Professor Kathleen Baird[1,2]
[1]School of Nursing and Midwifery, Griffith University, Meadowbrook, Australia, [2]Gold Coast University Hospital, Southport, Australia

Background

In Queensland, since 2006, 263 women, children and men have been killed by a family member or someone who were, or had been, in an intimate partner relationship. For every death, the ramifications are immense and widespread; affecting not only loved ones left behind but also the service providers required to respond to these situations. In addition, the health impacts of domestic and family are substantial, extending beyond just physical injuries and include a range of ongoing mental health problems, and substance abuse.

Aim

This presentation will provide an overview of the findings from the 2017 Queensland Domestic and Family Violence Death Review Report. Common themes, issues and patterns identified with respect to health system contact across the cases will be identified and reported upon during the presentation.

Method

The Board systematically reviewed 27 cases involving 29 deaths that occurred between 2011 and 2016. The cases were clustered together focusing on different types of deaths, cases were clustered together focusing on different types of deaths including homicide suicides; perpetrator suicides; intimate partner homicides; victim suicides; Aboriginal and Torres Strait Islander family violence homicides; and filicides.

Outcomes

A large proportion (70.4%) of both victims and perpetrators in the cases reviewed by the Board has a previous history of contact with health services. This included contact with a range of clinical and non-clinical staff within the hospital and health services, paramedics, general practitioners, counsellors, social workers, psychologists and psychiatrists; in both the private and public sectors.

Contribution to policy and practice

While each health sector and agency has a critical role in keeping victims and their children safe and holding perpetrators to account, all agencies must be consistent in their responses to both victims and perpetrators to ensure a robust and comprehensive service response.

Ensuring authentic indigenous youth voices within research: engagement processes.

Miss Te Wai Barbarich[1], Ms Terry Dobbs[1], Dr Moana Eruera[2]
[1]Auckland University of Technology, Auckland, New Zealand, [2]Oranga Tamariki: Ministry for Children, Wellington, New Zealand

Taitamariki (Māori young people aged 13-17 years old) voices are extremely important when wanting to support the development of their healthy intimate partner relationships within Aotearoa (New Zealand). Māori are the indigenous peoples of Aotearoa. The United Nations Convention on the Rights of the Child and the Declaration of Indigenous Rights offer strong foundations for the rights of all children to participate in matters affecting them. Like other young people, taitamariki Māori perceptions of their own lives and experiences can provide essential input towards creating better conditions for and with them in the future. Harmonised, a Māori-centred study that has been co-developed with taitamariki, has seen the creation of a smartphone application that promotes healthy relationships amongst secondary school students in Aotearoa. The study is currently being piloted within eight secondary schools including mainstream and full immersion Kura Kaupapa Māori schools.

This workshop will discuss culturally responsive engagement strategies. Workshop participants will have the opportunity to explore some methods and strategies used which are derived from an indigenous Māori-centred framework. These ensure the kaupapa (purpose) of the study remains taitamariki centred and strengths based throughout the research process. Tika (what is right), whakapapa (relationships), manākitanga (cultural responsibility) and mana (equity) are ethical guidelines that have closely guided all our engagement processes for the study, including the recruitment of secondary schools and their students. The importance of correct and culturally responsive engagement proves to be beneficial in the recruitment stages, as the access to taitamariki voices within a school setting remains a priority.

The aim of the workshop is to share with participant's learnings from our research and those aspects of engaging with schools and working with indigenous young people to gain their authentic voice. These methods may be transferable to enhance work with indigenous young people in different contexts.

Celebrating Strength and Resilience through stories of family violence

Ms Sophie Boord[1]
[1]Your Community Health, Preston, Australia, [2]Your Community Health, East Reservoir, Australia

Introduction:

"Celebration" is not a word often used in the area of family violence. Yet, when women who have lived through these experiences come together and share stories of survival and strength through therapeutic groups and activities, there is a shared understanding, validation and sense of hope.

Context and Aim:

Your Community Health counselling service has extensive history, practice knowledge and experience in providing individual counselling and therapeutic groups to women and children who have experienced family violence. For the last 15 years, the therapeutic family violence group, Women Standing Strong (WSS), has been run annually and for many years funded through the partnership with the Northern Integrated Family Violence Services. Evaluations from the groups highlighted the need for women to have a voice and to have space to share their stories.
This project aimed to explore women's stories of resilience and strength in surviving abusive relationships, and increase understanding of ways to share their lived experiences.

Method

Consultation was carried out by 1) structured questionnaires with existing counselling clients who were known to have experienced family violence 2) Counselling staff 3) focus group of women who previously attended WSS. Twenty clients and eight staff were consulted. Five women volunteered to participate in the video project and assist with co-design.

Findings

80% of women wanted to attend a group and activities to build relationships and share experiences. The Focus group
outcomes indicated the success of art therapy and open discussion. The final pre and post evaluation of this process will be completed in July 2018. The therapeutic impact of having a voice and sharing their story of family violence has increased feelings of resilience and reduced isolation.

Innovative contribution

The extensive consultation process and co-designed video will be used as an educational resource for clients, staff and the community.

Early Intervention Programs harness cultural strength

Ms Antoinette Braybrook[1]
[1]*Djirra (formerly Aboriginal Family Violence Prevention Legal Services Victoria), Abbotsford, Australia*

This concurrent session will go into detail on frontline experience of the Strong culture = strong women = strong families presentation.

For Aboriginal people, connection to culture, community, lore, language, land and stories – a connection that has been catastrophically interrupted by white colonisation – is the key to finding strength to reduce vulnerability to experiencing violence.

Sitting at the heart of domestic violence early intervention and prevention at Djirra is a fundamental belief that strong culture = strong women = strong families = strong communities.

Our early intervention and prevention programs are designed and delivered by Aboriginal women who know why cultural strength matters. Growing up in a society that reinforces negative stereotypes about Aboriginal women and simultaneously silences Aboriginal women's voices, our programs have been developed to support Aboriginal women's resilience, strength, culture and identify to reduce vulnerability to violence and build Aboriginal women's wellbeing.

Djirra has recently invested strongly in developing culturally safe and relevant evaluation strategies for our prevention programs – mapping out the critical contribution this work makes to breaking the cycle of violence and building the evidence base around 'what works'.

Attendees of this presentation will gain insight into how Djirra's early intervention programs harness cultural strength to increase resilience to domestic violence, leading to stronger, safer families and communities.

Strong culture = strong women = strong families

Ms Antoinette Braybrook[2]
[1]National Family Violence Prevention Legal Services Forum, Abbotsford, Australia, [2]Djirra (formerly Aboriginal Family Violence Prevention Legal Services Victoria), Abbotsford, Australia

Introduction

Family violence is a national epidemic and Aboriginal and Torres Strait Islander women are at the centre of this crisis. Nationally, Aboriginal and Torres Strait Islander women are 32 times more likely to be hospitalised because of family violence and 10 times more likely to be killed as a result of violent assault. The racism, poverty, gender inequality and discrimination experienced by our women is at the heart of this national tragedy.

Context and Aim

Nationally, Family Violence Prevention Legal Services work to prevent and address family violence and have over 17 years of extensive on-the-ground experience working with Aboriginal and Torres Strait Islander communities.

Method

For Djirra, this experience puts the voices of Aboriginal women are the heart of everything, Aboriginal women have the solutions to issues affecting their lives. Our community education and early intervention programs have been developed based on extensive feedback about what Aboriginal women want. Through listening to those with lived experiences of family violence we gain vital insight about how family violence operates and what victim/survivors need to make it stop.

Djirra's early intervention and prevention programs are designed and delivered by Aboriginal women who know why cultural strength matters. Our programs have been developed to support Aboriginal women's resilience, strength, culture and identify to reduce vulnerability to violence and build Aboriginal women's wellbeing.

Findings

Aboriginal and Torres Strait Islander women and their communities are key to preventing violence and creating change. Through promoting culture as protection and strength, and listening to Aboriginal and Torres Strait Islander women we can implement changes that will transform the landscape of family violence.

Innovative contribution to policy, practice and/or research

Attendees will gain insight into how early intervention programs harness cultural strength to increase resilience to domestic violence, leading to stronger, safer women, families and communities.

Translating evidence from the Maternal Health Study to inform system-reform

Prof Stephanie Brown[1], Dr Deirdre Gartland[1], Dr Laura Conway[1], Professor Harriet Hiscock[1]
[1]*Murdoch Children's Research Institute and The University of Melbourne, Parkville, Australia*

Introduction

Intimate partner violence (IPV) is a serious public health and human rights issue with potentially grave consequences for women's and children's health. While health consequences for women are well described, the evidence is weighted towards refuge and clinical samples. Few longitudinal studies have explored intergenerational cycles of abuse and/or documented health consequences for mothers and children in community samples.

Context and Aim

The Maternal Health Study is a longitudinal study investigating the health and wellbeing of over 1500 first-time mothers and their firstborn children. At 1, 4 and 10 years postpartum women reported on experiences of IPV. The aim of this symposium is to explore implications of the findings for early intervention.

Method

Prospective cohort of >1500 Victorian first-time mothers and their firstborn children followed-up to age 10. Study questionnaires included the Composite Abuse Scale, maternal experiences of abuse in childhood, mental and physical health measures (for mothers and children), and children's socio-behavioural outcomes. Face-to-face child assessments included cognitive functioning and physical measures.

Findings

More than 1 in 4 women (31%) experienced IPV in the first 10 years after having their first child. The prevalence of IPV remained relatively stable over this time period. Study findings provide evidence of the long-term consequences of IPV for women and children's health, and also demonstrate intergenerational patterns of family violence. Symposium presenters will discuss key findings and explore implications for early intervention.

Innovative contribution to policy, practice and/or research

IPV is at least as common as maternal depression, and in many cases more devastating. Despite this, the health sector has been slow to respond. There is an urgent need for systems change to strengthen the capacity of health services and practitioners to identify and respond to IPV, and provide care tailored to address individual needs of women and their children.

Engaging lived experience participants using integrated knowledge translation

Ms Jacqui Cameron[1], Professor Kelsey Hegarty[1], Professor Cathy Humphreys[1]
[1]*University of Melbourne, Carlton, Australia*

Introduction

Despite ten years of growth in knowledge translation research, there is still a gap between research findings and applying this knowledge in practice. Whilst there is a large body of literature on domestic violence, there is a relatively small body of literature on knowledge translation and domestic violence. Many projects in this area are developed without the inclusion of voices from women with lived experience.

Context & Aim

WEAVERs are a lived experience panel established by the Melbourne Research Alliance to End Violence against women and their children. The aim of this project was to include the voices of lived experience participants (from WEAVERs) as part of the implementation of an integrated knowledge translation model with a domestic violence research network.

Method

Integrated knowledge translation involves collaboration between the researchers and those with lived experience. This model using co-production principles ensures lived experience voices are active members of the research process. Lived experience participants will provide feedback on the development and implementation of the integrated translation support guide for the research network.

Findings

This rapid exchange presentation will provide preliminary results regarding the first six months of engagement with lived experience participants and include lessons learned regarding the engagement process.

Innovative contribution to policy, practice and/or research

This project ensures women's voices can be genuinely included as part of the knowledge translation model. This will not only offer new evidence regarding such an approach but will also potentially deliver a model for others interested in the inclusion of those with lived experience into their knowledge translation. Equally, it will add considerable value to the growing body of integrated knowledge translation literature internationally, especially in regards to the value of lived experience participants actively participating in integrated knowledge translation research.

How to implement knowledge translation support with a research network?

Ms Jacqui Cameron[1], Professor Cathy Humphreys[1], Professor Kelsey Hegarty[1], Associate Professor Anita Kothari[2]
[1]University of Melbourne, Carlton, Australia, [2]University of Western Ontario, Ontario, Canada

Introduction

One of the most important discussions in research is the uptake of knowledge translation. Whilst existing literature on knowledge translation is extensive, the quality is variable and the effectiveness unclear. Moreover, there remains no single model of knowledge translation applicable for areas such as domestic violence research.

However, integrated knowledge translation offers a potential model, as the underlying principle is a truly collaborative process (similar to that of co-production) engaging researchers, practitioners, managers, policy makers and participants who are all working together to achieve common goals.

Context & Aim

The aim of this project is to develop an integrated knowledge translation support guide for a domestic violence research network.

Whilst researchers and practitioners are generally aware of the importance of knowledge translation there are often barriers to knowledge translation.

Integrated knowledge translation has the capacity to reduce these barriers by providing practical tools and strategies for successful implementation. This model also ensures lived experience voices are active members of the research process.

The workshop will provide participants with:

- An integrated knowledge translation support guide;
- An understanding of the key elements of the integrated knowledge translation model;
- Examples of implementation of the support guide including voices of lived experience.

Method

This workshop will consist of three components:

1. An interactive presentation, where workshop facilitators will provide an overview of integrated knowledge translation model;
2. A small group activity where participants will engage in a group cognitive interview;
3. An interactive group discussion of how to successfully implement the support guide with a research network.

Findings

Not Applicable

Innovative contribution to policy, practice and/or research

This project has the potential to benefit researchers, practitioners and policymakers by providing them with a support guide tailored specifically for the area of domestic violence research and practice.

Translating research into practice: Family Violence Workplace Support

Ms Jenny Chapman[1], Ms Georgia Shepherd[1], Ms Julia Blackburn[1]
[1]*Royal Women's Hospital, Melbourne, Australia*

Introduction

The introduction of the Family Violence Workplace Support (FVWS) Program at The Women's emerged from a convergence of factors: the Strengthening Hospital Responses to Family Violence (SHRFV) initiative, the Victorian Royal Commission in FV recommendation 190, and the enterprise bargaining agreement processes.

The workplace has been identified in international and Australian literature as a key opportunity to support people experiencing family violence (Chung et. al, 2012). The Royal Commission into FV (2016), has outlined expectations for the public sector enterprise agreements, including family violence leave.

Context and Aim

Hospitals are uniquely placed to drive social change and help to reduce the impact of family violence. Early lessons from the SHRFV implementation demonstrated the importance of building manager capability to respond to the needs of staff experiencing family violence.

Method

This interactive workshop will be facilitated by the statewide project leads involved in the development and delivery of the FVWS program. The workshop will provide an opportunity for participants to explore the broad context of workplace support, understand the objectives of the training and experience the content.

Finding.

Human resource staff in health settings often report they feel unsure about the parameters and expectations of their managers in responding to FV. This workshop will enable health professionals and policy-makers to explore the challenges, skills and resources required to support staff experiencing FV.

Innovative contribution to policy, practice and/or research

This is an important example of research translation into clinical practice.
Learning objectives

- Understand the value of workplace support model in health settings as a site for secondary intervention with employees experiencing family violence
- Encourage participants to understand the complexity of first-line responses to staff in a health setting

Interactive elements

- Abridged version of statewide SHRFV train-the-trainer model including:
  - Role plays
  - Case-studies
  - Group work

Champions in Family Violence – Opinion Leaders or influencing change?

Ms Jenny Chapman[1]
[1]*Royal Women's Hospital, Melbourne, Australia*

Introduction

The Strengthening Hospital Responses to Family Violence (SHRFV) project provides a whole-of-hospital framework to support sustainable change in health system responses to FV. To support the sustainable implementation of SHRFV, the Women's Hospital in Melbourne has proposed a clinical champion model drawing on similar models operating in primary care and hospitals.

Context and Aim

The available literature on clinical champions details that successful clinical champions – or opinion leaders – are seen as likeable, trustworthy and influential (Flodgren, 2011). While clinical champions or local opinion leader models have been accepted practice for many years in hospital settings, it remains unclear if this model has been or could be applied effectively to FV as a domain.

Method

This study utilised a literature review via key medical databases to analyse the clinical champion model and its potential in the FV domain.

Findings

A Cochrane review by Flodgren et al (2011), found that the use of opinion leaders can successfully promote evidence-based practice in health care. While it examined the general management of clinical problems, the review did not include any psychosocial domains such as FV. This review identified no other evaluated models of FV clinical champions in a hospital setting, and only a limited amount of evidence in the wider domain of primary care (Young-Wolff et al, 2016). The current review analyses the effectiveness of champions suggesting the role of physicians in this model is important, as are characteristics of champions, and how champions can support change on a local and system level.

Innovative contribution to policy, practice and/or research

Clinical champions are an effective part of promoting evidence-based practice in health care. Clinical Champions in FV have emerged as an innovative model that is likely to assist with knowledge transfer and sustainability of first-line responses to FV victim/survivors in healthcare.

Turning points experienced by Bhutanese women experiencing Intimate Partner Violence(IPV)

Mrs Phuntsho Choden[1], Associate Professor Kerry Armstrong[1], Dr Marguerite Sendall[1]
[1]*Queensland University Of Technology, Kelvin Grove, Australia*

Background:
Asian countries have high prevalence of intimate partner violence (IPV) as compared to other regions of the world and it is often attributed to the regions unique social and cultural structures. Asian women are oppressed by these powerful structures and IPV is often endured in silence. The issue of IPV has also pervaded Bhutanese women's lives silently. This current study aimed to examine Bhutanese women's help-seeking behaviours as a result of IPV.

Method:
Semi-structured interviews were used to explore the sensitising concepts such as how Bhutanese women recognised IPV, when they recognised it, and how they responded to IPV. Fifteen women who had experienced IPV and currently seeking supportive services at RENEW (Respect, Educate, Nurture, Empower Women) were interviewed. The Trans-theoretical model of behaviour change (TTM) was used as a theoretical framework to understand women's cognitive, affective and behavioural change process. Thematic analysis was used to understand the patterns of responses across the transcript.

Findings:
Women's experiences of IPV and seeking help aligned with stages of change of TTM. Six distinct turning points were identified which influenced women's positive movement along the stages of change. It includes (1) Failure to change his behaviours; (2) Perceived threats to her values; (3) Pushed to act; (4) Noticing effect on her parents; (5) Gaining positive support; and (6) Reflecting, rebuilding and rejoicing.

Innovative contribution:
This study provides a novel insight on Bhutanese women's experiences of turning points and their help-seeking behaviours as a result of IPV. This information will be used to develop an intervention which may assist the relevant service providers in Bhutan to provide more acceptable services to vulnerable women.

Crisis centre staff experiences with sexual and gender diverse clients

Ms Georgina Clarke[1,2], Prof Kelsey Hegarty[2], Dr Gemma McKibbin[2]
[1]Melbourne Medical School, University of Melbourne, Melbourne, Australia, [2]Department of General Practice, University of Melbourne, Melbourne, Australia

Introduction

Intimate partner violence (IPV) is an urgent public health issue in Australia and internationally. Sexual and gender minorities experience IPV at equal or higher rates than heterosexual women, and the 2015 Victorian Royal Commission into Family Violence highlighted that more research is needed to understand IPV in this marginalised population. Lesbian, gay, bisexual, trans*, intersex, and queer (LGBTIQ) victims of IPV report discrimination from IPV services and want services to be more accessible and inclusive.

Context and Aims

There is a gap in existing literature exploring service provider experiences of responding to LGBTIQ victims experiencing LGBTIQ abuse, especially in Australia. Safe Steps Family Violence Response Centre, the Victorian Statewide crisis telephone service, has recently trained staff in this area and there is an opportunity to fill this gap. The aims of the project are to explore staff experiences of responding to LGBTIQ victims of IPV at Safe Steps and to investigate their suggestions for service improvement.

Method

Twelve staff of Safe Steps Family Violence Response Centre were recruited and interviewed. Interviews were recorded, transcribed, coded using Nvivo, cross-coded, and thematically analysed according to the method set out by Braun and Clarke (2006).

Findings

Some staff felt well supported when responding to LGBTIQ clients, but others wanted more training and support from management. Staff faced challenges such as difficulty identifying LGBTIQ clients and a lack of acceptable accommodation for this population. Suggestions for service improvement include: policies to identify LGBTIQ callers, data collection, comprehensive training, and better outreach to the LGBTIQ community.

Conclusion

Although limited to one service, this study provides the first Victorian data about front line staff experiences of responding to LGBTIQ victims of IPV. The data will be used to inform policy and practice at Safe Steps in the context of responding to LGBTIQ survivors.

Lessons for Social workers in providing crisis care to victim/survivors of sexual assault.

Dr Alissar El-Murr[1], Samantha Clavant
[1]*Australian Institute of Family Studies, Southbank, Australia*

Introduction:

The Centres Against Sexual Assault (CASAs) manage crisis care units (CCUs) for victims/survivors of sexual assault across the state of Victoria. This paper will focus on the CCU based at the Royal Women's Hospital, which applies an integrated model of care that depends on coordinated relationships between CASA counsellors/advocates, police, hospital staff and forensic doctors.

Context and Aim:

This project is interested in the ways that the voices of victims/survivors have shaped a health system response to sexual assault. This research asks: what can we learn from the CCU in its response to victims/survivors, and can elements of this model of integrated care be applied in a health system response to domestic violence?

Method:

While there is a paucity of formal evaluation data, CASA counsellors/advocates keep records of the experiences of victims/survivors who access the CCU. Research consultations with counsellors/advocates has provided anonymised, general data about victim/survivor experiences. This has been analysed alongside qualitative research into public health policy and programming in Victoria, which formed part of a recently completed doctoral project.

Findings:

The success of the CCU as a tertiary-level intervention is possible because of coordination between Victoria Police, CASA, and the Royal Women's Hospital. This type of intervention draws on principles of feminism and public health that centre the voices of victims/survivors, working as both an empowering and effective way of lessening the harms of sexual violence. Coordination between services, particularly with regard to referral pathways, enables adult men and women of diverse backgrounds to access free treatment at the CCU.

Innovative contribution to policy, practice and/or research:

This research contributes to the discussion about how to improve a health system response to domestic violence, and how certain elements of an integrated model of care for sexual assault victims/survivors could be applied in a domestic violence context.

Building confidence and capability in health professionals to respond to family violence

Associate Professor Helen Cleak[1], Ms Sue Hunt[2], Dr Fotina Hardy[3], Ms Jo Bell[4], Mr Brett Davies[4], Ms Adele Bentham

[1]Queensland University of Technology, Brisbane, Australia, [2]Mater Hospital, Brisbane, Australia, [3]Logan Hospital, Brisbane, Australia, [4]Logan Hospital, Brisbane, Australia, [5]Womens Legal Service, Brisbane, Australia

The Health-Justice Partnership was established between the Logan Hospital and the Women's Legal Service in Brisbane in 2016 to provide timely legal advice to women experiencing Domestic and Family Violence (DFV) within this complex health system. One of the features of the service was to offer training to improve health professional's legal literacy in the context of DFV. A review of the literature suggests that having sufficient knowledge and skills to respond to women experiencing family violence improves capacity, self-confidence and willingness of health professionals to refer to appropriate services.
This paper reports on a study that surveyed health staff to understand their knowledge, attitudes and practices in relation to domestic and family violence. The respondents were largely an experienced group who had worked in the health sector for a considerable time. The results showed wide agreement that health professionals have a responsibility to respond to domestic violence and that it should be part of their role. However, the majority of the respondents had not completed available Queensland Health training and only 12% had received face to face training, with most completing a two-hour training session. Across all disciplines, most had no external training. In relation to understanding family violence, approximately half believed that they could identify the elements and definition of family violence, or could provide an appropriate response in cases of family violence, and a significant number were unsure. The data is important as it provides additional information about the need for domestic violence training in health settings, supporting calls for more general education of health professionals, it identifies gaps and will promote discussion about opportunities and improvement in this space.

Severity of intimate partner physical abuse and formal help-seeking behavior

Ms Kim Carmela Co[1]
[1]*University Of The Philippines, Philippines*

Introduction

In the Philippines, 25% of ever-married women reported experiencing violence from their partner, but only 10% of them actually sought medical or legal help (NDHS, 2013).

Aim

The objective of this study was to determine the association between severity of physical abuse experienced and formal help-seeking among victim-survivors of intimate partner physical violence in the Philippines.

Methods

The data came from the National Demographic and Health Survey of women ages 15-49 years old (NDHS, 2013). A total of 1037 responses from women who reported experiencing physical abuse from their intimate partner were included in the analysis. Inverse probability weighting was used to adjust for confounding variables.

Results

Less than 5% of women who experienced intimate partner physical abuse formally sought help (45 out of 1037 women). Controlling for the effect of confounding variables (age, educational attainment, employment, socio-economic status, justification of abuse, and type of abuse experienced), women who experienced severe physical abuse were more likely to seek medical or legal assistance compared to those who experienced moderate physical abuse (OR=4.58, 95% confidence interval: 1.87-11.25).

Conclusions

Severity of abuse is an important factor influencing the woman's decision to seek medical and/or legal help among victims of intimate partner violence in the Philippines. These systems should be capable of handling severe cases of abuse in order to address the needs of women who seek help. Efforts should also be made to increase formal help-seeking rates among all victims of domestic violence.

The economics of empathy education - fighting hard for peace.

Ms Lisa Craig[1]
[1]*Womens Health And Family Services, Northbridge, Australia*

Introduction

Research conducted over a three-year period linking companion animal abuse and domestic violence (www.mysavinggrace.org.au) raised numerous questions regarding the appropriateness of current education in building a pro peace culture for individuals, families and communities. Creating a culture of change requires an understanding of how resistance to violence intersects with other form of resistance, which incorporate resilience and empathy as guiding principles.

Context and Aim (why this is important)

The aim of this inquiry is to bring together areas of peace building and resistance work that have not been included in current conversations and planning in regards to individual, family and community prevention and intervention work and in educational models.

Method

Drawing from first person interviews across the spectrum of survivors, service providers, health professionals, first responders, policy makers and educators develop an understanding of what they feel would be impactful at a community, grass roots, and health messaging level.

Findings

'My Saving Grace' research indicated that there is a need for a stated theory of change which brings together our understanding of violence and its determinants and how we believe we can grow as a compassionate, pro peace society. Recommendations from this research include models of empathy based training, principles from the rewilding movement and a push for understanding of resistance as a way to combat harmful cultural messaging.

Innovative contribution to policy, practice and/or research

'My Saving Grace' is the first project of its kind in Australia. Findings from this project have the potential to inform practice areas related to the health, safety and wellbeing of women and children and the development of curriculum across educational spectrums.

How Hospitals inadvertently collude with perpetrators and maintain the silence

Ms Christine Craik[1]
[1]*Rmit University, Melbourne, Australia*

Hospitals and health care providers in general have a huge role to play in detecting domestic and family violence (D/FV) and facilitating conversations which validate a survivor's strengths and resilience, and offer information for a possible way forward. In my research, women survivors discussed the ways in which hospital processes and health care professionals inadvertently collude with perpetrators and maintain the silence and the status quo of their situation.
Women living with or recovering from D/FV are more likely to visit a health professional than women in the general population. Presentations to emergency departments (ED's) are also significantly higher for women living with or recovering from domestic and family violence for a variety of reasons, including the accessibility of this service at high peak times for abuse (overnight, public holidays) anonymity, and financial implications, to name a few.
Many of the barriers to disclosure for women living with or recovering from D/FV have been well documented, and various programs are being rolled out across Australia to address these. However, in my interviews with both women survivors and health care professionals there was evidence of not only a subtle and persistent barrier on behalf of health care professionals that needs attention, but also a subtle and systemic assisting of perpetrators by hospital processes.
This PhD has included a literature review, 4 focus group interviews with women who have presented to health professionals and ED's while living with and recovering from D/FV; online surveys and interviews with ED workers across Australia; and interviews with Managers of peak D/FV agencies.

Two important findings from this research demonstrate that both Health care professionals and the processes of hospitals themselves, are contributing to aiding and colluding perpetrators, and maintaining the silence of victim/survivors, which has implications for policy, practice and further research.

Evaluation of a program for fathers who use violence

Dr Kristin Diemer[1], Ms Larissa Fogden[1], Professor Cathy Humphreys[1], Mr David Gallant[1]
[1]*University Of Melbourne, Australia*

Introduction

The Victorian Royal Commission into Family Violence has brought perpetrators of family violence into the view of practitioners working with families across Victoria. However, practitioners wishing to refer fathers who use violence to programs that will address the impact that the violence has on their children have limited options.

Context and Aim (why this is important)

Few existing programs specifically address fathering in the context of family violence: parenting programs do not focus on fathers' use of violence, while Men's Behaviour Change Programs are not fathering-specific. In response, a three-site program trial of the 17-week, evidence-based, intervention program Caring Dads (developed in Canada by the University of Toronto and Canadian agency Changing Ways) for fathers who expose their children to family violence is being trialled in Victoria.

Method

During the trial both process and program evaluations are being conducted using pre- and post-psychometric tests and semi-structured interviews with participant fathers, surveys and interviews with mothers of the men's children, referrers into the program facilitators, managers and coordinators. The evaluation seeks to explore how successfully the Caring Dads program fills the existing gap for referral pathways for fathers who use violence.

Findings Innovative contribution to policy, practice and/or research

The evaluation is currently in the second year and much can be said about the challenges in bringing a new program for a different client group, into an established service system. This presentation will discuss early findings of the process evaluation. The discussion will contribute to both policy and practice when developing programs for fathers who use violence in the home.

Trusting and telling: disclosure in a nurse home visiting program

Professor Lynn Kemp[1,2], Ms Tracey Bruce[1,2], Ms Emma Elcombe[1,2], Ms Fiona Byrne[1,2], Dr Susan Perlen[3,4], Professor Sharon Goldfeld[3,4,5]

[1]Western Sydney University, Liverpool, Australia, [2]Ingham Institute, Liverpool, Australia, [3]Centre for Community Child Health, Parkville, Australia, [4]Murdoch Children's Research Institute, Parkville, Australia, [5]Department of Paediatrics, University of Melbourne, Parkville, Australia

Introduction

There is considerable evidence that having adverse childhood experiences (ACEs), that is, exposure to serious risks such as domestic violence, parental mental health issues or drug use, is associated with poorer adult health. Action is needed to mitigate the impacts of children being exposed to serious risks that may lead to having ACEs.

Context and Aim

Early intervention requires that risks are identified and responded to. Public health screening methods for detection of domestic violence are debated, with evidence that families find the questions distressing and confusing and that many will not feel safe or confident to disclose.

Method

In the context of a trial of sustained nurse home visiting (SNHV) for families experiencing sociodemographic adversity, the “right@home” trial, we collected detailed data on family disclosure of domestic violence from the families offered the SNHV program. From these data we could identify what is disclosed and when, and whether there were patterns of nurses’ activity that supported disclosure and how nurses subsequently responded.

Findings

Serious risks associated with ACEs were prevalent in this population: 77% of families disclosed one or more serious risk; of these, families disclosed an average of four risks. Disclosure of domestic violence was associated with psycho-socio-demographic screening risks, particularly stress in pregnancy. A long term relationship between nurse and client facilitated disclosure. There were discernible patterns of activity that precede and follow disclosure of domestic violence.

Innovative contribution to policy, practice and/or research

Knowledge of what nurse activities are associated with families’ disclosure of domestic violence will inform training of nurses to support earlier disclosure and improve the detection of issues that could lead to children experiencing ACEs. Earlier detection will support responses to address the risk, and prevent or limit children’s exposure to ACEs, with long term benefits for both child and family.

Public trust in the Brazilian VAW legal and health response

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[1]Emory University, Atlanta, United States, [2]Faculdade da Medicina do ABC, Santo Andre, Brazil

Introduction:

In 2006, the Maria da Penha Law became the first federal law to define violence against women (VAW) and establish mechanisms to punish perpetrators in Brazil [Presidência da República 2006]. Yet half (50%) of Brazilians believe that the way the justice system punishes perpetrators does not reduce VAW. [DataSenado 2017] The lack of trust in government institutions to protect and safeguard women is found not only within the legal sector, but also within the health sector; only 24% of Brazilian women who experience violence sought out health care. [DataSenado 2017]

Aim:

The purpose of this study is to examine public trust in the ability of the Brazilian health and legal sectors to respond to VAW.

Methods:

Thirty in-depth interviews (IDIs) were conducted in Portuguese with women, aged 18 and older, and residents of São Paulo, Brazil. All IDIs were audio recorded, transcribed verbatim, and de-identified. Data were coded and analyzed for deductive and inductive themes using MAXQDA12.

Findings:

Most women were familiar with at least one federal VAW law. Thirty percent (30%) reported personal experiences of VAW, consistent with prior population-based studies. [WHO, 2003] Inductive themes included: a lack of trust in government, views that the legal sector is ineffective, and that VAW laws have little impact and may exacerbate violence. A widespread lack of trust in government was observed. VAW laws were seen as having minimal impact in protecting women; sometimes laws were perceived as exacerbating violence–specifically via retaliatory action. Disdain for the health sector was less prominent than the legal sector. Yet women were not enthusiastically receptive to health sector VAW response.

Practice implication: Since both legal and health sectors are government institutions, lack of trust in the legal sector appears to transfer to a lack of trust in the health sector when it comes to VAW.

Indigenous voices informing interventions: co-designing a technological family violence resource

Ms Renee Fiolet[1], Professor Kelsey Hegarty[1], Dr Laura Tarzia[1], Professor Kerry Arabena[1], Ms Renee Owen[2], Ms Corrina Eccles[3], Mr Syd Fry[3], Ms Kaley McGough[3], Mrs May Owen[3], Ms Jasmine Knox[3], Mr Terry Atkinson[3]
[1]University Of Melbourne, Melbourne, Australia, [2]Barwon Health, Geelong, Australia, [3]Wadawurrung Community Asdvisory Panel, Wadawurrung Country, Australia

Introduction:
Aboriginal and Torres Strait Islanders peoples experience family violence at much higher rates than that of non-Indigenous Australians. When attempting to seek help, Australia's Indigenous peoples also encounter a greater number of complex barriers to doing so. Nevertheless, interventions designed to address Indigenous family violence are rarely informed by the peoples who will be the end-users. Although Australia's Indigenous peoples have embraced the use of technology for communicating, social engagement and health advice, no studies to date have explored Australian Indigenous views on using technology to address family violence.

Context and Aim (why this is important):
To share Aboriginal and Torres Strait Islander people's voices on the potential for using technological resources to address family violence.

Method:
This project is being undertaken in collaboration with an Indigenous Australian community (Wadawurrung) to co-design a technological family violence resource using methods that ensure the voices of the community members - as end-users - are involved and heard. Since the project's inception there has been Aboriginal and Torres Strait Islander involvement; from the initial idea for the study, to the design and the face-to-face, semi-structured interviews (30-60 mins in length) with 20 Indigenous peoples residing on Wadawurrung country.

Findings:
Seeking help was often avoided through official channels, mostly because of family violence being a "shame job" or due to an absence of culturally suitable services. Participants were positive about the potential for a technological intervention, indicating they felt it would address some of the barriers faced when help-seeking.

Innovative contribution to policy, practice and/or research:
This research could add to the growing body of evidence supporting the need for co-designed, culturally informed family violence interventions that are usable and engaging for Australia's Indigenous peoples and support the growing evidence that technology can be a useful resource in help-seeking for family violence.

Assisting Patients/Clients Experiencing Family Violence: A Hospital Wide Staff Survey

Dr Caroline Fisher[1], Ms Catherine Ludbrook[1], Ms Amanda May[1], Ms B Allen[2], Dr. Emma O'Brien[1], Ms Elizabeth Bradbury[1], Dr Steve Pincus[1], Ms Toni Withiel[3], Ms Nadine Rudkin[4], Professor Karen Willis[3]
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Introduction

High levels of family violence (FV) result in significant adverse outcomes in Australian society. Recommendation 95 from the Victorian Royal Commission on FV outlined the need for health services to provide a whole of hospital response to patients experiencing FV.

Context and Aim

The study was conducted as part of the Royal Melbourne Hospital's Strengthening our Hospital Response to Family Violence initiative. The aim of the study was to provide baseline data on staff training, knowledge and confidence working in the area of FV. The study was conducted prior to the roll out of a hospital wide transformational change project involving policy development and upgrades, work-force wide staff training and integration with community support services.

Method and Findings

534 clinical staff (nursing, medical, allied health) responded to the online survey. The results indicated: 72 percent of staff had received no FV training in the last two years, 72 percent had little or no confidence working in the area of FV, 68 percent indicated that they never or rarely screen patients for FV, and 60 percent indicated that they do not know how to ask patients about FV. Staff identified barriers to working effectively in the area of FV included: a suspected perpetrator or other vulnerable person (i.e. children) being present during the consultation, patients' reluctance to disclose when asked, time limitations, staff not knowing what to do or say, concerns about offending the patient and language barriers.

Innovative contribution to policy, practice and/or research

These baseline results indicate suboptimal levels of staff training, screening and confidence working in the area of FV, and highlight a clear need for the roll out of the FV initiative. The results provide essential information to assist in the appropriate tailoring of training to meet staff needs by profession and clinical area.

The Hidden Majority: The Health Impacts of Emotional IPV

Ms Kelly FitzPatrick[1]
[1]*Murdoch Children's Research Institute, Australia*

Background

Intimate partner violence (IPV) is now widely agreed to consist of physical, sexual and emotional abuse. Women rarely experience physical abuse without concurrent emotional abuse. Despite this, most research has focussed on physical abuse alone or physical and sexual abuse. The prevalence and impacts of these different types of IPV are not well understood.

Context / Aim

The presentation draws on data from the Maternal Health Study, a longitudinal study of more than 1500 first-time mothers, to estimate the prevalence and associated impacts of emotional and physical IPV in the 12 months following the birth.

Method

A prospective pregnancy cohort of 1507 first-time mothers recruited in early pregnancy and followed up at 3, 6, 9 and 12 months postpartum. IPV was assessed using the Composite Abuse Scale, a multidimensional measure of physical and emotional abuse. Women also reported on their mental, physical and sexual health.

Findings

One in six women reported IPV in the first 12 months postpartum. Of the women reporting IPV, more than half reported emotional abuse alone (54.7%), and one in three reported both emotional and physical abuse (32.5%). Few women reported physical abuse alone (12.8%). Compared to women not experiencing IPV in the first 12 months postpartum, women who reported emotional abuse or both emotional and physical abuse had greater odds of reporting poorer physical, mental and sexual health.

Implications

The majority of women experiencing IPV in the first 12 months after having a first child report emotional IPV alone. These women report poorer mental, physical and sexual health than women not experiencing IPV in the postnatal period. There is a danger that this group of women are overlooked by services, despite evidence of marked impacts on mental and physical health.

The Power of eMR Alerts for Sharing Information

Ms Rosemaria Flaherty[1], Ms Jenna Meiksans[1]
[1]Northern NSW Local Health District, Australia, [2]Australian Centre for Child Protection, Australia

Introduction

Information sharing about victims of interpersonal violence, abuse, and neglect is a well-accepted way of attempting to reduce the likelihood of further harm to the victim and assist in provision of holistic care to this population. Child protection alerts on electronic medical records (eMR) are utilised by the United Kingdom, New Zealand, and some parts of the United States and Canada, to share information about victims of abuse.

Context and Aim

The Northern NSW Local Health District (NNSW LHD), in partnership with ANROWS and the Australian Centre for Child Protection examined the impact of a Child-At-Risk eMR Alert on health responses to at-risk children and at-risk pregnant women. When health workers see an alert on the eMR they are encouraged to consider discussing referrals to support services with the family, information sharing with appropriate services, and actively follow-up missed appointments. The research also sought to understand if other Health Departments across Australia were using domestic violence or child protection eMR alert systems and if so, what the features of those systems were.

Method

Two groups of staff (N=180) within the NNSW LHD were surveyed on the impact of the eMR alert on staff practice and perceived outcomes for women and children experiencing violence, abuse, and neglect.

Findings

87% of participants reported that when they saw an eMR alert they assessed the need for additional referrals, 75% shared information with other services and 60% tried to resolve barriers to appointment non-attendance. Three Health Departments in Australia use eMR alert systems: NSW, SA and Tasmania.

Innovative contribution to policy, practice and research

The first known study of its kind to date, this research contributes to the local and international evidence base on the use of interpersonal violence alerts in eMRs as a means to convey information to the treating health clinician.

Mother's perceptions of resilience in children exposed to IPV

Ms Alison Fogarty[1], Dr Hannah Woolhouse[1], Assoicate Professor Rebecca Giallo[1], Dr Catherine Wood[2], Associate Professor Jordy Kaufman[2], Professor Stephanie Brown[1]
[1]Murdoch Children's Research Institute, Parkville, Australia, [2]Swinburne University of Technology, Hawthorn, Australia

Introduction:
Intimate Partner Violence (IPV) can have detrimental effects on the health and wellbeing of women and children. Few studies however, have focused on the experience of mothering within the context of IPV, and what mothers and their children do to cope during this time.

Context and aim:
This study aimed to explore mothers' perceptions of their children's coping, and strategies they use to foster resilience in their children.

Method:
Nine women from the Maternal Health Study who had experienced IPV during pregnancy or following the birth of their first child participated in in depth semi-structured interviews. Data were analysed using Interpretative Phenomenological Analysis which has a focus on how individuals make meaning from their experience.

Findings:
Women discussed parenting strategies they use to foster their children's resilience including role modelling, creating stability in their child's life, and communicating with their children about healthy relationships. They also shared ways they protect their child from directly witnessing IPV, protecting a sense of family, and maintaining their own mental health and wellbeing.

Innovative Contribution:
This study offers a unique contribution to understanding what promotes resilience among children from the perspectives of mothers. Understanding what mothers are doing to promote resilience in their children is important to consider when working with families to encourage positive outcomes.

LGBTIQ+ Intimate Partner/Family Violence Practice: A Queer Feminist Approach

Dr Kate Foord[1], Maryclare Machen
[1]*queerspace, drummond street services, Carlton, Melbourne, Australia*

Introduction

queerspace at drummond street services is the lead agency for w/respect, an LGBTIQ+ intimate partner violence/family violence integrated service in Victoria. queerspace is providing training in LGBTIQ+-inclusive practice to staff of the 17 Victorian support and safety hubs.

Context and Aim

Current approaches to practice in family and intimate partner violence services are often not appropriately responsive to people in LGBTIQ+ relationships, for reasons that range from overt prejudice to ignorance. It is generally recognised that there is an absence of practice models to draw from. This workshop shows how practice can be truly inclusive of LBGITQ+ relationships without compromising a feminist approach to violence.

Method

This training module gives participants the conceptual and practical tools to put a queer lens on everyday practice in intimate partner and family violence. It:

- Moves beyond the gender lens but retains gender as an effect of structures of patriarchy/power
- Is queer /trans/non-binary inclusive
- Draws on evidence, lived experience, practitioner wisdom, and current and historical thinking
- Is experiential
- Focusses on practice, through case studies

Findings

In combining queer and feminist ideas with innovative approaches to identifying violence and abuse, the workshop offers a practice approach applicable to the complex presentations in family and intimate partner violence work. Additionally, it offers a framework for identifying and building knowledge regarding the significant gaps in research and evidence around LGBTIQ FV/IPV locally, nationally and internationally.

Innovative contribution

This LGBTIQ+ specialist training brings together the drummond street services' whole-of-family practice model with the LGBTIQ+-specific work of queerspace clinicians. This practice model arises from our workforce: queer-identified practitioners across the LGBTIQ+ spectrum, combining lived experience, practice experience and expertise in queer and feminist theory and practice. This experience tells us the importance of continuing to question what we 'know' and how we work.

Improving responses to children experiencing family violence: reform meeting practice

Ms Helen Forster[1], Ms Lanie Stockman[2]
[1]Good Shepherd Australia New Zealand, Abbotsford, Australia, [2]Good Shepherd Australia New Zealand, Abbotsford, Australia

Introduction:

With reforms underway to address family violence in Victoria and across Australia, there is an increased acknowledgement that children – once considered the "silent victims" of family violence – are impacted in their own right. Responses that consider and address particular risks to children's safety are therefore essential.

Context and Aim:

This understanding is reflected in both the recommendations from the Royal Commission into Family Violence (Victoria) and the National Plan to Reduce Violence against Women and their Children 2010-2020. This study aims to form an evidence base with which to help inform these developments and interventions, through providing insights from the practitioners who work with women, families and children impacted by family violence.

Method:

This study examined the ways in which family violence practitioners can and do respond to children during a time of policy reform. This study considered the information family violence practitioners receive on police referrals identifying nearly 2,000 children. Several information gaps were identified, along with inconsistent treatment of children identified on referrals. The views of 11 practitioners of three specialist family violence services in Victoria were sought.

Findings:

It was clear that the practitioners who participated in this project are overwhelmingly committed to providing holistic responses to children. However, they identified a number of barriers, including: the large volume of police referrals received daily, limiting practitioner capacity to respond more comprehensively; information sharing problems between and across agencies; a perceived lack of child-specific risk assessment tools; and variable levels of collaboration between the agencies responsible for children's welfare.

Innovative contribution to policy, practice and/or research:

The report highlights how important it is that the voices of the practitioners "on the ground" continue to be heard as part of the broader sectoral reforms being undertaken for children impacted by family violence.

Start of Change: mapping engagement with male perpetrators of violence

Ms Helen Forster[1], Ms Jacki Holland
[1]*Good Shepherd Australia New Zealand, Abbotsford, Australia*

Introduction:

Holding perpetrators accountable for their behaviour is one of the priorities of the Third Action Plan (2016-2019) of the National Plan to Reduce Violence against Women and their Children 2010-2022. Similarly, the Victorian Family Violence Rolling Action Plan 2017-2020 prioritises perpetrator accountability. Currently a small suite of strategically directed interventions operate across Victoria to hold perpetrators of family violence to account. Principal amongst these interventions are Men's Behaviour Change Programs (MBCPs). However as identified by the Victorian Royal Commission into Family Violence, the success or otherwise of these programs is difficult to assess.

Context and Aim:

In the main, research into MBCPs gives limited attention to intake and assessment processes, or the engagement techniques practitioners find most effective in facilitating men's entry into and completion of programs. This research will investigate the practices and tools used at a service level to engage men, to respond to often different and complex needs, and to foster the motivation in men to see a program through to its conclusion.

Method:

The project maps and reviews current intake and assessment processes across four service providers of MBCPs in Victoria. Data was collected via consultation with practitioners and semi-structured interviews with key personnel within each of the MBCPs.

Findings:

The research findings will be shared amongst the service providers in the region and the broader Family Violence sector.

Innovative contribution to policy, practice and/or research:

The research findings will contribute unique evidence to inform enhancement of MBCP interventions at the point of intake and assessment – the start of change.

Help seeking and IPV: longitudinal cohort data and women's voices.

Dr Deirdre Gartland[1,2], Dr Hannah Woolhouse[1], Ali Fogarty[1], Prof Stephanie Brown[1,2]
[1]Murdoch Children's Research Institute, Melbourne, Australia, [2]University of Melbourne, Melbourne, Australia

Introduction

Increased attention is being paid to the role of health services in identifying and responding to IPV. While enquiry about postnatal depression has become routine, enquiry about IPV is still relatively new. This presentation describes women's experiences of IPV and help seeking over 10 years.

Method

Prospective cohort of 1507 first time mothers recruited in pregnancy. Composite Abuse Scale completed at 1, 4 and 10 years postpartum. Women were also asked who they had spoken to about IPV, and contacts and enquiry by health professionals. Qualitative interviews were conducted with women who had reported IPV, about their experiences, relationship turning points and impacts.

Findings

Over 90% of women had visited a GP in the 1st, 4th and 10th years postpartum, with the majority attending more than once. Over a third of the women reporting IPV in the first year postpartum had not spoken to anyone about their experiences (37%), dropping to a quarter at 4 and 10 years. Of the women reporting IPV at 10 years postpartum, 26% had spoken to their GP about depression, but only 4% had spoken about IPV. Speaking to a mental health professional about IPV was more common (12%). In the 9 interviews, women spoke of seeing health professionals primarily for anxiety, depression and sleep issues, with a number prescribed medication without broader enquiry or psychological referral. Almost all women felt it would have been helpful to have been asked about IPV, but identified challenges for disclosure and support provided.

Implications

IPV is common, with major consequences for the health of women and children. In the first decade of mothering, women are in frequent contact with health services, yet few women experiencing IPV are accessing support from health professionals for this issue. Significant investment in systems change to strengthen health system responses is needed.

Insights on sustaining primary healthcare responses to intimate partner violence

Claire Gear[1], Professor Jane Koziol-McLain[1], Dr Elizabeth Eppel[2]
[1]Centre for Interdisciplinary Trauma Research, Auckland University of Technology, Auckland, New Zealand, [2]School of Government, Victoria University of Wellington, Wellington, New Zealand

Introduction

Internationally, integrating effective and sustainable responses to intimate partner violence (IPV) has proven challenging for health systems. In New Zealand, the Violence Intervention Programme has successfully implemented infrastructure within hospital settings to respond to those experiencing IPV and child abuse and neglect, however, similar engagement with the primary health care sector has been limited.

Aim

Utilizing complexity theory, we sought to understand what affects a sustainable response to IPV within New Zealand primary health care settings.

Methodology

Complexity theory calls attention to how patterns of interaction between system agents lead to the emergence of new system properties and behaviour. As such, we hypothesised a sustainable response to IPV may emerge when a care-seeker and health professional interact in a way which generates mutually beneficial outcomes. To explore agent interactions, we sought to identify health-system discourses shaping how health professionals respond, or do not respond, to their patients who experience(d) IPV. We conducted functional document analysis to access discourses operating at the health-system level alongside health professional interviews to access discourses operating in practice. We then brought these data sources together to develop an understanding of how discourses operate within agent interactions to either challenge or promote sustainable responses to IPV.

Findings

Our findings contribute innovative insights into the international challenge of sustaining effective IPV responses within health care. We show how agent interactions limited participation of primary health care in the health system response to IPV, diminishing potential for a whole health system approach to IPV in New Zealand. We also emphasise the unique potential of primary health care agent interactions for facilitating effective and sustainable first line responses to IPV. The lessons learnt from New Zealand's pathway will be of use to those currently developing and implementing health system approaches to IPV across secondary and primary health care.

Intimate partner violence among women seeking abortion in public clinic

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Intimate Partner Violence (IPV) is one of the forms of violence against women perpetrated either by husband or other intimate partner. It has been found to be associated with the consequences related to sexual and reproductive health such as less contraceptive use and elective abortion. The objective of this study was to find out the extent of intimate partner violence (physical and/or sexual) and its associated factors among women who undergo abortion. Cross sectional study using both quantitative and qualitative method was done. A total of 317 women who underwent abortion were interviewed face to face using semi structured questionnaire. Among the women identified positive for IPV, 14 were interviewed in depth to further explore their experiences. The results showed that one in three women (32.2%) had experienced violence from their partner ever in their life time. Physical violence was found in 22.1% of the women and 22.4% of the women reported that their partner had physically forced them to sexual intercourse even when they did not want. Regarding the reason for abortion majority (67.2%) shared that they did not want any more children and around 1% reported it be violence by their intimate partner. Multivariate analysis showed that education of women, alcohol drinking habit of partner, other relationships of partner, previous abortion, decision for abortion and refusal for contraceptive use by the partner were independently associated with ever experience of violence by the women. It was found that the women who undergo repeat abortion were almost two times more likely to have ever experienced violence compared to women undergoing abortion for the first time. The results were supported by qualitative information from the study. Considering the prevalence of IPV among the women seeking abortion, they should be recognized as potential groups to be screened for IPV.

Examining readiness to take safety actions among women seeking care

Dr Nancy Glass[1], Nancy Perrin[1], Amber Clough[1], Lisa James[2], Surabhi Kukke[2]
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Introduction

PATHS is a longitudinal study in 15 US primary care clinics to evaluate the effectiveness of an intimate partner violence (IPV) universal education and trauma-informed counseling intervention with tailored safety actions and referrals to community partner programs compared to standard practice.

Context and Aim

IPV has a profound impact on women's health. Primary care clinics are critical partners in prevention of IPV and response to survivors and our aim is to strengthen the healthcare sector to support safety actions.

Methods

We examined baseline data from 5,695 adult women screened for partner violence during their clinic visit for types of abuse, self-efficacy and readiness to take safety actions. We used cluster analysis to identify unique groups of women with a similar pattern of abuse and logistic regression to examine the association between type of abuse and safety actions.

Findings

We found that 15.8% of women experienced abuse from a partner in the past 6 months. When asked about readiness for safety actions, 30.2% of abused women reported never/rarely thinking about the violence, 19.6% thought about the violence but had not taken any actions, and 50.2% have taken safety actions. Self-efficacy was highest among women thinking about taking actions. Cluster analysis revealed 4 unique patterns of responses to types of abuse. The odds ratio of taking safety actions are 1.57 (p=.001) when afraid, 1.52 (p=.012) when raped, 1.52 (p=.023) when humiliated, and 1.35 (p=.027) when experiencing physical violence.

Innovative contribution

Being afraid of a partner is the strongest predictor of taking safety actions in an abusive relationship. Women that experience physical violence and are not afraid of their partner were 15% less likely to take safety actions compared with those afraid of their partner. Supporting women to assess and understand risk associated with violence may increase readiness to take safety actions.

Understanding Aboriginal women's experiences of partner violence to tailor early intervention strategies

Prof Stephanie Brown[1], Ms Karen Glover[2], Ms Amanda Mitchell[3], Ms Tania Axleby-Blake[1]
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Introduction
Intimate partner violence is a global human rights and public health issue. Few studies have been designed to draw on Indigenous voices to develop responses to family violence.

Context and aim
The Aboriginal Families Study – conducted in partnership with the Aboriginal Health Council of South Australia – has adapted and tested a modified version of the Composite Abuse Scale (CAS) with Aboriginal women in South Australia. The aim of the study is to inform and advocate for improvements to services to benefit Aboriginal families and communities.

Method
Population-based cohort of 344 mothers of Aboriginal children born July 2011 to June 2013, with follow-up as the children are turning 5-6 years. A pilot study in preparation for commencement of follow-up included development and testing of a modified version of the Composite Abuse Scale (modified CAS) adapted to be more culturally appropriate for use with Aboriginal women in South Australia.

Results
Fifty-eight women completed the questionnaire (9 as an interview, 49 by filling in the questionnaire themselves), and 14 women participated in discussion groups led by Aboriginal researchers. There was strong support for inclusion of: modified CAS items asking about physical, psychological and financial abuse; two new items asking about abuse related to Aboriginality; the use of Aboriginal words familiar to South Australian Aboriginal women; and additional questions asking what women do to stay strong and protect themselves when these things happen.

Implications
The modified CAS was acceptable to Aboriginal women as a way for researchers to inquire about intimate partner violence when embedded in a questionnaire that asked about what women do to stay strong and protect themselves and their children. Community engagement and partnership between researchers and Aboriginal communities and community organisations are crucial to the development of study measures providing meaningful information to inform policy and services.

www.SARA.org.au - Using Technology for Sexual Assault Response in Australia

Ms Juliet Summers, Phd Candidate Monica Hadges[1], Ms Juliet Summers
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Innovation to Practice & Context:

Family violence is a major societal challenge in Australia, and often involves sexual violence. Australia's leadership and innovation of online, remote-service digital technologies across many health sciences is well established. Online tools often provide easier access, privacy and convenience for adults who want information and links with support for emotional, psychological or behavioural distress. We cannot underestimate how difficult it can feel to ask for help. Stigma and uncertainty can still influence an individual's choice or ability to disclose abuse or seek help.
SECASA's Sexual Assault Report Anonymously online reporting program was launched in 2013 at www.SARA.org.au. SARA was designed for both witnesses and victims to report incidents of sexual assault and harassment, historic or current, which have not been reported to the police. It takes reports from all over Australia and these reports are passed on to law enforcement in each State and Territory so this information is not lost. It is the only service of its kind in Australia. The SARA program is being modelled around the world.

Method and Findings

Part one of this paper will trace the history and evolution of SARA. It will detail some technical and social issues that have brought about changes to the program, and examine some of the benefits and challenges of running an online service.
The second part of our paper will examine how common, co-occurring and high-prevalence needs like depression, anxiety, response to trauma and sexual violence require accessible, timely, responsive and client-centred interventions and how responses such as SARA.org.au help imbed e-MH platforms in first-line response.

The socio-cultural factors associated with adult familial homicide

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Introduction

While considerable research has been previously conducted on homicide between intimate partners, there has been less focus on other adult familial relationships which result in homicide. Socio-cultural determinants have also not been a significant consideration in past research into the constructs of interpersonal violence, and particularly, violence which leads to homicide within the family. The research will address this gap by examining the socio-cultural determinants of adult familial homicide in Victoria.

Context and Aim:

The research aims to examine the role that socio-cultural determinants can play for the deceased and the offender, within both intimate partner and other (non-intimate) family relationships.

Method:

The primary data source for this research is the Victorian Homicide Register (VHR), which was established and is managed by the Coroners Court of Victoria. The VHR comprises coded and free text data on socio-demographic characteristics of the deceased and the offender; the role of the deceased and offender as the victim or perpetrator of prior episodes of violence; physical and mental health profile, situational and interpersonal stressors, and the nature and proximity of contact with services.

Findings:

During the study period 2009-2014, 99 intimate or other familial homicides occurred between adults in Victoria. The proposed results will comprise a series of univariate and bivariate descriptive statistical analyses and content analysis to identify trends and patterns among cases. It is proposed that there are both commonalties and differences in the circumstances and underlying determinants of these homicides.

Innovative contribution to policy, practice and/or research:

It is intended that the research into adult familial homicides will lead to a better understanding of the reasons and circumstances for adult familial homicide, be this intimate partner based or other types of family relationships. The ultimate intention of the project is crime prevention, in reducing future family homicide deaths.

Remaining pregnant after reproductive coercion: Listening to women's voices

Ms Rosie Brennan[1], Ms Patricia Hayes[2]
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Introduction

Over the last decade reproductive coercion has emerged as an area of focus for women's health research within Australia and internationally. Reproductive coercion (RC) - the interference with a woman's reproductive autonomy by an intimate partner or family member (Grace & Anderson, 2016) - is not a new phenomenon. However, in 2010 it was formally defined in the literature by (Miller, 2010) as a type of violence negatively affecting women's reproductive and sexual health and autonomy. An understanding of the full spectrum of women's experiences including those who remain pregnant following coercion is a gap in current research.

Context and aim

Why is this important?
Research into RC is limited. The majority of available research focuses on clinical interventions and responses (Grace & Anderson, 2016). Studies into women's experiences of RC is most commonly focused on women seeking an abortion. The focus of this study will be the research detailing the lived experiences of women who have a history of RC.

Method

A literature review from relevant academic databases highlights the need for further research into women's experiences of RC. We will present grey literature that highlights women's voices and present emerging themes and concepts in the area of remaining pregnant following RC. This literature review and analysis of grey literature will inform the development of future research, practice and policy in the area of maternity care of women following reproductive coercion.

Findings

Early scoping reviews consistently suggest, the need for academic research into women's experiences and prioritising women's voices, to inform best practice intervention, particularly in the area of women remaining pregnant following RC. Other findings suggest a strong link between the experience of reproductive coercion and an increased risk of intimate partner violence and/or family violence (Miller, 2010).

Supporting safety: women and children with disability leaving violence

Mrs Leonie Hazelton[1], Ms Meredith Lea[1]
[1]*People with Disability Australia, Australia*

People with Disability Australia (PWDA) is a leading disability rights, advocacy and representative organisation of and for all people with disability. PWDA's primary membership is made up of people with disability and organisations primarily constituted by people with disability.

One of the key areas of PWDA's strategic work is violence prevention. Women with disability are 40% more likely to experience domestic and family violence (DFV) than women without disability. In addition, the children of parents with disability are more likely to become involved in statutory child protection systems.

PWDA's individual and systemic advocates support many women with disability who are seeking to leave DFV and retain care of their children. In this workshop, we will brainstorm some of the barriers facing women with disability in this situation, including limited access to appropriate information or services, difficulties altering NDIS packages or being reliant on the perpetrator of violence for ongoing personal care.

We will also discuss possible strategies to enable a better response for women with disability and their children by government and service providers in the health, justice and care and protection systems. The current response from the NDIS to women and children in crisis will also be discussed. This workshop will be solutions focused, looking at the various ways in which people with disability and their representative organisations can work alongside government agencies and service providers to ensure appropriate and accessible DFV and child protection responses are available to women with disability and their children.

Throughout this interactive workshop, participants will be encouraged to brainstorm, network, collaborate and share how they could facilitate positive change so that women with disability and their children are better able to not only access services to keep them safe, but also those that support the non-offending family to remain together.

Couples programming in Rwanda to prevent intimate partner violence

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Introduction
Although intimate partner violence (IPV) is the most common form of violence against women, there is limited understanding of best practices to prevent such violence through working directly with couples. This is due to valid concerns of safely conducting research and programming with couples, including for implying mutual responsibility for violence among partners. Yet, couples programming responds to the fact that many couples may want to stay together, but require support and skills to manage violence.

Context and Aim
This paper presents rare evaluation data of a programme that worked directly with couples to prevent IPV. The Indashyikirwa programme in Rwanda implemented a 5-month curriculum with couples to support equitable, non-violent relationships. Approximately 25% of partners of couples were subsequently further trained and supported as community activists for an additional two years.

Methods
A quantitative randomized control trial among couples exposed and not exposed to the Indashyikirwa programme indicated a significant and sustained reduction in physical and sexual victimization by women and perpetration by men. Drawing on longitudinal qualitative interviews conducted separately with 28 partners of couples before, immediately after and one year following the curriculum, this paper unpacks how and why the programme reduced IPV. Thematic and dyadic analysis of both partners' accounts was conducted.

Findings
This paper will present relationship processes of change around IPV, decision-making, and relationship quality. It will consider the interaction of programme elements, such as how the micro-finance component alleviated financial stress, and provided a platform for shared economic decision-making. The women's safe spaces for referral, and community activism, supported couples enacting changes.

Implications
The findings suggest the efficacy of couples programming within the context of a supportive intervention, confidentiality, highly trained facilitators, and strong referral networks. Implications for couples IPV programming and research will be considered, including for the health sector.

Reconnecting mothers and children after violence (RECOVER): Child-Parent Psychotherapy pilot

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Introduction

Intimate partner violence detrimentally affects women and their children who are the most common victims of abuse. The mother-child relationship is often impaired as a consequence. Dyadic or relational interventions that include mothers and children, such as Child-Parent Psychotherapy, are effective in restoring maternal and child health and reducing trauma.

Context and Aim

While Child-Parent Psychotherapy has been trialled in the USA, across several populations, Australian research on dyadic interventions for abused women and children is limited. The aim of this project is to test the feasibility of implementing Child- Parent Psychotherapy in Australia.

Method

Using a mixed method, pre-post design, this pilot study examined the acceptability of the intervention to women (n=15) and providers (n=9), across three Melbourne and rural Victorian sites and identified process issues including barriers to program implementation and sustainability. Intervention efficacy was assessed using maternal, child health and mother-child relationship outcome measures. These included a range of parental self-report measures on maternal physical and mental health (trauma symptoms, depression), intimate partner violence exposure, parenting behaviours (reflective functioning), and child trauma symptoms and mental health. Direct observation of mother child interaction was also captured for analysis.

Findings

Preliminary results will be discussed including baseline data on women and pre-school age children's social and emotional health, attachment and wellbeing. Program feasibility and acceptability, including women's expectations of program outcomes and early implementation issues will be shared.

Contribution

This information will be of interest to delegates interested in intimate partner violence and infant mental health and researchers /practitioners seeking to implement relational interventions in this particular cohort.

Regional Partnerships for Strengthening Hospital Responses to Family Violence

Ms Simone Meade[1], Ms Anna Howell[1]
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Introduction

The Strengthening Hospital Responses to Family Violence (SHRFV) initiative is a systems approach to embedding the practice of identifying, responding and referring to those impacted by family violence (FV) in the hospital setting.
Ballarat Health Services (BHS) as a lead service provide support to six rural health services to implement the SHRFV initiative.

Context and Aim

FV is a significant health issue. In the 2016/17 financial year 76,500 incidents of FV were reported to Victoria police; 4057 in the Grampians region.
The health sector is a critical entry point for identifying FV. Research indicates an under identification and reporting of family violence in hospital settings and a need to increase the capacity of staff to identify, respond and refer.

Method

BHS support implementation of strategies across seven health services to strengthen the workplace response for employees experiencing family violence and to improve the response to consumers impacted by family violence.
A regional approach ensures consistency across health services and efficient use of resources.
Regional strategies include leadership engagement, establishing FV profiles for individual services to inform regional planning, uniformed FV policy and procedures, shared professional development and a community of practice.
An evaluation framework is being established to review implementation.

Findings

Traditionally health services are not viewed as a FV responder.
Building on existing area-based partnerships is essential for gaining leadership commitment and creating a foundation for innovative FV responses.
Intensive support provided to individual health services builds momentum for a shared response at a regional level.

Innovative contribution to practice

Innovation in practice and targeted policy and procedure within the Health Service Sector is intrinsic to the coordinated implementation of the 'best practice model.'
Partnerships across the region ensure imbedded change and sustainable outcomes resulting in an effective response and improved referral for staff and consumers experiencing FV.

Working with fathers who use violence: Addressing complexity and resilience

Prof Cathy Humphreys[1], Dr Lucy Healey[1], Dr Kristin Diemer[1]
[1]*University Of Melbourne, Parkville, Australia*

The research evidence that children are harmed by their exposure to domestic violence is well established. However, less attention has been given to intervening effectively with fathers who use domestic violence.

This presentation aims to present key elements required in the organisational environment for workers to be able to work effectively and safely with fathers who use violence.
The presentation will draw from a research project Invisible Practices: Intervening with fathers who use violence. Communities of Practice of child protection workers, specialist family violence workers, family services workers and researchers were established in four Australian states and provided with expert (virtual) consultation by David Mandel and Kyle Pinto from the Safe and Together Institute.

A mixed method approach using questionnaires, focus groups and ethnographic note taking explored with practitioners the complexities of working with fathers who use violence in a form of practice led knowledge building.

This presentation will focus on the findings which specified the forms of organisational change which are required to ensure that workers, women and children are supported and safer when there are interventions which tilt the practice to the perpetrator of domestic violence and his parenting.

Support from senior management, stronger collaboration and information sharing between organisations (specifically but not exclusively child protection, police and women's services), detailed and case specific attention to worker safety, training, coaching and supervision to work with men with a specific focus on their parenting were key themes derived from the practitioners across four states.

The attention to practitioner-led knowledge building in an area where empirical evidence is partial, alongside the specific challenges and opportunities to work with fathers who use violence contribute to policy, practice and research when working with domestic and family violence.

Improving domestic violence information in national hospitals data

Ms Ann Hunt[1], Ms Louise York[1], Ms Karen Webber[1]
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Introduction

Hospitals and emergency departments can be an important first contact for victims of domestic violence. Currently, national data exist for reporting on hospitalisations for assault injuries due to domestic violence, but there are limited national data for identifying these presentations to emergency departments.

Context and Aim

Without proper identification of domestic violence cases, the extent of these cases treated in hospitals will be underestimated and victims may fail to receive vital support services.

Findings

For admitted patients, more than 19,000 people were hospitalised due to assault injuries in 2014-15. Of these, 3,400 (18%) reported that the perpetrator was a spouse or domestic partner, and 1,700 (9%) another family member. Information about the perpetrator relationship was missing for 43% of these assault hospitalisations, with the perpetrator recorded as unspecified for 54% of male and 22% of female hospitalisations.

For emergency departments, currently very few jurisdictions capture information on victims and the perpetrators of domestic violence.

Innovative contribution to policy, practice and/or research

Improved perpetrator identification and collection in hospitals data will create technological pathways for more accurate identification of domestic violence assaults presenting to hospitals. This information will help policy makers better target policies and programs to help prevent and respond to domestic violence.
The Australian Institute of Health and Welfare is working with states and territories to improve the capture of perpetrator information for assault cases admitted to hospitals and initiate collection of perpetrator information in assault cases presenting to emergency departments.

Using feminist participatory research in family violence system reform

Ms Michelle Hunt[1]
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Introduction

The lived experience of women and children is essential to family violence policy and system reform in Victoria. Innovative participatory research produced as part of industry/university collaboration is one way that the experienced-based knowledge of women is being included in service reform in the Central Highlands region of Victoria.

Context and Aim

Service user input needs to be more than an afterthought to service reform, the experience-based knowledge of women must be central to change. Implementing ways to gather this knowledge is a challenge for the sector. Feminist participatory research that is supported by industry and university is one method that can be used to produce local knowledge that is practice relevant and academically rigorous.

Method

Over the last 18 months in the Central Highlands region, the Family Violence sector and Federation University have been collaborating in participatory research with women who have experienced family violence. Through the strong industry/university relationship, identified issues such as participant safety, recruitment, support, autonomy and self-determination are being managed and addressed.

Findings

There is a desire from women who have experienced family violence to use public platforms to share their experiences and influence public policy. University led feminist participatory research with strong industry links, is one method that can be used to gather this knowledge using a process that is ethically thorough and promotes women's safety and autonomy.

Innovative contribution to policy, practice and/or research

This presentation will highlight that targeted approaches, with designated resourcing can support the meaningful contribution of women and children to family violence policy and service reform. Feminist participatory research provides the opportunity to capture significant experience-based knowledge for the sector using a method that provides a positive and empowering experience for women.

Immigrant women's responses to intimate partner violence: a transnational perspective

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Introduction

In Canada, as in other settings worldwide, women are the most common victims of intimate partner violence (IPV). Immigrant women, however, face an additional risk of IPV; the abuse can begin or escalate post-migration. Immigrant women's response to IPV and the factors that shape their ability to seek recourse from abuse in the context of their migration experience, is less well-known.

Context and Aim

The aim of this paper is to understand immigrant women's response to IPV from a transnational perspective. Transnationalism is recognizing that people are more likely to maintain contact with their cultures and countries of origin and less likely to assimilate to their destination country as cross-border movements, ties, and communications have become stronger.

Method

Based on studies of Sri Lankan women's responses to IPV pre-and post-migration in Canada, this review seeks to understand immigrant women's care seeking behaviours and ability to seek recourse from IPV from a transnational lens.

Findings

Sri Lankan immigrant women are more likely to stay in abusive relationships, seek support from family and friends in Sri Lanka and Canada, and visit healthcare services rather than seek help from social workers, legal service providers, counsellors, or settlement services providers. They are less likely to stay in transit homes or shelters when leaving abusive men - responses to IPV that are uncommon in their home country.

Innovative contribution to policy, practice

An awareness of how women respond to IPV in their countries of origin could help gain a better understanding of the nature of services and supports that could be useful to immigrant women dealing with IPV in Canada. A broader understanding of transnational ties and connections that people maintain could be as important as improving access to services in helping immigrant women respond to IPV in Canada and other immigrant receiving countries.

Finding safe spaces in a busy public hospital

Ms Anne Ingram[1], Ms Assunta Morrone[1], Ms Sarah Booth[1], Ms Karina Rosa[1]
[1]Western Health, Melbourne, Australia, [2]Western Health, Melbourne, Australia

Introduction

Family violence has been long recognised as a major health issue which will effect up to 1 in 3 women across their lifespan. In Australia, 8 women are hospitalised everyday as a result of family violence.

The World Health Organization also recognises the important role health services can play in the prevention of violence against women and girls.

Context and Aim

Evidence suggests women who have experienced violence, seek health care more often than non-abused women. They also identify health-care providers as professionals they trust with disclosures of abuse. Having a safe and confidential environment where disclosures are welcomed in Health settings is crucial to creating a culture of respect and non-judgmental support to victim/survivors of Family Violence.

Anecdotal evidence from Western Health Social Work teams identified the consequences of having no safe space in which to conduct sensitive conversations. These included;

- Walking the victim/survivor through multiple locations to ensure privacy and confidentiality
- victim/survivors voicing frustration regarding lack of privacy in assessments
- Lost opportunities to build the rapport necessary to foster an environment of trust and confidentiality.

Method

Pre and post observational audits of room availability will be conducted to measure the impact of the project on availability of safe spaces.

Findings

This project has identified safe spaces within the hospital and developed protocols for use, resulting in more immediate access to appropriate environments in which to support victim/survivors of Family Violence.

Innovative contribution to policy, practice and/or research

It is anticipated that the evidence gathered will provide the impetus to support recommendations regarding the availability of safe spaces in future and enable a culture of support and confidentiality to women wishing to disclose their experience of violence.

Prevalence of Intimate Partner Violence among Married Women in Pakistan

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Introduction, context and aim:

Intimate partner violence (IPV) affects millions of women across the world and Pakistan is no exception. However, there is wide variance in reported frequencies worldwide and even within the same population. No standardized representative national and subnational estimates were available for IPV in Pakistan.

Method:

We analyzed 3666 ever-married women (15-49 years), from the most recent Pakistan Demographic and Health Survey (2012-13), to determine the prevalence of emotional and physical violence among women in Pakistan and its major sub-populations. The Conflicts Tactics Scale (CTS) was used to ascertain violence. Furthermore, we examined the socio-economic and demographic characteristics. Weighted multivariate logistic regression was carried out to determine the association of IPV with the potential risk factors using Stata V 13.0.

Findings:

The prevalence of emotional and physical violence was, respectively, 36.4 % (95%CI: 33.8-39.1) and 18.4% (95%CI: 16.4-20.6), in Pakistan. The frequency of emotional and physical violence was highest in Khyber Pakhtunkhwa (KPK) (54.9% and 36.4%) followed by Balochistan (50.0% and 25.5%), Punjab (35.9% and 15.8%) and Sindh (24.7% and 13.3%) provinces. The prevalence of any form of violence (emotional or physical or both) was higher in rural than urban areas (45.2% vs 30.6%). Higher age of the husband and lower socio-economic status were associated with emotional violence in KPK. Furthermore, alcohol intake by the husband, and lower educational status of women or the husband were associated with greater risk.

Innovative contribution:

IPV is high in Pakistan and large variations exist in the prevalence of violence across the provinces. The predictors of violence included occupation and education of the husband, alcohol intake, woman's occupation and wealth index. Studies are needed to explore the underlying factors of violence and reasons for variation across different regions in the country for contextual interventions.

Australian young women's perceptions of dating and dating violence

Dr Deepthi Iyer[1]
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Context

Dating violence is a significant problem in Australia affecting at least 1 in 4 young women [1]. It has devastating impacts on young women and the community [2]. There is evidence that attitudes supporting violence against women are widespread in Australia [3]. However, there is a need for qualitative research exploring Australian young women's views on dating and dating violence [4].

Aim

To explore how Australian young women perceive dating and dating violence in heterosexual relationships.

Method

A qualitative study was undertaken to explore young women's perceptions of dating violence. 17-25 year old young women who had experienced dating violence were recruited from across Australia. Narrative interviews were conducted face-to-face and via telephone. Interviews were analysed thematically and then social script theory was applied as an explanatory framework to interpret the findings.

Findings

35 young women from urban and rural Australia were interviewed. The young women had experienced casual and committed romantic relationships. These relationships were overwhelmingly gendered and scripted, with predictable roles and events. The young women adopted submissive roles in the relationships while the young men had more control.

Conclusion

Current heterosexual dating scripts in Australia appear to be heavily influenced by traditional patriarchal values. This emphasises male control over females and thus influences young women's perceptions of dating violence.

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2. Exner-Cortens, D., et al., Longitudinal Associations Between Teen Dating Violence Victimization and Adverse Health Outcomes. Pediatrics, 2013. 131(1): p. 71-78.
3. Webster, K., et al., Australians' attitudes to violence against women: Full technical report, Findings from the 2013 National Community Attitudes towards Violence Against Women Survey (NCAS). 2014, Victorian Health Promotion Foundation: Melbourne.
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Addressing IPV in Health Settings: Limits to Disclosure Driven Practice

Mx Kate Vander Tuig[1]
[1]*Futures Without Violence, San Francisco, United States*

Introduction

What if we challenge the limits to disclosure driven practice? Studies show that talking with all patients about healthy relationships and how unhealthy relationships affect health, can improve health + safety and provide an opportunity for violence prevention. In this interactive workshop, participants will learn a comprehensive, evidence-based intervention to address IPV in health settings that ensures that all patients have access to resources and support, not just those who choose to disclose violence.

Context and Aim (why this is important)

Experiences of IPV and trauma are not only extremely common, but have serious impacts on health of individuals across the lifespan (Black, etc. 2010), families and communities. Because many survivors chose not to disclose, providers have a unique opportunity to promote prevention and to support the health and safety of survivors by offering trauma informed care plans and warm referrals.

Method

This workshop relies heavily on interactive learning activities including role playing, large group discussion, small group work, and pair/share. Participants will be able to:
1. Understand the health consequences associated with IPV and trauma,
2. Identify the limits of disclosure driven practice and be able to provide the evidence-based CUES (confidentiality, universal education, empowerment and support) intervention
3. Take planning steps for comprehensive implementation in health centers.

Findings

The brief intervention that will be shared in this workshop has been evaluated in reproductive and adolescent health settings and has been shown to improve health and safety outcomes for survivors (Miller, 2010), (Miller, 2015).

Innovative contribution to policy, practice and/or research

As health providers grapple with limits of screening, this intervention offers an alternative that can reach all patients and move away from a checklist approach to addressing violence and trauma. This intervention has been implemented in hundreds of community and reproductive health centers across the United States.

Impact of sexual abuse on gynaecological health

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[1]Flinders Medical Centre, Australia, [2]Lyell McEwin Hospital, Australia, [3]Monash University, Australia

BACKGROUND:
Current Australian data estimates one in five women have experienced sexual violence, with a substantial proportion of cases perpetrated by a current or former partner (Australian Institute of Health and Welfare, 2018). While the psychological impacts of sexual abuse have been extensively studied, data regarding long-term gynaecological impacts remains limited.

AIM:
This study aimed to evaluate current observational data surrounding the association between sexual abuse and gynaecological symptoms in order to further ascertain risk factors for adverse gynaecological outcomes.

METHODS:
We searched for studies reporting on the association between a history of sexual abuse and gynaecological complaints. We screened online electronic databases from 1993 till now for variants of terms associated with sexual abuse and domestic violence, in association with terms related to gynaecological symptoms. Language restrictions were not applied. References were manually screened to further select observational studies with relevance to the clinical question. Articles were assessed for quality, and data extracted to ascertain the association between specific and general gynaecological symptoms and a history of sexual abuse.

RESULTS:
We identified 1846 citations of which 98 studies were selected for data extraction based on pre-defined criteria. Studies primarily addressed chronic pelvic pain, dyspareunia (painful intercourse) and bladder dysfunction (i.e. pelvic floor complaints). A history of sexual abuse was found to be associated with each gynaecological complaint assessed, positively identifying sexual abuse as a risk factor for gynaecological symptoms.

CONTRIBUTION:
These results suggest that the health impacts of abuse are much wider reaching than those sustained from the initial insult. First line response to sexual abuse should include multidisciplinary assessment and support to assist in preventing later health sequelae. Furthermore, women's health professionals should enquire about a history of abuse in their overall investigation of common gynaecological complaints in order to avoid potentially invasive and traumatic examinations and procedures.

Experiences of women defendants in domestic and family violence cases

A/Prof Rita Shackel[1], Ms Anna Kerr
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Introduction:

Evidence is emerging that women in Australia and overseas are increasingly being charged with family violence and related offences. Recent data indicates a greater increase proportionally in arrests of females for domestic and family related violence compared to males. Data also indicates a sharp increase in female defendants in Apprehended Violence Orders (AVO) in the last decade in some jurisdictions. Anecdotally many women report being the victim of ongoing domestic violence and acting in self-defence, alleging their version of events is often treated inappropriately by police and/or that the other party is using AVO proceedings to threaten or control them. There is also emerging evidence that women defendants in domestic violence cases are generally poorly supported. This evidence indicates that Indigenous women are over represented as defendants in domestic violence cases and treated most unfairly.

Context and aim:

However, there is relatively little information and research based data regarding women's actual experiences as defendants in criminal proceedings and their specific needs and priorities. This paper will present a review of some recent data on women as criminal defendants in domestic and family violence related proceedings in Australia and overseas. It will also present preliminary findings of a qualitative research study being conducted by the authors which involves speaking with women defendants (n=50) in NSW regarding how their cases were investigated, charges laid, evidence used, outcomes, and how they were generally treated and supported in the course of such criminal processes.

Method:

(i) Desk review of data/statistics related to women defendants in domestic violence criminal proceedings;

and

(ii) In-depth semi-structured interviews with women defendants in domestic and family violence proceedings in NSW.

Findings:

in process.

Innovative contribution to policy, practice and/or research:

This research will inform development of tailored resources for women defendants and future research, advocacy and service delivery

Hello Cass — an easier way to talk about violence

Ms Emma Koster[1]
[1]Good Hood, Melbourne, Australia, [2]2018 Myer Innovation Fellow,

Introduction

Hello Cass is an SMS chatbot delivering simple, discreet and accessible support for women affected by family and sexual violence—and it feel just like texting a friend.

Context and Aim

Violence against women is one of our community's most pervasive problems. One in four women in Australia have experienced intimate partner violence (Australian Institute of Criminology [AIC] 2017), and one in five women have experienced sexual violence since the age of 15 (Australian Bureau of Statistics [ABS], 2017).

Despite the prevalence, less than 15% of incidents of violence are reported to the police (ABS, 2017). Fear, shame, embarrassment, self-doubt, sympathy for the abuser and feeling that they won't be believed are some reasons women give for not talking about or reporting violence (AIC, 2001). Additionally, the intimacy and density that characterise small communities in isolated regions make it more difficult to disclose, report and seek support.

Method

When the 'user' sends a message via SMS or WhatsApp to the Hello Cass number, they instantly and anonymously connect with Cass, a friendly, multilingual chatbot (computer simulated conversation agent).

Based on the user's query, Cass responds, providing localised and culturally-safe information and support that has been developed in consultation with Victorian PVAW practice partners.

Findings

As discussed with the CRE Manager 26/03/18, the pilot program is due to commence May 2018, the findings of which to be submitted upon completion.

Innovative contribution to policy, practice and/or research

Hello Cass is the first SMS-enabled chatbot for family and sexual violence support in the world. It combines cutting-edge artificial intelligence technology with the stability and accessibility of mobile networks to deliver a truly transformative way of providing isolated and vulnerable women with instant, discreet information and support, as well as generating unprecedented insights into our community's experiences and understandings of violence.

What factors influence the decision to report child abuse?

Miss Jacqueline Kuruppu[1], Professor Kelsey Hegarty[1]
[1]*University Of Melbourne, Carlton, Melbourne, Australia*

Introduction:

Child abuse (CA) is an important issue responsible for approximately 12% of all homicides in Australia. It also leads to several significant health and developmental effects in children. Given the association between CA and health, GPs and practice nurses are well-placed to identify and respond to this issue. However, the reporting rate for health professionals is very low.

Context and Aim:

Factors that may contribute to low reporting rates among health professionals include the emotional burden involved in the decision-making process and a lack of information about the reporting process available to health professionals. This literature review will inform the development of a decision-making tool that aims to support GPs and practice nurses as they undertake the decision to report CA.

Method:

A systematic review of journal published literature on existing decision-making tools using Medline (Ovid), PsycINFO and SocINDEX (full text). Databases weresearched with key words relating to the concepts of 'decision-making tool', 'child abuse' and 'healthcare setting'. Papers published in English were included.

Results:

Current analysis shows 15 papers that meet the eligibility criteria. These were thematically analysed and highlight the need for a decision-making tool to aid GPs and practice nurses through the decision to report CA.

Innovative contribution to policy, practice and/or research:

This literature review will inform the development of a decision-making tool that aims to support GPs and practice nurses as they undertake the decision to report CA. Creating such a tool may help to alleviate some of the emotional burden of reporting and provide more information to allow informed decision making. Providing GPs and practice nurses with support can help enable them to provide the best possible care to Australian children.

Listening and Responding to children and young people's experiences of family violence

Dr Katie Lamb[1], Professor Cathy Humphreys[2], Professor Kelsey Hegarty[3]
[1]The University Of Melbourne, Australia, [2]The University of Melbourne, Australia, [3]The University of Melbourne, Australia

Introduction

Domestic violence impacts many families in Australia. The violence has significant effects on the lives of children and young people. While historically children have been considered merely witnesses of domestic violence, they are now acknowledged as experiencing violence.

Aim

This study aimed to explore children and young people's perspectives on fathering in the context of domestic violence using a combination of traditional research methods and digital technology. Digital storytelling is increasingly being used to capture the perspectives of both vulnerable adults and young people about sensitive issues and experiences. Research suggests that participants describe the process of participating in a digital storytelling workshop as having therapeutic benefits.

Method

This presentation will focus on the findings from qualitative research undertaken with children and young people (aged 9-19 years) who had fathers who use violence in Victoria, Australia. The research method comprised three stages: interviews/focus groups with children and young people, a two-day digital storytelling workshop as well as a workshop with practitioners.

Findings

The research found that children and young people embrace opportunities to share their perspectives on domestic violence. Children and young people had strong ideas about what constitutes 'a good father' and how their fathers compared. A key message to come emerge was the importance of reparation after domestic violence, both for children and young people who wished to have no further contact with their fathers as well as those who did.

Innovation

This research has made a significant contribution to the way in which we understand children and young people's perspectives on their relationship with their fathers after domestic violence. It also resulted in the creation of eight digital stories by children and young people which are now available for use by those working with children, fathers and families who have experienced domestic violence.

Sibling bullying; the elephant in the room

Dr John Litt[1], Dr James Scott[2,3]
[1]Flinders University, Bedford Park, Adelaide, Australia, [2]Queensland Centre for Mental Health Research, University of Queensland Centre for Clinical Research, Herston, Brisbane, Australia, [3]Metro North Mental Health Service, Royal Brisbane and Women's Hospital, Herston, Brisbane, Australia

Introduction

Bullying has a consistent, strong and graded association with a large number of physical and psychological symptoms (1-4). Sibling bullying is a form of aggression between siblings that involves direct or indirect intentional and persistent behaviours with an imbalance of power. Prevalence estimates vary from about 15% to 50% for victimisation by siblings, and 10% to 40% for perpetrating sibling bullying, making it the commonest type of violence within a family. Sibling bullying is frequent in families of all social classes and status (5).

Sibling bullying has been found to compound the impact of bullying in other settings, including work, school and online (5). A US survey showed that sibling bullying independently predicted mental distress as much as child maltreatment and more than sexual victimisation by adults (4)

Context

Sibling bullying has largely been ignored as a public health issue until recently (6, 7) despite the fact that it is prevalent and can be viewed as a multifaceted form of aggression/violence. As highlighted above, it is linked to a wide range of health issues and can result in injury, distress, or death. There are risk factors for sibling bullying or being a victim of sibling bullying and it may be preventable.

Aim and Method

A literature review was conducted to look at:
a) the prevalence and burden of morbidity associated with sibling bullying and
b) the case for viewing sibling bullying as a public health issue

Findings

The key findings from the literature review will be presented.

Innovative contribution to policy, practice and/or research

The review of the literature will provide an up to date summary of the prevalence of sibling bullying together with an assessment of the associated burden of morbidity. The case will be made for viewing sibling bullying as a public health issue.

iHeal - developing a workforce of peers from diverse backgrounds

Ms Karen Field[1], Ms Jemma Mead[2]
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Introduction

iHeal is a program for victim survivors of family violence across a range of diverse backgrounds, including people from Culturally and Linguistically Diverse (CALD) communities, people from Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer (LGBTIQ+) communities and people living with a disability. Key to the model is a strong focus on harnessing the lived experience of survivors.

Context and Aim

The model was developed in response to Department of Premier and Cabinet (2016) survivor focus groups showing that survivors wanted a workforce of survivors who also reflected themselves (ethnicity, faith, LGBTIQ+). The Royal Commission into Family Violence recommended further services, focussing on empowering survivors to recover from violence and trauma (RCFV, 2016).

iHeal breaks down barriers between service providers and end users, empowering survivors to take control of their recovery process, valuing them as co-producers/developers/deliverers/evaluators of the services that affect them.

Method

iHeal employed twelve people from diverse backgrounds, with lived experience, as Recovery Support Workers (RSW's). They undertook a tailored training package including a Certificate IV in Community Development and trauma informed practice. Each RSW works alongside an iHeal Case Coordinators, delivering case work, support groups and recovery education to other survivors

Findings

Peer work support and co-production frameworks are transforming Mental Health Care across the Western world, with a building evidence base that they provide better outcomes for consumers. In line with this, the initial findings of iHeal demonstrate more positive outcomes for both the RSW’s and the clients they are supporting.

Innovative contribution to policy, practice and/or research

iHeal is funded under the Demonstration Projects: Therapeutic Interventions for Family Violence Victim Survivors. The outcomes will contribute to the development of a Family Violence peer workforce in a time of unprecedented sector growth, providing career pathways for survivors and achieving better outcomes for other victim/survivors.

Violence Suffered by Married Females in Haryana, India

Prof Jagbir Malik[3]
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Violence is common among married men and women but females suffer the most. Violence disturbs family and has a negative effect on children upbringing. A community based cross sectional study carried out to know extent and reasons for violence among 880 married females in northern India. Participants from rural and urban areas were interviewed. Informed verbal consent obtained from participants. Data thus obtained was analysed.

Females in age group 30-39 years experienced violence (35.2%), these were housewives. Life time violence was experienced by 40.6% rural and 28.1% urban females,8.5% were currently experiencing violence. Emotional violence was most common (20%), physical violence (17. 5%).Prevalence of sexual and economic form of violence was 12.3 % & 7.6% respectively. Perpetrators of domestic violence were husbands, mother in laws and close relatives. Females were slapped, arms twisted, punched, kicked, dragged and threatened using knives and weapons. Forced sexual intercourse by spouse was reported by 14.4% victims. Financial help was denied to 6.0% females. Alcohol consumption by spouse was main reason for domestic violence (61. 7%). Females with three or more girl children suffered most. Females married to illiterate labourers experienced more acts of violence. All females opined that domestic violence can be prevented by empowering women, making them self-reliant, family support and strict enforcement of laws related to crime against women. Government and social organizations need to curb use of alcohol by males to safeguard interests of women for safer family life. At present in India participation of health sector in preventing and reporting violence against women is minimum hence there is urgent need to involve, train health manpower particularly primary care providers and health workers to report acts of violence against women& communicate with violence victims. This will help to promote safer families and violence free females in the society.

MABELS: a practice-informed model in early intervention family violence support

Miss Marika Manioudakis[1], Miss Anita Koochew[1]
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MABELS is an integrated program based on the Health Justice Partnership model that identifies and responds to violence against women and children within the Maternal and Child Health (MCH) context. The impetus for MABELS was the significant body of research and literature showing an increased risk of family violence for women and children during pregnancy or in the early stages of parenting.
As the Victorian Royal Commission into Family Violence has found, universal services that are available to all community members are ideally placed to have a much greater role in identifying and effectively responding to family violence.

In 2015, MABELS was established as an innovative early intervention response to family violence, by providing women attending maternal and child health services the opportunity to receive integrated family violence and related legal advice, safety planning, information and referrals from a community lawyer and a family violence advocate. In addition, Aboriginal women are provided with the option of a specialist family violence service from an Aboriginal community-controlled organisation. As a partnership we are bringing together our resources, knowledge and expertise to provide an improved response.

Based on the experience and learnings of MABELS, the two key elements that highlight the value of the program have been identified as:

- the earlier time at which information and advice is provided to women; and
- the integrated nature of the MABELS program model.

We would like to share the practice-based evidence gained through the successful implementation of the MABELS model as an example of how health, legal and advocacy services are working together to provide a practice-informed approach in early intervention family violence support.

Women's voices: counselling from psychologists after intimate partner violence

Ms Sally Marsden[1], Professor Kelsey Hegarty[1], Professor Cathy Humphreys[1]
[1]*University Of Melbourne, Australia*

Introduction

Experiencing intimate partner violence often has an impact on women's mental health and emotional wellbeing. Seeking counselling from a psychologist is a common response to this. It is important that psychologists have a good understanding of the complexities of intimate partner violence and its impact on women; as well as understanding how women experience the counselling they receive.

Context and Aim (why this is important)

Currently, there is limited research about psychologist-delivered counselling after intimate partner violence and very little which explores women's experiences of such counselling outside specialist domestic violence services. From a feminist perspective, is it vital that women's voices and experiences are at the centre of any research related to intimate partner violence. This PhD project aims to ensure that the voices of women who have experienced intimate partner violence and have sought counselling from psychologists are heard. Their voices will contribute to identifying the most useful elements of counselling for intimate partner violence.

Method

This study will conduct semi-structured interviews with 20 women about their expectations and experiences of counselling with a psychologist after intimate partner violence. Further interviews with psychologists will explore their understandings and approaches to their work in this area. Thematic analysis will be used to understand and interpret the women's experiences within this context.

Findings

Preliminary themes will be presented from the interviews with women. This presentation will discuss the emerging themes and interpretations and illustrate these by drawing heavily on the women's own words.

Innovative contribution to policy, practice and/or research

The findings from this project will centre women's voices in informing a best-practice framework to underpin training and practice for psychologists working with women who have experienced intimate partner violence

Pathways between childhood trauma, intimate partner violence, and harsh parenting

Dr Emma Fulu[1], Ms Stephanie Miedema[2], Mr Tim Roselli, Ms Sarah McCook[1], Dr Ko Ling Chan[3], Dr Regine Haardörfer[2], Prof Rachel Jewkes[4]

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Introduction:

Few population-based data from low- and middle-income countries exist about the links between childhood trauma and violence against women. We present data from the UN Multi-country Study on Men and Violence in Asia and the Pacific, exploring pathways between these different forms of violence.

Context and aim:

This study aimed to move beyond linear associations between violence against children and violence against women, and to disentangle the complex and intersecting pathways and risk factors that connect both forms of violence.

Method:

From 2011-2012, we interviewed representative samples of men and women aged 18-49 years, using standardised population-based household surveys across nine sites in Asia-Pacific. Respondents were asked questions about intimate partner violence or non-partner sexual violence, experiences of childhood trauma, and use of harsh parenting (smacking their children as a form of discipline). We used maximum likelihood multivariate logit models to explore associations between childhood trauma and violence against women, and fitted path models to explore associations between experience and perpetration of child maltreatment.

Findings:

The proportion of men who experienced any childhood trauma varied between 59% (Indonesia, rural site) and 92% (Bougainville). For women, the results ranged from 44% (Sri Lanka) to 84% (Bougainville). For men, all forms of childhood trauma were associated with all forms of intimate partner violence perpetration. For women, all forms of childhood trauma were associated with experiences of physical intimate partner violence, and both physical and sexual intimate partner violence. There were significant, often gendered, pathways between men's and women's experiences of childhood trauma, physical intimate partner violence, harsh parenting, and other factors.

Contribution:

The data emphasise the importance of a meaningful integrated approach to violence against children and violence against women. Priorities include positive parenting, addressing normalisation of violence across the life-course, and transforming men's power over women and children.

Staying Mum: Parenting Stress and Intimate Partner Violence

CQUniversity Maria McDade[1], Associate Professor Tania Signal[1], Associate Professor Karena Burke[1], Associate Professor Annabel Taylor[2]
[1]Central Queensland University, Rockhampton, Australia, [2]Queensland Centre for Domestic and Family Violence Research, Mackay, Australia

Intimate Partner Violence (IPV) is a challenging context in which to parent, and while negative parenting outcomes are not inevitable, it is generally acknowledged that IPV has at least some adverse effect on maternal parenting. Whilst some women and children display remarkable resilience, it should come as no surprise, given the context of abuse and violence, that mothers who experience IPV also report high, if not clinically significant, levels of parenting stress. Parenting stress is broadly defined as the level of stress in the performance of the parenting role, the parent/child relationship and the parental perception of the ease/difficulty in managing the child's behaviour (Farmer & Peterson, 2012). Broadly, Abidin's model suggests that parenting behaviours mediate the association between parenting stress and child emotional and behavioural problems. In the context of IPV however, there appears to be little support for this mediational model, with the results suggesting a direct association between parenting stress and child behavioural problems. To date however, research which has examined parenting stress in the context of IPV, has been predominately focussed upon child outcomes and the deficiencies and failures of mothers as contributors to these outcomes; rather than examining parenting stress as an outcome of IPV. The potential significance of this gap in the literature becomes apparent given that not only are current interventions not performing as expected particularly with regards to parenting stress, but that mothers also report that parenting interventions are not addressing their needs. This study draws on the quantitative data from 28 mothers who attended a regional service provider for women/children who have experienced IPV. The results provide some preliminary insight into parenting stress in the context of IPV; the implications of the findings are discussed with a view to informing programs, policies and interventions to better support mothers and their children.

Learning about knowledge translation: Findings from Women, disability and violence

Professor JaneMaree Maher[1], Ms Patricia Malowney, Dr Jasmine McGowan[1]
[1]*Monash University, Gender And Family Violence Focus Program: New Frameworks In Prevention, Clayton, Australia*

This paper reflects on the processes and findings of the ANROWS-funded project Women, disability and violence: Creating access to Justice (April 2018) and the Knowledge Translation and Exchange (KTE) workshops held with the specialist family violence and disability sectors that concluded the project. The KTE is a key feature of ANROWS' research to policy and practice trajectory. We spoke with 36 women living in NSW and Victoria about their experiences of seeking justice and security in the context of violence that they had experienced. Our research examined the pathways and obstacles these women encountered in seeking redress and support, and was augmented by 18 interviews with service providers. The insights of the women shaped the key findings of the report and the intended aim of the KTE workshops – to embed the priorities and needs of women into the structure of service and ultimately policy responses tailored to these women. The paper reflects on the process of stripping back academic and institutional privilege that took place throughout the project, in both academic and service provision contexts. Such stripping back, we discovered, is a difficult yet essential process if researchers are to attentively listen and adequately hear 'the other', the subject of their research. We were faced with consistent challenges in asking women what they want and then effectively embedding those responses meaningfully into outcomes such as recommendations and systems responses. A key finding in this project was that women want to be heard; taking this seriously meant changing the communication and knowledge framework rather than simply 'adding' their voices to what we found out. For many this 'listening' was a critical aspect of justice. Taking KTE seriously means stripping back assumptions about the who, where and how of translation and rethinking modes of communication and target audiences for research findings.

The FRIEND study: FRiends IntervENing in Dating violence

Ms Mandy Mckenzie[1], Professor Kelsey Hegarty[1], Dr Laura Tarzia[1]
[1]*Department Of General Practice, University Of Melbourne, Parkville, Australia*

Introduction:

Young women are at higher risk of experiencing dating violence (DV) than older women. Research identifies that they are more likely to disclose it to their friends than to family members or service providers. Friends also witness incidents of violence or abuse. Friends are therefore in a critical position to support and protect young women, however they often feel ill-equipped to respond. The recent Victorian Royal Commission into Family Violence identified a need for online interventions to assist friends and family to respond. However, there is little research on how young women disclose to friends, the responses they find helpful, and the experiences and challenges friends face in responding to DV. This hinders the development of interventions to assist friends of young women.

Context and aim:

In order to inform the development of online interventions for friends of young women experiencing DV, the study will explore how friends recognise DV and respond to young women experiencing it, and how young women experiencing DV perceive their friends' responses.

Method:

This qualitative study draws on approximately 15 in-depth interviews with young women aged 16-25 who have experienced DV, and 15 interviews with male and female friends. A narrative feminist analysis will shed light on how gender influences participants' narratives of friendship in the context of DV.

Findings:

Preliminary findings will be presented about the process of disclosure of DV, the challenges faced by friends, and how responses unfold over time. Implications the development of interventions for friends will be discussed.

Innovative contribution:

This is the first study to provide a multi-layered understanding of the process of recognising and responding to DV by friends, from both the perspectives of friends and young women who have experienced DV. This will help inform interventions to assist friends of young women to respond to DV.

Reflections from the field: Women's voice can it transform practice?

Ms Shona Mcleod[1], Professor Jane Koziol-McLain[1], Professor Marilyn Waring[2], Dr Alayne Mikahere-Hall[3]
[1]Centre for Interdisciplinary Trauma Research, Auckland University of Technology, New Zealand, [2]Institute of Public Policy, Auckland University of Technology, NewZealand, [3]Taupua Waiora Centre for Māori Health Research, Auckland University of Technology, Auckland, New Zealand

Introduction

New Zealand's Ministry of Health (MOH) Violence Intervention Programme (VIP) aims to prevent and reduce the health impacts of family violence through the early identification, assessment and referral of victims presenting to designated District Health Board (DHB) services. The VIP includes the routine screening of women (aged 15+) in priority health settings and the assessment of children for signs of child abuse and neglect.

Context and Aim (why this is important)

Many of the elements found in successful family violence screening programmes (national guidelines, standardised training and national resources) are present in the Violence Intervention Program. However, there remains significant variation in service delivery between and within health care settings. There is a need to transform clinical practice to fully achieve benefits of such a screening programme.

Method

This presentation reports on the experience of the researcher in engaging with women with experience of intimate partner violence, as well as health services, to establish Appreciative Inquiry (AI) research to transform clinical practice.

Findings

Women's experience of participating in such processes along with the views of health providers will be presented. Early reflections on the results of change with the services being studied will also be discussed.

Innovative contribution to policy, practice and/or research

There is limited research using Appreciative Inquiry in health care settings in New Zealand and no research using Appreciative Inquiry in the family violence arena has been published. Additionally, the impact of women's voice on health care policy and service delivery has received little research in New Zealand to date.

The survivor nurse: Implications for health professionals and their workplace

Ms Elizabeth Mclindon[1], Professor Kelsey Hegarty[1], Professor Cathy Humphreys[1]
[1]*University Of Melbourne, Parkville, Australia*

Introduction:
Health professionals (HPs) have a critical role to play in identifying and responding to survivors of domestic violence (DV). However, until now, the role of the health system in responding to survivor HPs, and thus enhancing the clinical care of survivor patients, has not received adequate attention.

Context and Aims:
The aims of this project were to: investigate the prevalence of DV in a sample of HP women (Phase 1), consider associations with clinical practice (Phase 2), and explore implications for health system change aimed at supporting survivor HPs in their practice of early identification and first line response with patients (Phase 3).

Method:
Mixed methods study, including a descriptive, cross-sectional survey of female health professionals in a large Australian tertiary maternity hospital (n=471, 45.0% response rate) and 18 key stakeholder interviews. Univariate analysis measured the prevalence of DV amongst a sample of HPs, and logistic and linear regression examined whether personal exposure to DV was associated with clinical care of survivor patients. Thematic analysis was used to explore the views of HPs and key stakeholders about the role of the healthcare workplace in responding to survivor HPs and creating health system change.

Findings:
The 12-month prevalence of partner violence was 11.5%, the adult lifetime prevalence was 33.6%, and the lifetime prevalence of partner violence and/or family violence was 45.2% (Phase 1). An adjusted regression analysis indicated that being a survivor HP was not a barrier, and may have been a facilitator, to best practice with patients (Phase 2). A thematic analysis of the qualitative survey and interview data explored the experience of survivor health professionals and the role of the health system (Phase 3).

Innovative contribution:
This study has important implications for survivor health professionals, their patients, and a health system-wide DV strategy.

Community of Practice Supporting Health Sector Responses to Family Violence

Ms Simone Meade[1], Ms Anna Howell[1]
[1]*Ballarat Health Services, Ballarat, Australia*

Introduction

The health sector is a critical entry point for identifying family violence (FV). Despite this, research indicates an under identification of FV in hospital settings and a need to increase the knowledge and skills of staff to identify, respond and refer.
Ballarat Health Services (BHS) is the lead health service to six additional health services in the Grampians region for the implementation of the Strengthening Hospital Responses to Family Violence (SHRFV) initiative; a system wide approach to embedding the practice of identifying and responding to FV in the hospital setting.

Context and aim

A community of practice (CoP) lead by BHS in collaboration with six additional health services has been established to support implementation of the SHRFV initiative.
The aim is to determine the acceptability and feasibility of a CoP to promote best practice implementation of the SHRFV initiative in the Grampians region.

Method

The CoP is a "group of people who share a concern, set of problems, or passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis."
Held quarterly for four hours, the CoP provides opportunities to network, access resources to improve practice and facilitates the exchange of skills, knowledge and problem solving approaches.
Seven publicly funded health services participate.
The CoP will be evaluated via facilitated reflection and post session surveys.

Findings

Three sessions have been held with strong engagement across services.
Initial feedback indicates value in sharing knowledge and devising shared approaches to practice.
Intended implications for practice is the coordinated implementation of the SHRFV initiative, an increase in identification of FV, an effective response and improved referral.

Innovative contribution to practice

The CoP is a multidisciplinary forum connecting health services to inform and improve hospital responses to FV.

From mother blame to father accountability - responding to family violence

Dr Silke Meyer[1]
[1]*Central Queensland University, Brisbane, Australia*

Domestic and family violence (DFV) has been associated with a range of adverse short- and long-term outcomes for adult as well as child victims. As a result, DFV raises a range of child welfare concerns and places mothers at the spotlight of interventions. While in need of support and protection around their own experiences of violence, mothers have historically been held responsible for their children's safety and wellbeing. Recent practice and policy shifts in family welfare and perpetrator interventions increasingly focus on empowering the non-abusive parent and holding the abusive one to account. As a result, we see an increasing number of programs and interventions targeting perpetrators of DFV in their role as fathers. This presentation is based on early learnings from two current program evaluations. It highlights emerging practice shifts in child protection and perpetrator interventions, the benefits these can have for victims, perpetrators and children exposed to DFV and the implications they raise around workforce capacity.

Tūhono Māori: A secure base for indigenous children and sustainable safe futures.

Dr Alayne Mikahere-Hall[1]
[1]*Taupua Waiora Centre for Māori Health Research-Auckland University Of Technology, Manukau, Aotearoa New Zealand*

Introduction

Tūhono Māori is an indigenous research project that investigates attachment relationships from a culturally nuanced and uniquely Māori (indigenous people of New Zealand) perspective. The concept 'Tūhono' (attach/bond) is a relational concept connected to people and places that promote the importance of a secure base. The purpose is to shape violence and trauma-informed interventions for Māori and indigenous children and to effect improved child welfare and agency responses. Developing solutions for indigenous children, as vulnerable targets of domestic violence and consequential trauma is critical. Interventions for indigenous children require distinctive and innovative research approaches to change the current situation. Tūhono Māori seeks to foster sustainable and secure futures for indigenous children by contributing to both their healing and their success.

Context and Aim

The research aims to develop tūhono and related concepts such as tūhonotanga (attachment/connectedness) as a theory of indigenous attachment. Māori children have been over-represented in the New Zealand welfare system for some decades, which have led to rigorous debates regarding the effectiveness of child welfare services and agencies to respond appropriately. The over-representation of Māori children in state welfare care corresponds with high rates of social and economic disadvantage and violence in families.

Method

Kaupapa Māori methodology to include pūrakāu and Te-ata-tū pūrakāu as indigenous data collection and data analysis qualitative methods.

Findings

Preliminary findings suggest that indigenous perspectives on secure attachments are mediated through a multi-generational approach to caregiving. The study has found that a healthy multi-generational support system buffers children and caregivers from potential harm.

The innovative contribution to policy, practice and/or research.

The findings from Tūhono Māori will have broader systematic consequences for the way in which child welfare and health professionals respond to the needs of Māori children in need of care and support.

E Tu Wāhine: Reclaiming and restoring Indigenous knowledge and wisdom

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Introduction

Wāhine (women) Māori traditionally held mana (status), particularly their role as the bearers of future generations and as kaitiaki (guardians) of the whānau. Traditional cultural values and practices that ensured their safety and wellbeing – transgressions were addressed harshly. Today, wāhine Māori are at significantly and inequitably at risk of harm and death as a result of partner violence compared to other women in Aotearoa.

Context and Aim (why this is important)

Wāhine and their tamariki (children) are victims of deliberate acts of emotional, physical and sexual violence. However, wāhine are characterised as perpetrators of violence with their partners (or ex-partners), neglectful mothers, and as 'victims'. Such characterisations are unhelpful and disregard their protective acts or those embedded in traditional Māori cultural values and practices. We aim to (re)produce new culturally-informed knowledge about how wāhine Māori keep safe in unsafe partner relationships.

Method

We are using a qualitative design with a kaupapa Māori research methodology embedded in Māori cultural worldviews, beliefs, and processes and decolonisation, with constructivist grounded theory. Semi-structured interviews with kaumātua, kuia (elders) and key informants offering kaupapa Māori services; wāhine Māori; tāne Māori; and young Māori women to gather traditional and contemporary knowledge about how Māori women keep safe in 'unsafe' relationships.

Findings

Preliminary findings reclaim traditional mātauranga (knowledge) hold solutions to restoring values and practices to promote safe whānau (extended family networks), while interviews with wāhine, tāne and tamariki offer the opportunities to decolonise common understandings of the foundations on which relationships exist. We also present the realities and strategies contemporary wāhine Māori use to keep safe in their daily lives.

Innovative contribution to policy, practice and/or research

This research provides alternative ways to understand wāhine Māori and inform better both policy and practice.

DVIAF: A brief structured psychosocial assessment and intervention tool

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Introduction

Routine screening for domestic violence (DV) of women attending health services has been established as a key strategy for early identification and response to domestic violence. St Vincent's Hospital Sydney recently participated in a multi- site pilot introducing routine screening for domestic violence in the Emergency Department. This paper reports on the implementation of a structured intervention and assessment tool for women who identified they were experiencing DV through screening.

Context and Aim

Where studies have reported on the benefits or not of the screening process, they have historically focussed on the identification process, largely ignoring the significance of the intervention that follows and the influence that that next stage of intervention has on outcomes.

Innovative contribution to practice and policy

We developed a Domestic Violence Initial Assessment Form (DVIAF) to ensure consistency in the content of initial brief psychosocial assessment and intervention with patients identified through a screening program.

Method

The DVIAF was informed by NSW Health Policy and Procedures for Responding to Domestic Violence, the WHO's Clinical and policy guidelines for responding to intimate partner violence and sexual violence against women, as well as studies reviewing the evidence about screening and psychosocial interventions. The final protocol for this tool included an assessment of danger; development of a safety plan, provision of emotional support, and facilitation of referrals to local advocacy programs.

Findings

Surveys found that social workers using the (DVIAF) felt the quality of their interventions, assessments and documentation improved with use of the tool. All surveyed stated that they would like to continue to use the tool and suggested only minor structural adjustments. We intend to now review records of psychosocial interventions prior to the introduction of the DVIAF which will provide objective comparison to records where the DVIAF has been utilized.

Building Safe Communities for Aboriginal Women and Children

Ms Amanda Mitchell[1], Dr Gokhan Ayturk[1]
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In 2017, AHCSA conducted the first ever scoping review in South Australia of services for Aboriginal victims of domestic and family violence in collaboration with the Department of Social Services and the Aboriginal Community Controlled Health Organisations.

The scoping reviewed focused on the dynamics of collaboration between networks to improve service delivery, understanding of community strengths and protective factors, and aimed to build on evidence base. The scoping review indicated that Aboriginal communities in SA need to be serviced with tailored approaches to family violence prevention and victim support with an emphasis on how existing strengths can be built upon to increase capacity for the implementation.

The key recommendation of the scoping review was that Aboriginal family violence services should be co-designed and funded, and outcomes measured in partnership with Aboriginal organisations and in accordance with the requisite cultural overlay. It was found that Aboriginal community driven initiatives are more likely to be successful in such a sensitive issue as they organically build on community strengths and are tailored to the unique cultural and spiritual needs of their context.

The knowledge translation outputs included a webpage mainly targeting both the victims and perpetrators of family violence (http://safecommunities.ahcsa.org.au), fact sheets regarding where to seek help and resources targeted at increased service collaboration, greater community knowledge, and improved service access.

The study also identified the need for further research into what victims need to feel and stay safe, as well as how services and communities can best meet these needs.

What about perpetrators? Group-based interventions in ADVANCE & REPROVIDE programmes

Dr Gail Gilchrist[1], Professor Gene Feder[2], Dr Helen Cramer[2], Dr Karen Morgan[2]

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If we want to support survivors of intimate partner violence (IPV) and their families and make them safer, perpetrators cannot be ignored. Evidence for what makes an IPV perpetrator programme most effective, is unclear. Furthermore, some populations, such as those who use substances, may require more tailored approaches.

Two research programmes, funded by the UK's National Institute of Health Research, are trialling new non-mandatory group-based interventions for male perpetrators who want to change their behaviour. The REPROVIDE intervention accepts self and agency referrals, including from children's services and specialist domestic violence services. The ADVANCE integrated substance use and IPV intervention is delivered in substance use treatment services.

The symposium will present an overview and initial findings from both programmes to address the following key questions:

1. What are the main help-seeking routes and motivations for change for men who perpetrate IPV?
2. What is the relationship between substance use and IPV?
3. What interventions may be feasible and acceptable to address IPV in non-mandated populations?

These questions will be answered by drawing on a mixed methods process evaluation including field notes, observations of group sessions, and interviews with male perpetrators from REPROVIDE; and findings from a meta-ethnography, systematic review and in-depth interviews with men in substance use treatment and their female current or ex-partners from ADVANCE. Preliminary findings from the acceptability and feasibility of delivering the REPROVIDE and ADVANCE perpetrator interventions will also be presented. The implications of these two interventions for the targeting and provision of support for abusive men will be considered. Opening up the discussion to the audience will enable comparisons between the UK and Australian contexts and the sharing of good practice in the early identification of IPV as well as in the development of appropriate referral pathways and responses.

Listening and Responding: Children and Young People's Family Violence Experiences

Dr Anita Morris[1]
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Introduction

Australian children's experiences of safety and resiliency in the context of family violence have not been the focus of research. Much less is known about how such experiences can be acknowledged and responded to in health settings.

Context and Aim (why this is important)

To address this gap in research and practice, an Australian PhD study aimed to hear the voices of children who had experienced family violence and determine an appropriate primary care response.

Method

A qualitative approach underpinned the research which involved semi-structured interviews and focus groups with 23 children and 18 mothers from primary care settings. All of the families had experienced family violence. Ethical and safe methods were employed to reflected a child-centred approach. The analysis drew on ethics of care and dialogical ethics.

Findings

The findings revealed that children require agency to negotiate their safety in the context of family violence and post separation. Children's understanding of their own resiliency aligned with the concept of relational self-worth. Primary care findings focused on the health practitioner role, and relationship, modelling and communication in the child-mother-health practitioner triad.

Innovative contribution to policy, practice and/or research

A model of children's agency and an informed trialogue approach are proposed as an integrated theoretical model that informs an appropriate primary care response to children experiencing family violence.

My Safety: Scoping On-line Safety and Communication Tools for Children

Dr Anita Morris[1]
[1]*University Of Melbourne, Melbourne, Australia,* [2]*Department of Health and Human Services, Melbourne, Australia*

Introduction

Technology can be harnessed to support the safety of family violence victims. Children are frequent and competent users of technology in their everyday lives. Children want to talk to someone about their experiences of family violence and rely on trusted adults to facilitate such communication. Research to understand how technology may assist children's safety planning and communication can inform the development of appropriate on-line tools.

Context & Aim

The need for on-line tools for children experiencing family violence is noted in the Third Action Plan 2016 - 2019 of Australia's National Plan to Reduce Violence Against Women and Their Children 2010 - 2022. The My Safety project aims to scope the style and content of a safety planning and communication tool for primary school age children who are experiencing family violence.

Method

Focus groups are being conducted with children and mothers using a child centred approach with sample prototypes to guide discussion.

Findings

Themes related to the on-line experience including user journey, suitable content and necessary precautions will be explored in a summary of the findings.

Innovative contribution to policy, practice and/or research

It is anticipated that by seeking the views of children and their mothers about an appropriate and child-friendly on-line tool, the findings will guide the development of a prototype for real world testing.

Bring the invisible child into focus: Evidence-based family violence practice

Mr Dom Alford, Mr Dan Moss[1], Ms Nicola Palfrey[2], Mr David Tully[3]
[1]Emerging Minds, Adelaide, Australia, [2]Australian National University, Canberra, Australia, [3]Relationships Australia - South Australia, Adelaide, Australia

The Emerging Minds National Workforce Development Centre collaborates with practitioners to explore opportunities for parents to have conversations about their children's social and emotional wellbeing and their mental health. Working with parents where intimate partner violence (IPV) is present is a key area of practice development in the early identification and prevention of difficulties for children. Practitioners have discussed the challenges of applying child-focused frameworks while engaging with adults regarding their experiences of IPV. Children can be the passive victims of intimate partner violence, and invisible within practices that engage male perpetrators and female victims. Child-focused practices bring the experiences of children living with adults who are frightening or frightened to the centre of practices, ensuring accountability to their experiences and voice.

Men's behaviour change programs have developed robust partner accountability processes, but these do not always extend to the wellbeing of children. Children's voices are often unheard, even when their experience, needs and feelings are the topics being discussed. Men who perpetrate IPV are often motivated to make change because of their children and there are currently positive examples of practice that incorporates the social and emotional wellbeing of children as a primary component of behavioural change. Additionally, there is emerging evidence of promising practice in collaborative work with families where gendered control and abuse has negatively affected the mother-child relationship.

This presentation brings together practice learning from Relationships Australia and child-focused research from Emerging Minds, Parenting Research Centre and Australian National University, to demonstrate:

- Child-inclusive and child-focused practice that supports male perpetrators and female victims in ways that are respectful, holistic and collaborative
- Recommendations relating to integrated practice, policy and service delivery
- Short case studies that demonstrate connection between children's experience of IPV and practices that evidence effective outcomes for children's social and emotional wellbeing.

Knowledge and practice of child abuse among Primary school teachers

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Introduction:
Child abuse represents a significant global public health problem. It is estimated that about 3,500 children and adolescents die every year because of physical abuse or neglect. Child abuse crosses all socio-economic, cultural, and educational boundaries. A growing number of literature, reports, and research have examined various dimensions of the problem. Nigerian society is still plagued with incidences of child labour/maltreatment, trafficking, neglect, and child prostitution. Effects of such abuses have eaten deep into the Nigerian society, leading to teenage pregnancies, youth restiveness and violence. Lack of understanding of its lifelong consequences, cost and burden on society has hampered investment in prevention policies/programs.

Aim is to assess knowledge, attitude and practice of child abuse in Nigerai

Method:
Cross-sectional descriptive study in Zaria LGA, Kaduna State. Self-administered questionnaire used to obtain information on knowledge, attitude and practice of child abuse. Data analyzed using SPSS version 21 and relationships established using Chi-square test. A P-value less than 0.05 was considered significant.
Results: Of 152 respondents, about half (50.7%) were within the age group 25-35 years. Majority (93.4%) were aware but about two-thirds (69.7%) have fair knowledge of child abuse. Most (72.4%) of the respondents had physcially disciplined a child before and the commonest methods employed were kneeling down (74.5%), flogging (71.8%) and slapping (50.9%). Educational qualification, ethnicity and gender have statistically significant relationships with KAP of child abuse among primary school teachers in Zaria.

Conclusions:
The study revealed that though respondents have high awareness their knowledge of child abuse is only fair and associated with negative attitude towards corporal punishment. Recommendation: Health education programmes are urgently needed to increase public awareness on child abuse and its consequences on overall development of the child using strategic behaviour change communication strategies, promotion of child rights, and children-friendly primary school learning environment.

An electronic interdisciplinary care plan to enhance safety for victim/survivors

Ms Kellie Muir[1]
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Introduction

Information sharing and security is a major concern for health services when caring for victim survivors of family violence (Pagliari et al 2007, WHO 2014). The risk of harm for victim survivors may increase when a disclosure is made (DHHS, 2014). Finding ways to that mitigate this risk was a priority for Alfred Health.

Context and Aim

The development of electronic medical records provided an opportunity to create a technological pathway for 1) early identification, 2) information safety, and 3) safer continuity of care for victim survivors of family violence across encounters at Alfred Health.

The primary purpose of the electronic Family Violence Interdisciplinary Care plan ('FV IPOC') is to protect a patient experiencing family violence, in the context of their health care treatment. It also considers the safety of staff and others in the hospital environment. The FV IPOC will be used by the multi-disciplinary team to document the victim survivor's goals in addressing family violence, and to provide continuity of safe care across Alfred Health encounters.

Method

The FV IPOC provides a series of goals and interventions that prompt clinicians to ensure essential safety requirements are met for family violence victim/survivors. It includes a range of options: use of patient alert, FOI exemption, up to date contact details, use of an alias, recording visiting restrictions, ensuring safety of medical discharge summary. The IPOC was designed in consultation with victim survivors and key organisational stakeholders.

Findings

The IPOC will be analysed using a Quality Assurance framework. At present the IPOC is in testing stages, and will be implemented during our electronic medical record roll out in late 2018.

Innovative contribution to policy, practice and/or research

The FV IPOC provides a specific and unique response to addressing our safety concerns for victim/survivors within our new electronic medical record system.

Reaching Children Through Universal Services - evidence-informed children's therapeutic program

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The impact of family violence on children has been underestimated, with children the 'silent victims' and without access to the specialised support they need (Royal Commission into Family Violence, 2016). Reaching Children through Universal Services (RCUS) is an innovative demonstration project, funded by the Victorian Department of Health and Human Services, that combines evidence-based and evidence-informed practice to achieve a holistic, trauma informed, multi-faceted service that is easily accessible, especially for 'hard-to-engage' families.

RCUS provides children aged 0-18 years, who have experienced family violence with a post crisis therapeutic response at an early stage, so that they can achieve improved immediate and long-term life outcomes. In line with Socio-ecological theory, the project works with the child, family and supporting community. Services cover counselling and therapeutic case management, including equine and EMDR therapy, resilience building and life skills, education, health, connections to community and culture. Accredited parenting programs and family work, as well as trauma training and secondary consults to build staff capacity in universal services, are all part of the program.

As the name suggests, RCUS is co-located with partners within universal services so that services are delivered in locations best suited and least disruptive to the child and their family. RCUS partners were selected based on their levels of engagement with children affected by family violence and culturally diverse communities. There are strong relationships with the partners, service providers and a high engagement rate with clients, includes some fathers. The program is being independently evaluated and initial findings are illustrating the program's positive impact. RCUS is addressing a significant service gap with more referrals to the program than capacity allows.

This paper will delineate the RCUS model, its trauma-informed therapeutic approach and engagement strategies when working with this vulnerable cohort, partnership development and sustainability strategies, program outcomes and impacts.

"Do you feel safe?" Views on screening for DV in pregnancy.

Dr Amelia Lee[1], Miss Robyn Matthews[2], Ms Jeannette Walsh[3], Dr Jo Spangaro[3], Dr Kelsey Hegarty[1]
[1]University Of Melbourne, Carlton, Australia, [2]Royal Women's Hospital, Parkville, Australia, [3]University of New South Wales, Sydney, Australia

Introduction:
A recent review by the Australian Institute of Health showed that majority of the states and territories do not have standard pregnancy screening tool for domestic violence (DV). Only half of health professionals find screening acceptable.

Context:
Victoria will be mandated to screen in antenatal care from 2018.

Aim:
To explore clinicians' views and attitudes in identifying and responding to women experiencing domestic violence.

Method:
Doctors and midwives providing pregnancy care in a metropolitan maternity hospital were invited to attend a one-hour focus group. They were asked about their views and attitudes towards screening, risk assessment and responses to DV; views on system elements that need to change to implement effective and sustained screening. Focus groups were recorded and transcribed verbatim. Thematic analysis was conducted.

Findings:
Four focus groups were conducted (21 doctors and 23 midwives). Six themes emerged across both groups of clinicians: barriers to screening and responding to DV, training and/or education, perceptions of self-efficacy, enabling screening for DV, practice guidelines and/or policy, and referrals and/or resources. Innovative contribution to policy, practice and/or research: Findings will help to provide recommendations for safe and effective evidenced-based screening for DV in pregnancy care.

Family Violence across the lifespan – applying a universal approach

Dr Meghan OBrien[1], Ms Jenny Chapman[2], Ms Danny Gold[3]
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Introduction:

Hospitals are a key contact point for people experiencing family violence (FV). Health professionals can apply a universal approach to support patients of all ages at risk or experiencing FV.

Context and Aim:

The Strengthening Hospital Responses to Family Violence (SHRFV) provides an evidenced informed model for a whole-of hospital response.

Importantly it provides a platform for health professionals to re-frame their understanding of FV which is inclusive of a child, adult and an elder victim/survivor experience.

Method:

This workshop will be facilitated by the key staff who developed the training content which underpins the current SHRFV model. The workshop will demonstrate how a lifespan approach can be applied within diverse health settings through shared principles and a common understanding. Gender, ageism, trauma-informed care, human rights and the intergenerational impact of FV will be explored.

Learning objectives:

- Understand the value of the lifespan model as a universal approach in a health setting
- Encourage participants to explore the complexity of first-line responses to family violence in different clinical settings.

Interactive elements:

- Principles of deliberative dialogue
- Hypothetical scenario
- Groupwork (role plays)

Findings:

The model has been refined and tested to reflect how FV can be identified and responded to within and across patient cohorts. Health professionals report they can be challenged by the 'unfixable' nature of FV. This workshop will enable health professionals to reflect on relevant evidence and test frameworks to explore the ethics of clinical practice and the skills needed to address FV across the lifespan.

Innovative contribution to policy, practice and/or research:

This workshop will challenge health professionals to extend their practice into the difficult and often uncomfortable terrain of responding to FV. It will aim to contribute to best practice, policy reform, and enshrine the "best interest framework" across all victim/survivor groups.

Culturally constructed trauma therapy for South Asian Family Violence victim-survivors

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Context and Aim

Violence against women is a global phenomenon. Feminist theory of Family Violence (FV) argues that gender equality is an important pathway to stopping FV. A recent Australian survey (2016) identifies lack of progress in reported FV rates in the past 11 years survey suggesting that the Theory of Change needs to be revised. Australia is a highly multicultural country and interventions need to work with tradition and culture from across the globe. Australian South Asian (ASA) community is the third largest community in Australia. Yet there is little evidence to guide prevention and intervention strategies in this community. This paper describes innovative strategy aimed at exploring cultural construction of FV in ASA, and exploring culturally responsive interventions to treat the victims-survivors.

Method

A community based action research project captured the voices of South Asian immigrant community of Australia. The interactive theatre process and dialogue with and by the community was video-recorded and transcribed. Interactive theatre facilitated reflections on new and old culture, exploring underlying structure of violence against women. All conversations were transcribed and thematically analysed by NVivo.

Findings

In seeming chaos of voices there are factors that make order, pattern and structure and maintain equilibrium as stated in the complexity theory. Six cultural factors underpinning FV in this migrant community are identified. The factors provide theoretical scaffolding for prevention programs and interventions that are culturally responsive. The cultural factors thus identified inform trauma based therapy for ASA victim-survivors of family violence. A brief video showcasing the methodology will be showcased

Innovative contribution to policy, practice and/or research

Interactive participatory theatre is commonly used method but its role as action research methodology is new. In addition, this paper reports culturally responsive trauma therapy model for ASA migrants that arose from collective community knowledge.

A Gender Sensitive Approach in Psychiatric Inpatient Units

Ms Carol O'Dwyer[1], Dr Laura Tarzia[1], Dr Sabin Fernbacher[2], Professor Kelsey Hegarty[1]
[1]University Of Melbourne, Melbourne, Australia, [2]Northern Area Mental Health Service, Melbourne Health, Melbourne, Australia

There are strong associations between sexual violence victimisation and mental illness, with one in three women presenting at inpatient mental health services have experienced domestic violence, including sexual violence. Women are often disempowered and revictimised while in psychiatric inpatient units. The Gender Sensitivity and Safety (GSS) Guideline was developed to improve the safety and provide practical directions to practitioners and organisations to adequately support women who have a trauma history and co-morbid mental illness.

A case study design was utilised, including semi-structured interviews, documents and observations. Participants included management and staff of both genders from different occupational groups; including medical, nursing and allied health professionals. Normalisation Process Theory (NPT) was used to analyse the data collected to develop a rich understanding of how gender sensitive care is enacted in psychiatric inpatient settings.

Findings suggest that there are barriers to the implementation of gender sensitive care. Sexual violence is often minimised or ignored due to a focus on mental illness. The care provided is often impacted by staffs' attitudes, gender, training and profession. The implementation of gender sensitive care was further examined using the lens of NPT to highlight possible areas for improvement to be identified at an organisational level.

Gender sensitive care has the potential to improve women's experiences within an inpatient setting by recognising and responding to the complexity of their trauma and well-being. A case study design using NPT provides an in-depth understanding of the perceived enablers and barriers to implementing gender sensitive care in psychiatric inpatient units. Staff require a comprehensive shared understanding of what is gender sensitive care and how it is carried out by all staff members to then increase collective action and reflexive monitoring between staff and management. This research seeks to inform policy development to further improve the mental health system.

Influence of African cultural factors on domestic violence

Prof. Obiageli Omeje[1], Mr. Chimezie Chikwendu[2]
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Intimate partner relationship seems to be dominated by conflict and violence. Everyday observation and clinical experience portrays a picture of pain, dissatisfaction and stress among couples and children, hence the phenomenon of domestic violence. Domestic violence manifests in coercion, threat, control and other such acts interfering in the freedom of victims. These inhuman acts most of the time results in financial impoverishment, emotional pain, mental health challenges, physical injuries, among others. The incidence seems to be on the increase especially against women and children. Thus, to proffer solution to this menace, this present study investigated African cultural factors precipitating and exacerbating it. One hundred and sixty-one participants comprising 56 males and 105 females were drawn from married population in Enugu metropolis in Nigeria, using incidental sampling technique. A-9 item questionnaire developed by the researchers and descriptive survey design were used to collect the data. Result analyses using chi square revealed that some African cultural factors mediate domestic violence thus: gender inequality ($X^2=13.72$, $P<.01$), non-involvement of women in family decisions ($X^2=60.88$, $P<.01$), making sexual advances by men alone ($X^2=4.52$, $P<.05$), denial of women access to property and resources ($X^2=71.12$, $P<.01$), patriarchal system ($X^2=82.14$, $P<.01$), different training giving to male and female ($X^2=20.20$, $P<.01$), and relegation of women to the kitchen ($X^2=17.44$, $P<.01$). The patriarchal system had the highest coefficient ($X^2=82.14$, $P<.01$), and such proven to be the strongest cultural factor that promotes domestic violence, while making sexual advances by men alone ($X^2=4.52$, $P<.05$) yielded least factor of domestic violence. It was therefore recommended that there is need to modify some of these African cultural factors that mediate domestic violence in order to forestall it and its devastating consequences.

Domestic Violence Screening Practices: Qualitative Insights of Primary Health Care Providers

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Introduction

Domestic violence (DV) is a global issue that has far reaching implications for individuals, families and communities. One in six Australian women has reported experiencing some form of DV since the age of 15. This makes DV the most common form of violence against women in Australia (ABS 2014).

Context and Aim

During pregnancy and the post-natal period, women generally have greater contact with health care providers (HCPs), presenting opportunity for HCPs to screen for DV. While known barriers exist that prevent many HCPs from implementing DV screening, little is known about what may enhance screening rates. The aim of this presentation is to present qualitative insights from primary HCPs on barriers and facilitators for DV screening.

Method

This paper reports on the qualitative findings of a larger sequential mixed method research study. The qualitative, semi-structured interviews were undertaken to elicit key stakeholders' experiences with, and insights about, DV screening of antenatal and post-natal women.

Findings

The following themes emerged from the qualitative interviews
Theme 1: Why HCPs screen
Theme 2: What enhances the woman to disclose
Theme 3: Barriers to screening
Theme 4: Methods of screening
Theme 5: What is done with a positive result
Theme 6: The Needs of the Health Care Provider

Innovative contribution to policy, practice and/or research

The research presented contributes to identification of what is needed to support HCPs become more proficient, knowledgeable and confident in identifying DV, and intervening effectively. This also addresses the gap in research about the screening practices of community HCPs in Australia.

Reference

Australian Bureau of Statistics [ABS]. (2014).4102.0 - Australian Social Trends, 2014. Accessed 21 June 2015 at http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4102.0main+features602014

Lessons learnt: developing an innovative tech family violence resource

Ms Louise Monahan[1], Ms Liz Ratcliffe[1]
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Introduction

Feelings of being minimised by professionals, family and friends when disclosing family violence compounds the oft eroded self-belief created by the perpetrator. This, coupled with societal stigma and lack of secure avenues for recording experiences, can significantly undermine the confidence to report/disclose family violence, safety planning and action.

Context and Aim

DVRCV created an app 'SmartSafe+' in 2015 aimed to help women record and then report experiences of family violence to police and at court, and lower the rates of women being misunderstood or disbelieved. This direction was taken following research into tech-facilitated abuse; SmartSafe (2013) and ReCharge (2015) to reframe smartphones as a tool to empower women rather than a tool for abuse.

In 2017, DVRCV was successful in their bid for Department of Premier and Cabinet (Victorian Government) and Department of Social Services (Australian Government) funding to improve this technology.

Method

DVRCV aligned our approach to the Federal and State governments digital standards ensuring a depth of knowledge regarding the 'users' and their context for using this tool, and a solid understanding of 'user' needs.

Findings and Innovative contribution

The redevelopment of the app increased awareness among victim/survivors of their family violence experience, increased capacity among victim/survivors of self-advocacy and decision making that is right for them as well as easing the interface with police and justice systems for victim/survivors if/when needed.

DVRCV has gathered significant learning's about how as a not-for-profit organisation we navigated the delivery of innovative tech resources in collaboration with victims / survivors (users), stakeholders and a commercial digital partner. We will explore how we unearthed and challenged assumptions of what users need, a crucial shift in thinking in terms of who the tech tool could help, enabling a framework of clarity regarding purpose and decision making.

Good things take time… complex things take decades

Miss Miranda Ritchie[1], Associate Professor Janet Fanslow[2], Ms Helen Fraser[3]
[1]Health Networks, Havelock North, New Zealand, [2]Univeristy of Auckland, Auckland, New Zealand, [3]Ministry of Health, Hamilton, New Zealand

Introduction

The symposium reflects New Zealand's national violence intervention programme (VIP) that integrates health care intervention addressing intimate partner violence and child abuse and neglect.

Context and method

We will present a timeline of the strategic approach and key steps used to support changes in policy and practice to improve public healthcare services for those who are being abused.

Findings

In the 1990s work explored potential health care responses to family violence. Lessons that emerged included the importance of routine enquiry, structured training and senior manager/clinician leadership and support. In the 2000s, a sentinel event triggered a multi-ministerial enquiry, which led to development and publication of national health Guidelines and pilot work within health boards. Subsequent work by all health boards led the government to invest in the VIP that was launched in 2007. This supported the funding of all 20 health boards for programme coordination and development of national programme infrastructure. In the 2010s, VIP outputs delivered included consistent organisational infrastructure e.g. policy, training of healthcare providers and evaluation activities.

Innovative contributions to policy/practice

Quality improvements have incrementally occurred, many of which have been incorporated in the refreshed national Guideline released in 2016, e.g. the non-fatal strangulation clinical guideline. Standardisation and efficiency has been enhanced with the development and use of templates, including national interagency agreements adopted at local level. Anecdotally, we know that the improved response (VIP) from health is making a difference for individuals. Reasons why it may be decades before outcomes are evident at a population level will be explored.

By the end of the symposium participants will have:

1. An understanding of the key elements of the VIP and the challenges encountered
2. Engaged in discussions regarding the programme and its components including potential transferability and applicability
3. An opportunity to debate proposed strategies/next steps.

The New Frontier – Leveraging technology to address family violence

Ms Pip Robertson[1]
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Ask Izzy is an innovative mobile website that connects people who are at risk or experiencing homelessness with essential services funded by Google. Since launching in 2015, there have been over a million searches Australia wide. Ask Izzy acts as an early intervention response tool to address health and wellbeing for marginalised groups, by connecting people to services.

The largest search group for Ask Izzy in housing are women and children leaving family violence situations, and the highest search term being domestic violence. Research from DVRCV (2015) highlighted that 98% of workers had clients experiencing tech abuse. This has led to the Ask Izzy Help at Hand project funded by the NAB Foundation.

The development of Ask Izzy Help at Hand seeks to engage and connect people at risk or experiencing family violence with services that are nearby and responsive to their needs, as well as empowering organisations to support their clients with relevant referrals. The project has undertaken co-design research across Australia with 37 individuals with lived experience of family violence and key family violence organisations. Research explored victim / survivors attitudes to engaging with technology, help seeking behaviour, service segmentation through the family violence journey, along with the role technology can play in mitigating technology facilitated abuse.

The website is being technically enhanced to embed a trauma informed, strengths based approach to supporting people at risk or experiencing violence to identify their experience and access the multitude of service they need to navigate their individual

Promoting best practice systemic responses to child and family safety

Ms Natalie Ross[1], Ms Meredith Lea[1]
[1]*People With Disability Australia, Australia*

People with Disability Australia (PWDA) is a leading disability rights, advocacy and representative organisation of and for all people with disability. PWDA's primary membership is made up of people with disability and organisations primarily constituted by people with disability.

PWDA's individual advocates routinely support people with disability to engage with the National Disability Insurance Scheme (NDIS). From these interactions, it is clear that while the NDIS is individually focussed and should respond more appropriately to the nuances of individual situations and experiences, this is not always the case when it comes to working safely with families. The implications for family safety are complex, and requires early intervention that is proactive, well-resourced and based on a shared understanding of what constitutes best practice to adequately meet the needs of these families.

In this presentation, we will share our experience of the NDIS and its impacts on the security and functioning of families. For instance, families are experiencing loss of services due to poorly informed funding decisions, difficulties navigating the NDIS, significant stress on carers and their capability to care, and narrow service provision rules that do not take the broader needs of families into consideration. Furthermore, the bureaucratic context of the NDIS can alienate at risk families, and can increase the risk of violence and family breakdown. In turn, this can place children of parents with disability and children with disability at risk of being placed in statutory child protection systems.

Throughout this presentation, we will provide examples of best practice, whereby families are supported by systems that are accessible, informed, flexible, and able to respond quickly in times of crisis. Such systems must be sensitive to difference, must be child focused, and must be integrated to ensure they appropriately respond to safety concerns of families receiving support through the NDIS.

Oro-facial injuries in child and adolescent victims of family violence

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Background:
Orofacial injuries may be early events in the family violence (FV)-related injury profile. Owing to the practice of documenting the exposed orofacial region during dental examination, dentists have the potential to be early responders. By generating a reliable evidence base regarding oro-facial injuries in FV victims, an early informed response to FV could be tailored.

Problems:
Knowledge of the patterns of abusive oro-facial injuries in the Victorian population is lacking.
The role and efficacy of dentists as early responders to FV is undefined.

Aims:
To investigate the patterns of orofacial injuries in family violence victims as compared to unintentional trauma victims.

Methods:
A systematic review was conducted to identify the oro-facial injuries associated with child physical abuse (CPA).
For the 0-17 years age group, all cases of deceased Victorian FV and an age- and sex-matched sample of unintentional trauma deaths from 1st January 2000 to 31st March 2018 were studied in a retrospectively designed whole population cohort study. Injury characteristics in the exposed oro-facial region were analysed for correlation with coexistent injuries, demographic and contextual information. Patterns of abusive/ unintentional oro-facial injuries in the case/comparison groups were statistically analysed.

Results and discussion:
Owing to limitations of the systematic review studies, no patterns of oro-facial injuries were generalizable in physically abused children. A significant gap remains in the literature regarding orofacial injuries associated with CPA.

The database search identified 50 FV victims aged 0-17 years and multiple age- and sex-matched deceased unintentional trauma cases.

Descriptive findings will be discussed for the case and comparison groups, including autopsy findings, medical cause of death, past medical history, coexistent injuries, photographic information, post-mortem CT scan findings regarding oral tissues and exposed skin of face, ear and anterior neck and statistically significant differences highlighted. Study limitations and conclusions will be discussed.

Safe and Understood CRCT: Effect on Worker Conceptualization and Self-Efficacy

Dr. Katreena Scott[1], Dr. Angelique Jenney[2], Ms. Marlena Colasanto[1]
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Exposure to domestic violence (DV) is one of the most frequently substantiated forms of child maltreatment in Canada (Fallon, 2016). As with other forms of maltreatment, very young children experience disproportionately high levels of victimization. Given the developmental and neurocognitive vulnerability of infants and toddlers, it is essential that effective services are available for this population. One potential means to improve service is collaborate across child and family mental health and men's violence intervention services to embed early parenting interventions within child protection practice. Our research team is currently in the midst of a cluster randomized control trial (NCT03198429) of the efficacy of embedding two parenting interventions – a trauma-informed mother-child dyadic program focused on preventing impairment in very young children (Mothers in Mind) and a group-based, motivation interviewing and CBT intervention for fathers focused on preventing recurrence of abuse perpetration (Caring Dads) – within child protection teams randomly assigned to additional training and support for referral to Mothers in Mind, Caring Dads, both, or to standard care. Herein, we present preliminary data on two secondary outcomes of this trial: workers' conceptualization of the risks and needs associated with domestic violence and their self-efficacy for referring and collaborating with embedded interventions. We will also talk about the implementation challenges our team has faced (e.g., rapid turn-over of child protection staff) and our successes, and failures, in addressing these challenges.

Women's Response to Domestic Violence: Silence or Struggle

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Introduction:
Domestic violence against women is widely recognized as a public health problem. There is paucity of evidence on women's response to domestic violence in India. Present study aimed to identify the response and help seeking behavior of women for domestic violence.

Methods:
This community based, cross sectional, mixed methods study was carried out among 827 ever married women aged upto 60 years, from Delhi, selected through cluster sampling followed by systematic random sampling. Data were collected using pretested structured questionnaires and in-depth interview guide. Analysis was done using Stata 11.0.

Findings:
The prevalence of physical or sexual violence against women was 28.2% ever in life. Among these women (n=233), 81.1% fought back physically to defend themselves and 76.4% informed at least one person or agency about the violence; mostly own family (69.9%), husband's family (38.6%), friends (12.5%), neighbours (9.9%) and only 7.6% (18/233) women approached formal agencies. Eight women left their husbands/ divorced. As many as 54.9% women (128/233) reported that no one tried to intervene/help. Almost a quarter (23.6%) of women did not inform anyone about their violence experience.
The chief barriers to seeking help were fear of bringing bad name to family or threats/consequences; considering violence as normal, and more importantly nowhere to go.

Conclusion:
Women keep silent about violence hoping it will go away on its own or for the fear of repercussions. Those who do seek help do not always receive satisfactory response. There is need to use multipronged approach including public health interventions for effective and sustainable response.

Key words: Domestic violence, response, help seeking behavior, women

Association between women's violence perception and reproductive health service utilization.

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Introduction:
Intimate partner violence (IPV) negatively affects women's reproductive health outcomes, however, little is known about the impact of perception of IPV on reproductive health service utilization. Therefore, this study aims to find association between women's perception on wife beating and reproductive health services utilization in South Asian countries.

Methodology:
The study analysed nationally representative cross-sectional samples of multiple indicator cluster surveys of Nepal, Afghanistan, Bhutan and Pakistan (Punjab and Sindh provinces) conducted between the period of 2010 to 2014. A total of 26,029 reproductive women were included in this study who had pregnancy outcome within last 2 years.

Logistic regression with random effect that allowed clustering at the country level was used to find the association between justified wife beating and reproductive health service utilization after controlling for potential confounders, while linear regression was used to find the delay in timing of first Antenatal Care (ANC) visit. We used a likelihood ratio test to conduct trend analysis for reproductive health service utilization associated with increasing levels of justified wife beating.

Results:
The study found women who justified wife beating from their partners were less likely to use family planning methods (OR=0.92, 95%CI: 0.86, 0.97), access ANC service (OR=0.88, 95%CI: 0.82, 0.96), complete four or more ANC visits (OR=0.82, 95%CI: 0.77, 0.87) and have institutional delivery at health facilities (OR=0.93, 95%CI: 0.88, 0.99).

In addition, women who justified IPV were likely to delay accessing first ANC service by almost 0.49 months (95%CI: 0.24, 0.75) compared to their relative counterparts. We also found evidence of linear decreasing tread of utilization of family planning services, four or more ANC visits and institutional delivery associated with increasing level of justified IPV.

Conclusion:
The perceived justification of IPV was associated with decreased odds of utilizing reproductive health care services in South Asian region.

Asking about 'fear of partner' in measuring intimate partner abuse

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We need to determine the best questions to ask women in measuring intimate partner abuse (IPA), that reliably identify abuse.

We estimate the sensitivity and specificity of three brief questions about fear of a partner compared to the 30-item Composite Abuse Scale (CAS).

We conducted a secondary cross-sectional analysis comparing data from four existing studies with robust samples sizes (1257 to 5871 adult women). All studies asked women attending clinical settings about IPA using both the CAS and the fear items. We analysed sensitivity, specificity and Receiver Operating Curve (ROC). We also examined associations between demographic factors and fear through univariable logistic regression.

The prevalence of IPA (CAS ≥ 7) varied from 6.5% to 16% among the project samples. The prevalence of fear of partner varied from: 9.5% to 26.7% (lifetime fear); 14% (fear in the past 12 months); and 1.3% to 3.3% (fear currently). 'Fear in the past 12 months' had the greatest area under the ROC curve (AUC = 0.80 95% CI 0.78 to 0.81) compared to 'fear currently' (AUC from 0.57 to 0.61); or 'lifetime fear' (AUC from 0.71 to 0.77); and demonstrated better sensitivity (64.6%) and specificity (94.8%) compared to other questions. Demographic factors associated with fear of a partner in the past 12 months included being divorced/separated (OR=8.3, 95% CI 6.56 to 10.49); having a low income (OR=4.21, 95% CI 3.46 to 5.13); and having less than 12 years of education (OR=2.48, 95% CI 2.04 to 3.02); with p<0,001 for all variables.

Asking about 'fear of a partner' may improve our ability to accurately identify a significant proportion of women experiencing IPA, particularly if the question asked is 'Have you been afraid of a partner in the past 12 months?' These results suggest that this question is useful in surveys designed to measure IPA.

Emergency Department intimate partner violence screening: A multi-site feasibility study

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Introduction

Emergency Departments (EDs) have potential for identification and response to domestic violence, with studies indicating that abused women are more likely to present to EDs and to use them frequently. The NSW Domestic Violence Death Review Team recommended that NSW Health coordinate the development and implementation of domestic violence referral strategy for NSW hospital emergency departments.

Context and aim

This feasibility study was conducted at one urban and two regional EDs from May-November 2017. The study aimed to examine the extent to which domestic violence screening and response in EDs can be routinely implemented through an integrated protocol incorporating staff training and social work response within one hour.

Method

Women aged 16-45 years, triaged in Categories 3 -5, (ie requiring response in > 30 minutes) were asked standardized questions by nurses using a modified version of the HITS tool. Respondents estimated the frequency on a five-point scale from “never” to “frequently” of: i) Hitting/physical hurting; ii) Insults; iii) Threats; iv) Screaming/swearing - by their partner/ ex-partner. A score >10 of a possible 20, was taken to indicate current abuse, with referral to social work for response within one hour.

Findings

Of 12,131 ED presentations by 9,177 eligible women who met the inclusion criteria, 1,047 women were screened, averaging 11.4%. Nineteen percent of women presented more than once during the study period. Of the 868 women screened at their index presentation, 154 women (17.7%) scored >10 on the HITS.
Innovative contribution to policy, practice and/or research

This study demonstrated strong support by health staff in participating EDs for improving identification and response to domestic violence. Prior to further implementation there is a need for further research on a model that addresses low screening rates through greater integration of tools, along with attention to resourcing and training issues.

Women's Experiences of Reproductive Coercion and Expectations of Health Professionals

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INTRODUCTION:
Reproductive coercion refers to behaviours that interfere with a woman's autonomy over her reproductive choices, and is generally considered an element of control exerted by an abusive man over his female partner. Despite a lack of reliable prevalence data, it is estimated that 8-24% of women have experienced some form of reproductive coercion, such as birth control sabotage, pregnancy coercion and partner control over the outcome of a pregnancy. Reproductive coercion is associated with unintended pregnancy and intimate partner violence, which has significant implications for women's reproductive health and family planning.

CONTEXT AND AIM:
Women experiencing reproductive coercion are more likely to have made repeated visits to a healthcare provider for care, which highlights an opportunity for providers to engage with at-risk or affected women and intervene early. However, little is known about women's expectations of health professionals in the context of reproductive coercion, and there is a lack of qualitative research on how women understand and experience reproductive coercion. To address these gaps in the literature, we report findings from a study exploring women's experiences of reproductive coercion and their expectations of health professionals.

METHODS:
Adult women self-selected to participate in this study by responding to flyers placed in hospital clinics. Semi-structured interviews were conducted, with qualitative data undergoing thematic analysis.

FINDINGS:
Preliminary results suggest that reproductive coercion is a varied phenomenon that exists both within and outside physically violent relationships, and that in both cases, women often do not recognise this experience as abuse. Similarly, women feel that this phenomenon is poorly understood by health professionals, and they expect their doctors to be aware, responsive and supportive when treating affected women. The results of this study will be used to inform clinical practice and develop effective interventions to support women affected by reproductive coercion.

Indashyikirwa: Couples Curriculum and Women's Safe Spaces

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Introduction

Within intimate partner violence (IPV) prevention programmes, there is a need for tailored response mechanisms for survivors of IPV. This is especially important among programmes that raise awareness of women's rights and IPV, in communities with limited knowledge of or access to available response services.

Context and Aim

Indashyikirwa is a Rwandan IPV prevention programme, which ensured dedicated responses through establishing 14 women's safe spaces. Female community members were recruited and trained to provide venues for women and men to disclose IPV, facilitate participatory dialogues about IPV and gender inequality, educate women about their rights, refer or accompany IPV survivors for health, social or justice services. The programme undertook advocacy to improve services for survivors of IPV.

Methods

Qualitative interviews with facilitators, attendees and observations of activities at the spaces were conducted at three different points across the programme to assess the impact of the safe spaces. A sub-set of programme staff were also interviewed at two different points. The data was analyzed thematically.

Findings

The findings suggest that many individuals prefer reporting IPV to the spaces over other options for having dedicated time, confidential and non-judgmental responses, being offered solutions, and not fearing consequences, such as their experiences being shared publicly, paying a fine, or their partner being arrested. Accessing further health, justice and social services was improved through the spaces raising awareness of these services and accompaniment. Attendees were encouraged to provide feedback on the quality of services they accessed, to inform programme advocacy. A key advocacy success given was to ensure health providers freely offer services to GBV survivors, by raising awareness of related policies.

Implications

The findings suggest the value of dedicated response mechanisms among IPV prevention programmes. This is critical for safety, sustainability, and to empower survivors' access to services, including the health sector.

Harmony - bilingual GP/advocate systems model in migrant communities

Professor Angela Taft[1], Associate Professor Jane Yelland[2], Professor Kelsey Hegarty[3], Professor Alan Shiell[1], Professor Gene Feder[4]
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Australia benefits from migrant populations including bilingual/bicultural clinicians, but migrant/refugee women in diaspora communities are very vulnerable to family violence (FV) and rates of victimisation and murder similar to those in home countries.

Context and Aim

Evidence for culturally sensitive interventions to improve the health and well-being of abused migrant/refugee women is sparse. Primary care software systems to enhance effective FV documentation are currently poor.
Our aim was to test feasibility of a GP systems model in a CALD community to increase (a) GP identification and (b) referral of DFV, especially among female migrants, measured by routine clinic data and referrals received by a migrant FV service

Method

With bilingual advocates, we adapted the UK IRIS (Feder 2006) model to a culturally sensitive Australian model (Harmony). We randomised four GP practices (n=~40 clinicians) in areas with large CALD communities in NW Melbourne. We conducted joint training of all intervention clinicians by a bilingual FV advocate with a GP trainer, and trained all administrative staff. Medical software programs were re-designed to capture female patients 16-64, COB, FV identification and referral, and GPs in both arms trained in routine FV documentation. Referrals of all women were systematically recorded by the multicultural FV service. De-identified data from all clinics were routinely downloaded. The model was tested from Oct 2015-Feb 2016.

Findings

The Harmony model was feasible and may be effective. 13 women were referred to the multi-cultural service while comparison practices referred none. Data for CALD women were poorly recorded and referral data are complex.

Innovative contribution to policy, practice and/or research

The Harmony model has potential to improve GP FV clinic support and we report on a larger study now commencing. Clinic software data for monitoring DFV trends in primary care offer great promise but need refinement and improved clinician engagement.

Working with men who use violence in relationships: GPs' experiences

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Introduction

General practitioners (GPs) are well placed in the healthcare system to identify and respond effectively to male patients who perpetrate intimate partner violence (IPV) against their partners. GPs generally see the whole family and have regular contact with patients. Despite this, there is an evidence gap around how GPs can intervene early with men using violence in relationships and what methods are effective. We also know little about what barriers and facilitators GPs experience in undertaking this work.

Context and Aim

This presentation reports findings from research exploring GPs' experiences of intervening early with male patients who use violence in their relationships, and how GPs perceive they can be best supported in this work

Methods

For this qualitative study, we undertook semi structured telephone interviews with 19 GPs in Victoria. Interviews were audio recorded, transcribed, and analysed thematically to explore patterns across the sample.

Findings

Our findings suggest a number of emerging themes: that GPs have difficulty identifying men who perpetrate IPV; that they believe they have a role to play in intervening with these men; that there is a need for more training in this area and that awareness of referral services needs to be increased.

Innovative contribution to policy, practice and/or research

This presentation provides important insight into GPs' experiences of responding to perpetrators and what supports they require to carry out intervention work effectively. Data from this study will contribute to the development of a consumer-informed early intervention in primary care for men who perpetrate violence against their intimate partners

Synthesising qualitative evidence to improve the healthcare response to IPV

Dr Laura Tarzia[1], Ms Renee Fiolet[1], Dr Gemma McKibbin[1], Dr Leesa Hooker[2], Professor Kelsey Hegarty[1], Dr Mohajer Hameed[1]
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Introduction

Qualitative meta-synthesis is a process of drawing together and re-interpreting qualitative evidence to identify common themes and gain a deeper understanding of a phenomena. Feder and colleagues (2006) conducted a qualitative meta-ethnography of women victim/survivors' experiences and expectations when encountering health professionals, suggesting that women value a non-judgemental, nondirective and tailored response. Although this review has been extremely influential, it is now over 10 years old, and the body of qualitative evidence has since increased substantially. Additionally, robust meta-syntheses of qualitative data exploring the experiences and expectations of other vulnerable groups affected by IPV, and health professionals themselves, are lacking.

Context and Aim

It is vital that qualitative evidence be made accessible to policy-makers and clinicians. By synthesising and critically examining the qualitative research we aim to highlight key priority areas that can be targeted to improve the response to women, children, and Aboriginal and Torres Strait Islanders, and provide better support for health professionals. This symposium reports on the findings and methodological processes of four qualitative meta-syntheses conducted in 2018 focusing on these areas.

Method

Four separate qualitative meta-syntheses have been undertaken addressing the experiences and expectations of 1) women; 2) children and young people; 3) Aboriginal and Torres Strait Islanders and 4) health practitioners. A framework thematic synthesis methodology was utilised in each review to analyse the data.

Findings

The findings of each qualitative meta-synthesis will be reported, highlighting the experience and expectations of each group and the implications for practice. We will also reflect on the process of conducting these qualitative meta-syntheses and the particular methodologies chosen.

Innovative contribution to policy, practice and/or research

These qualitative meta-syntheses facilitate the foregrounding of the voices of victim/survivors and health practitioners to inform critical improvements to policy and practice.

Technology-facilitated pathways to safety and healing: Global perspectives

Dr Laura Tarzia[1], Professor Kelsey Hegarty[1], Professor Nancy Glass[2], Professor Jane Koziol-McLain[3], Professor Marilyn Ford-Gilboe[4]

[1]The University Of Melbourne, Carlton, Australia, [2]Johns Hopkins University, Baltimore, USA, [3]Auckland University of Technology, Auckland, New Zealand, [4]Western University, London, Canada

Introduction

The health sector has been identified as having a key role in responding to women experiencing intimate partner violence (IPV). Despite this, a range of barriers exist that prevent some women from seeking help face-to-face. Technology has shown great promise as an alternative pathway to safety and healing for these women, providing a private, anonymous space to seek information and support. A global research collaboration was established to explore, evaluate and advance the development of technological interventions for IPV. Beginning with a series of interactive, contextually appropriate and personalised safety decision aids in the US (IRIS), New Zealand (I-Safe) and Canada (iCAN), and a healthy relationship tool in Australia (I-DECIDE), the teams have gone on to develop new interventions and refine and test the original ones in new settings and with new populations.

Context and Aim

It is vital that we understand how technology can be most effectively and safely harnessed in the context of IPV, as well as how this varies across contexts and populations. The aim of this presentation is to highlight the latest interventions being developed by our global research partnership, and how we have built on learnings from the original suite of tools.

Method

Each presenter will outline the methods used to develop and evaluate their interventions, with a focus on experience-led co-design.

Findings

Findings from each team support the continuation of this program of research into technological interventions. We will incorporate qualitative data, randomised controlled trial evaluations, and process evaluations as appropriate, as well as examples from the interventions themselves.

Innovative contribution to policy, practice and/or research

Technological interventions for IPV that are evidence-based and rigorously evaluated are lacking. Our presentation highlights the latest developments in this key area and how they could be used in policy and practice.

Domestic Violence Screening in the Emergency Department.

Dr Thomas Torpie[1], Miss Michele Romeo[1], Dr Kathleen Baird[1,10], Dr Sally Sargeant[1,11], Ms Amy Sweeny[1,2], Dr Sheree Conroy[3], Dr Neale Thornton[4], Mr James Hughes[5], Ms Catherine Walsh[6], Ms Julie Watson[7], Dr Eric Richman[8], Mr Angel Carasco[1], Ms Kym Tighe[1], Ms Bronwyn Brabrook[3], Ms Bernadette Bradshaw[9], Ms Nancy Brennan[4], Mr James Ready[5], Dr Chaley McNab[6], Ms Jane Logan[7], Mr Craig Birrell[8], MS Peta McLean[9]
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Aims:
The aims of this project were to characterise the domestic and family violence (DFV) screening culture of emergency department (ED) staff, and identify any screening methods used, and the perceived barriers and enablers to DFV screening in EDs.

Context and Aim (why this is important):
DFV is now recognised as a global health and societal issue. Healthcare providers working in front line services such as are well placed and can play a crucial role in the identification, prevention and management of DFV including referral to appropriate support services. Research exploring optional methods of DFV screening and factors affecting DFV screening in EDs is limited and recommendations for best-practice in DFV screening is at its best controversial and contradictory.

Method:
As part of the Domestic and Family Violence Screening in the ED: Who's doing it? How are they doing it? How often? Project, an online survey designed using a knowledge, attitudes and behaviour construct was administered to ED clinicians, nurses and social workers from 10 hospitals in Queensland.

Findings:
Data analysis is in process and preliminary results will be available by the conference date reporting on the practices of, and perceived barriers and enablers to, screening for DFV in the ED.

Innovative contribution to policy, practice and/or research:
EDs provide a unique venue and opportunity for healthcare professionals to screen patients for DFV. This project is the first Australian multi-site research project to examine the practice of DFV screening in the ED, as well as examining the current impact of DFV presentations to ED. This synthesised knowledge of DFV screening methods and factors affecting DFV screening in the ED can help clinicians, nurses and decision-makers to provide patient centred and effective care to victims of abuse attending the ED, which may include developing an ED screening algorithm.

Beyond trauma assessments: Ensuring social justice outcomes

Dr Emma Tseris[1]
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Introduction

After decades of ignoring women's experiences of Intimate Partner Violence (IPV), notions about the importance of traumatic life events in shaping mental distress and emotional difficulties are becoming increasingly acknowledged within health service contexts. This trend is encouraging, however there are some aspects of trauma-informed work that require further exploration. For example, it has been argued that trauma assessments may at times focus too heavily on diagnosing "symptoms" within individual women, at the expense of recognising broader social and gender inequalities.

Context and Aim

Trauma assessments are usually understood as strongly connected to social justice aims. This paper explores the important question of whether trauma-informed assessments are always connected to the empowerment of women and feminist knowledge about violence against women.

Method

A qualitative literature review was conducted to explore contested views about the implications of trauma assessments for women with experiences of IPV.

Findings

While the available literature on trauma-informed practices is overwhelmingly positive, an emerging body of literature highlights the capacity for trauma-informed assessments to overlook social and gendered contexts, leading to reductionist claims and at times rendering individual women responsible for managing the effects of violence. Furthermore, the literature on IPV, trauma and mothering is sometimes highly deterministic and deficit-focused.

Innovative contribution to policy, practice and/or research

Although trauma assessments have been a positive "game changer" within health services, due to their connection to feminist understandings of the effects of violence against women, there is a need to utilise critical thinking in order to avoid the hazards of mother-blaming and the pathologisation of women's experiences. As trauma-informed practices are being increasingly drawn upon across a broad range of healthcare contexts, knowledge about the potential pitfalls that may occur when enacting them is necessary in shaping practices and ensuring that trauma-informed practices remain connected to women's empowerment.

Health justice partnerships: joining the dots in family violence

Dr Tessa Boyd-caine[1]
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Introduction

Health Justice Australia is the national centre for health justice partnerships: collaborations between health and legal services bringing lawyers into health care teams to join the dots between legal and health problems and providing solutions through integrated services. Many of them are providing innovative ways to support people experiencing family violence through the trust and confidence they have in their health settings.

Context and Aim (why this is important)

When people do seek advice for legal problems, they are more likely to ask a non-legal advisor, including health professionals, than a lawyer. Where these legal problems include family violence, many health professionals are ill-equipped to respond appropriately. Health justice partnerships are improving the health system's responses to family violence by integrating lawyers into health care teams to provide legal help at the point of violence being disclosed. This workshop will showcase the approach of health justice partnerships to family violence; and the outcomes they are making possible for people who may only access support for family violence through the health system.

Method

- Survey methodology (2017);
- Interviews with practitioners (2016-2018).

Findings

Of almost 50 health justice partnerships across Australia, one in five are supporting people experiencing family violence. They're spread across:

- capital cities;
- regional centres;
- hospitals;
- community health services;

and work with diverse communities including Aboriginal and Torres Strait Islander people.

Innovative contribution to policy, practice and/or research

From coronial inquiries to Royal Commissions, there is extensive evidence of the gaps created by siloed health and human services through which people experiencing family violence continually fall – but little evidence of how to fill those gaps. Health justice partnerships are an innovative, practitioner-led model of collaboration between health and legal services that is bridging those gaps for people experiencing family violence.

Family violence against migrant and refugee women: Prevention to response

Dr Cathy Vaughan[1], Dr Adele Murdolo[2], Ms Erin Davis[3], Ms Manasi Nikam[4], Dr Karen Block[1], Dr Regina Quiazon[2]

[1]University Of Melbourne, Australia, [2]Multicultural Centre for Women's Health, Australia, [3]Domestic Violence Victoria, Australia, [4]Women's Health in the North, Australia

Australia has one of the most ethnically diverse populations in the world – over a quarter of Australians were born overseas and over 300 different languages are spoken in Australian homes. Despite this, responses to family violence have not always been appropriate for, or inclusive of, migrant and refugee women and their children. Research undertaken with migrant and refugee women who have experienced family violence has demonstrated that they face particular barriers when trying to access the family violence response system. These include, but are not limited to, language barriers, limited awareness of the service system among migrant and refugee women and communities, women's precarious residency rights, social isolation, and negative experiences with service providers including racism and cultural insensitivity. Responses to family violence do not always take in account all the forms of violence that migrant and refugee women may experience, such as immigration-related abuse or multi-perpetrator violence. Migrant and refugee women report 'missed opportunities' for early intervention and referral through health, settlement and other non-violence specific services; and initiatives aiming to prevent family violence in migrant and refugee communities have often been short-term pilot projects, limiting their ability to contribute to sustained social change.

This symposium will bring together migrant and refugee women with lived experience of violence, practitioners, advocates, and researchers to discuss key considerations when working with migrant and refugee women and communities in family violence prevention, early intervention, response and research. Promising practices will be identified, and future priorities outlined. The symposium will be based on a panel discussion format, facilitate questions and discussion from the audience, and include a short audio-visual presentation.

Approaches of Emergency Nurses in Caring for Victims of IPV

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Introduction

Intimate Partner Violence (IPV) is the most common form of violence against women in the 21st century. One in three Australian women will experience IPV in their lifetime; two Australian women die at the hands of an intimate partner every ten days. Statistics indicate that female IPV victims are accessing emergency departments (EDs) for assistance more than any other health facility. Therefore, it is critical that ED nurses have the capacity to care effectively for female victims of IPV.

Aim

To explore nurses' capacity to care for female victims of IPV, through outlining the underlying inhibiting factors that limit nurses' capacity to care, and create a discourse that may contribute to addressing these factors.

Method

A critical qualitative research study was conducted. Through action research grounded in post structural feminism, data was collected from pre and post focus groups with ED nurses studying post graduate qualifications (n=8) in 2016. In between the two focus groups an intervention was applied in the form of an educational poster, and the textual data obtained from these FGs, was analysed using Willig's (1999) method of Foucauldian discourse analysis.

Results

ED nurses' capacity to care for female victims of IPV was found to be based on the values they have formed of IPV as shaped by their nurse training. The formation of boundaries, a term used to describe the unspoken individual and group understandings of limitations in nurses' professional, ideological and moral capabilities, were established to be fundamental in inhibiting nurses' capacity to care (i.e no time to have vulnerable conversations with patients)

Conclusion

The challenging of these perceived boundaries through educational inquiry into nursing values was a recommendation to assist in moving the discipline forward. Consciousness raising education was offered for its potential to further shape and improve ED nurses' capacity to care.

Identifying Forced Marriage in the Context of Family Violence

Ms Laura Vidal[1]
[1]*Good Shepherd Australia New Zealand, Marrickville, Australia*

Forced marriage was criminalised as a practice of slavery in Australia in 2013. The practice being defined and understood as a practice of slavery. The true extent of the issue in Australia is unknown as available data is not comprehensive. Over the last 5 years, the Australian Federal Police have investigated over 170 cases of alleged forced marriage—this number is believed to be only the tip of the iceberg.

Child, early and forced marriage impacts a wide cross section of our community, and it is important to note that the practice is not isolated to any one community, culture or religion. Whilst the practice impacts on boys and men, girls and women, it is universally understood that the practice disproportionately impacts women and girls. The practice causes long-lasting, life altering and detrimental impacts— (often related to long-term health outcomes) on the lives of women and girls affecting their opportunities to live free and independent lives.

Whilst defining child, early and forced marriage as slavery is not an incorrect definition, arguably, it is incomplete. Defining the issue explicitly as slavery falls short of recognizing the complexities and intersections that form the motivations of the practice, how people experience the practice and how we respond.

Practice shows us that the issue is multi-faceted and requires a nuanced and intersectional approach—better placed under the definition of family violence with family violence practitioners particularly within the health services profession best placed to identify and respond.

This workshop aims to:

1. Build skills of participants to identify and respond to forced marriage

2. Consider how existing family violence screening tools and interventions can be adapted to include forced marriage

3. Understand the current framework of response identifying participants themselves as as critical partners in early intervention and prevention.

Reproductive health decision-making - potential violent consequences for Timorese women.

Ms Heather Julie Wallace[1], Professor Susan McDonald[1], Associate Professor Suzanne Belton[2], Mr Livio da Concencao Matos[4], Ms Agueda Isolina Miranda[3], Mr Eurico da Costa[3], Ms Helen Henderson[3], Professor Angela Taft[1]

[1]La Trobe University, Australia, [2]Menzies School of Health Research, Darwin, Australia, [3]Marie Stopes Timor-Leste, Dili, Timor-Leste, [4]National University Timor-Leste, Dili, Timor-Leste

Introduction:

Women who are more empowered have greater opportunity to make sexual and reproductive health (SRH) decisions. However, the reality for many are multiple barriers to such autonomy.

Context:

Despite national policies supporting SRH, Timorese women face barriers when making these decisions. Timor-Leste's health indicators illustrate numerous challenges facing women, including high maternal mortality, high fertility rates, low contraceptive use and high levels of family violence. Gaining contextual understanding of SRH decision making is imperative for policy makers and service providers to target resources appropriately and improve women's health.

Aims:

This paper examines the complexities around decisions to have sex or use contraception in Timor-Leste, and illustrates potential consequences for women when making such decisions.

Methods:

We used a collaborative ethnographic design with decolonising methodology. Data collection occurred in 2013 and 2015 using focus groups (8 with 51 women, 9 with 80 men), body mapping (67 men and 40 women), and reproductive history interviews (17 women). Data was thematically coded using descriptive and in-vivo coding, and triangulated across sites, methods and the literature.

Findings:

Women experienced violence in multiple SRH situations. If women did not seek their husband's permission to use contraception, they could expect violent consequences. If women did not 'produce' the desired number or sex of children, they faced abandonment or infidelity. Refusing to have sex with their husband resulted in coercion or forced sex. Women linked this decreased autonomy with feelings of sadness, stress, risk of sexually transmitted infections, unintended pregnancies or inability to care for other children.

Traditional practices such as barlake (brideprice), socio-cultural factors such as sensitivities around SRH, and gender norms supporting inequality, all influence SRH decision-making in Timor-Leste.

Innovative contribution to policy/practice:

Contextual understanding provides policy makers and practitioners with insight to provide targeted, appropriate SRH services and impact women's health and rights.

Antenatal screening for domestic violence: women's health and support needs

Ms Jeannette Walsh[1], Dr Jo Spangaro[1]
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Introduction

Routine screening for domestic violence has been state-wide policy in New South Wales public obstetric hospitals for the past 14 years. It is an early identification and intervention strategy to identify domestic violence and intervene early to improve health and wellbeing of women and babies.

Context and aim

In NSW, screening rates in antenatal settings are high (approximately 90%) but identification rates low (3.4%) compared to prevalence studies identifying that 4% to 8% of pregnant women experience domestic violence.

Screening for domestic violence occurs alongside screening for other psychosocial factors known to impact significantly on ability to parent, and subsequent child development.
The aim of the research was to identify differences in psychosocial risk factors for women experiencing domestic violence compared to those not experiencing domestic violence.

Method

Retrospective examination of obstetric clinical records at two metropolitan NSW obstetric hospitals, using a structured file audit tool.
Women who answered positively to domestic violence screening questions were determined from the ObstetriX database resulting in identification of 100 women with positive responses to domestic violence screening questions. These women's clinical records were reviewed and compared to records of 100 women where domestic violence was not identified during obstetric care, matched by child's birth date and postcode.

Findings

There were significant differences between the two groups: 90% of women who disclosed domestic violence also experienced other psychosocial factors, compared to 20% of the group not disclosing domestic violence. There were highly significant differences between the cohorts in history of mental health problems, and anxiety and depression and significant differences in drug health concerns.

Innovative contribution to policy, practice and/or research

Women who disclose domestic violence have co-existing health and psychosocial factors requiring a high level of health and support needs compared to women who have not disclosed domestic violence.

Reproductive coercion: Understandings and perceptions of health professionals

Miss Molly Wellington[1], Dr Laura Tarzia[1], Dr Jennifer Marino[2], Professor Kelsey Hegarty[1]
[1]The University Of Melbourne, Australia, [2]The Royal Women's Hospital, Parkville, Australia

Introduction

Reproductive coercion (RC) is defined as specific behaviour (including threats and acts of violence) that interferes with the autonomous decision-making of a woman, regarding reproductive health. It is associated with many harmful outcomes, including unwanted pregnancies and STIs. Two main types of behaviours constitute RC; contraceptive sabotage and pregnancy coercion.

Context and Aim

Women who have experienced RC are more likely to seek reproductive health services than women who have not. Health professionals (HPs) are therefore well-placed to identify and support women experiencing RC. Despite this, little is known about how HPs understand and respond to RC in female patients. This presentation reports findings from research aiming to explore what HPs understand about RC, how they identify women experiencing RC, where they see their role in responding and what barriers/facilitators they experience.

Method

Our research utilised a qualitative approach to illicit the views of a range of HPs working broadly across women's health. Semi-structured interviews were conducted with HPs working in 1) a specialist women's hospital; 2) rural and metropolitan clinics who provide surgical or medical terminations. Thematic analysis was conducted to explore understandings, barriers and facilitators across the sample.

Findings

Findings suggest a number of challenges for HPs in responding to RC, including a lack of awareness in the community; an absence of shared language between and across professions; and inconsistency around how RC ought to be responded to and the parameters of the HP's role. Despite this HPs agreed that collaboration between different departments/professions was critical and enhanced the response.

Innovative contribution to policy, practice and/or research

This research will shape the future directions of guidelines for best practice in responding to RC in the Australian health system. This is the first study to our knowledge addressing the views of Australian HPs on this hidden issue.

Quantifying Health Social Work Assessment of Risk in Family Violence

Ms Louisa Whitwam[1], Ms Joanne Sharp[1], Dr Meghan O'Brien[1]
[1]*Peninsula Health, Frankston, Australia*

Introduction:

Family violence has become an emerging issue for health social workers who play a critical role as first line responders to disclosures of family violence.
This study has been undertaken to determine what constitutes the levels of risk within an ecological framework for all forms of family violence across the lifespan.

Context and aim (why this is important):

The aim of this study is to develop and apply a risk matrix in occasions where family violence has been identified within a health context.
In early 2017, Peninsula Health's Social Work Department undertook a survey exploring social workers' response to family violence. Results highlighted that 35% of social workers did not feel confident working with children at risk. Peninsula Health is currently funded to implement the SHRFV Project and employs two family violence social work clinical liaison positions. Data collected (n=97) demonstrates that 32% of contacts have involved a child at risk. Findings confirm a gap in practice for social workers who balance risk within episodes of family violence. The challenges and barriers have informed this study.

Method:

A sequential, mixed-methods design.
First phase – Qualitative analysis of survey data using the Ritchie & Spencer 2004 Thematic Framework
Second phase –Anonymous Delphi-method survey to obtain consensus relating to risk indicators and thresholds.

Findings:

The introduction of a self-reporting risk matrix (n=34) confirms the high levels of risk undertaken by hospital social workers when dealing with family violence. Indicators are consistent with factors including: patient safety, workplace violence, legal and ethical issues. This study confirms the importance in addressing organisational risk beyond the victim/survivor.

Innovative contribution to policy, practice and/or research:

The development of a risk matrix has provided a unique opportunity to quantify the challenges in dealing with family violence and to provide leadership and direction for sustaining our workforce.

Women's voices shaping healthcare responses in low-resource settings

Mrs Guilhermina de Araujo[1], Dr Kayli Wild[1], Dr Lidia Gomes[2], Mrs Angelina Fernandes[3], Professor Angela Taft[1]
[1]La Trobe University, Australia, [2]Universidade Nacional Timor Lorosa'e, Dili, Timor-Leste, [3]Institutu Superior Cristal, Dili, Timor-Leste

Introduction:

The development of locally-relevant health system responses to violence against women remains a key challenge in many low and middle income countries, and particularly in rural and remote areas. Context: In Timor-Leste, the involvement of primary health providers is important as nearly half (47%) of women had experienced physical and/or sexual violence in the previous 12 months and more than 70% of the population live in rural areas with little access to support services (The Asia Foundation 2016).

Aim:

This research draws on the lived experience of women in domestic violence situations to help inform a health system response to violence against women and children in Timor-Leste. Methods: In 2017, in-depth narrative interviews were conducted with 28 women across three districts of Timor-Leste.

Findings:

The findings explore women's perceptions about the role of health services and reveal the significance of local healers in women's health seeking and support. Their stories also reveal sources of safety and risk for women in Timor, and the significant challenges they overcome in the face of multiple vulnerabilities.

Contribution:

In foregrounding women's voices, this research has implications for the development of appropriate health system responses in low resource settings. It raises further questions as to whether and how we can engage with informal health providers to improve the overall response to violence against women and children.

Insights from adapting and piloting WHO's pre-service curriculum in Timor-Leste

Dr Kayli Wild[1], Mrs Guilhermina de Araujo[1], Dr Lidia Gomes[2], Mrs Angelina Fernandes[3], Professor Angela Taft[1]
[1]La Trobe University, Melbourne, Australia, [2]Universidade Nacional Timor Lorosa'e, Dili, Timor-Leste, [3]Institutu Superior Cristal, Dili, Timor-Leste

Introduction:
Embedding pre-service training on violence against women (VAW) within health curricula is a key strategy in sustainable health system responses. Low-cost approaches to training are increasingly important as more low- and middle-income countries seek to address VAW within their health systems.

Aim:
We report on learning outcomes as well as the collaborative process and critical factors in adapting the World Health Organisation's (WHO) pre-service curriculum on VAW within two Universities in Timor-Leste.

Methods:
Participatory adaptation of the pre-service curriculum by three Timorese midwifery leaders in collaboration with researchers in Australia, pre- and post-survey of learning outcomes, structured observation of classes, participant feedback and qualitative interviews with students and lecturers. Findings: The pre-requisites for successfully embedding the curriculum were existing collaborative and cross-institutional relationships, shared values and trust between people with different areas of expertise, advocates embedded in leadership positions within their institutions, and flexible budgets. Findings from the course evaluation and learning outcomes will also be presented to highlight successful approaches to teaching nursing and midwifery students in low-resource settings.

Implications:
This project provides a detailed case study of successful curriculum development and adaptation in Timor-Leste. In evaluating successful approaches, it provides insights for how to support ownership and action on VAW within teaching institutions in other low-income countries.

Association for Women's Sanctuary and Development (AWSAD) Organisational Presentation

Mrs Maria Yusuf[1]
[1]*Association For Women's Sanctuary And Development (awsad), Addis Ababa, Ethiopia*

Introduction

Association for Women's Sanctuary & Development (AWSAD) 's overall goal: - to contribute to women and girls social and economic advancement and development in Ethiopia.

Aim

To present our work on Gender Based Violence Against women and girls (VAWG) in Ethiopia and share Experience.

Content

Our Vision
Safe environment for all.

Our Mission
To create a supportive environment for women and girls by providing psycho-social support and creating social economic independence.

What we do
Rehabilitation & reintegration services to women and girl survivors violence.
Capacity-building programs aimed at preventing violence against women and girls.

Our Programs

1. Safe House

The safe house service focuses on providing holistic services for women/girls survivors of violence such as:

- Provision of safe home, food, medication, counselling, basic literacy education, Legal follow up & empowerment programs.
- Provision of formal educational support for girls in the safe house (primary-university & college education).
- Re-integration of survivors to the society.

2. Capacity Building

Focuses on enhancing the capacity of community and governmental institutions:

- to provide quality services
- create supportive environment for women and girls.
- Building the capacity of media personnel in reporting GBV cases.

3. Economic Empowerment

Skill development programs and Business Development Trainings:

- for survivors of violence in the safe house with low or no income & economically disadvantaged women to enable them generate their own income and be economically empowered.

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