



Screening for Domestic and Family Abuse in Australian Public Hospital Emergency Departments:
Extent, Models and Impacts

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Declaration

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Signed Christine Craik

Date 23rd June 2022

Dedication

This research is dedicated to the 25 women who generously shared their stories and experiences with me in the hope that we might make a difference for all survivors. I will be forever grateful, and your courage, knowledge and hope for the future will always inspire me.

I also dedicate this research to my children Paul, Lisa, Kylie, Jessica and Chloe and to their children. You were the reason I got up every morning and the reason I want to make this world a safer, kinder and more 'just' place.

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List of Abbreviations

AAS	Abuse Assessment Screen
AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
ACEP	American College of Emergency Physicians
ACEM	Australasian College of Emergency Medicine
ACT	Australian Capital Territory
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
ANROWS	Australian National Research Organisation for Women's Safety
ASA	Abuse Assessment Screen
ASWEAS	Australian Social Work Education and Accreditation Standards
CALD	Culturally and linguistically diverse
CDC	Center for Disease Control
CRAF	Common Risk Assessment Framework
CTS	Conflict Tactics Scale
DFA	Domestic and Family Abuse
DVIT	Domestic Violence Identification Tool
EPDS	Edinburgh post-natal Depression Scale
FSV	Family Safety Victoria
HITS	Hurts, Insults, Threatens and Screams
MARAM	Multi-Agency Risk Assessment Management
NCAS	National Community Attitudes Survey
NHMRC	National Health and Medical Research Council
NHS	National Health Service
NICE	National Institute of Health and Care Excellence
NRAP	National Risk Assessment Principles
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand
OAS	Ongoing Abuse Screen
OVAT	Ongoing Violence Assessment Tool
PSSS	Patient Satisfaction and Safety Survey
PVS	Partner Violence Screen
SA	South Australia
SHRFV	Strengthening Hospital Responses to Family Violence
UN	United Nations
UK	United Kingdom
US	United States
VEGA	Violence, Evidence, Guidance and Action
VIP	Violence Intervention Program
VRCFV	Victorian Royal Commission for Family Violence
WA	Western Australia
WBL	Women, Business and the Law
WHO	World Health Organization

Abstract

In Australia at least one woman is killed every week as a result of abusive and controlling behaviours by a current or former partner (Bricknell 2020). Accurate statistics on prevalence and mortality are difficult to obtain as all states and territories have their own legislation with different definitions and diverse record keeping procedures (AIHW 2018). Despite these challenges, data compiled and compared from 20 major sources demonstrates that domestic and family abuse is the third greatest health risk for women in Australia between 25 and 44 years of age (AIHW 2021), and the consequences of this result in many presentations to health settings for assistance. It is estimated that up to ten women a day are hospitalised as a result of an assault by a current or former partner (AIHW 2021). Research indicates that women living with or recovering from domestic and family abuse will present to emergency departments three times more often than other women and are more likely to present frequently (Power, Bahnisch and McCarthy 2011). However, these statistics are likely to be an underestimate because there is under-identification of domestic abuse related health issues in presentations to hospitals in Australia (State of Victoria 2016c).

This thesis examines contemporary screening programs within Australia and internationally and explores the nature of and extent to which emergency departments of public hospitals within Australia screen, identify and respond to women who present with health issues resulting from domestic and family abuse. The experiences of women victim/survivors upon presentation to emergency departments, are central to this exploration. This thesis draws on qualitative and quantitative methodologies in order to gain information from various sources in this area. This research included an online survey completed by 35 emergency department social workers in order to gain insight into their understanding and practice knowledge around domestic and family abuse and screening programs to address this issue. This research also included the facilitation of four focus groups comprising in total 25 women victim/survivors of domestic and family abuse, alongside interviews with ten emergency department social workers and five family violence agency managers from organisations across Australia. These qualitative methods provided in-depth information from well-informed participants.

In Australia and internationally, there are many debates within hospitals and health settings arguing the usefulness and integrity of universal screening programs to identify and

manage women presenting with health impacts resulting from domestic and family abuse. This research acknowledges those debates, examines good practice in screening programs, and argues for the implementation of universal screening in the Australian context.

A review of screening programs in emergency departments found a preference in Australia for selective screening models where women are screened in health areas known for elevated risk of domestic and family abuse, or upon the presence of clinical indicators. The social work participants in this research nominated several clinical indicators that would lead them and/or their colleagues to ask screening questions of women presenting to the emergency department.

The experiences of the women victim/survivor participants validated information from the literature review which found that domestic and family abuse impacts on the health of victim/survivors, who present to a variety of health sites for assistance (including emergency departments) but are unlikely to disclose during these presentations. The women in this research presented with many of the clinical indicators nominated by the emergency department social workers, yet did not have their abuse identified, even in situations where there was a selective screening program in place. Further to this, the responses and treatment received by the women focussed on the individual mental health of the women, rather than understanding presentations in the context of responding to gendered violence. These actions worked to strengthen the accounts often provided by perpetrators and led to increased risk for the women and their children.

This research is based on a feminist critical social work approach, and as such was committed to a gendered structural analysis of current practice and participant responses. Therefore, barriers to disclosure on behalf of the women victim/survivors were viewed through the lens of perpetrator tactics to ensure that the focus was on the perpetrators' abuse and violence. Similarly, the reluctance or inability of health professionals to enquire or identify domestic and family abuse, and evidence of collusion with the perpetrator, was also seen through the lens of perpetrator tactics, alongside the influence of macro structures such as gender-blind medical practices and internalisation of gendered community beliefs within health professionals.

This research concludes by arguing the case for implementation of universal screening in emergency departments and proposes a framework for good practice.

Chapter 1. Introduction

In October 2012, the *Herald Sun* newspaper covered a story describing the tragic death of a young woman murdered by her husband (White and Flower 2012). This woman had presented to numerous hospitals for physical injuries in the months prior to her death. This story brought to my mind another young woman who I worked with during my 12 years as a crisis response social worker in the intensive care unit of a major trauma hospital in Victoria. The woman I met was later found burnt to death in her house, alongside her husband. Her husband had killed her, set fire to the house, and then killed himself. The newspaper reports at the time mentioned that the woman had been injured in a car accident some time before this house fire. I recognised her name.

I had met this young woman because of that earlier car accident. My work as a weekend crisis social worker in that hospital involved supporting trauma patients and their families. It was rare to talk to the patients themselves in this role as they were usually unconscious, however, this young woman was conscious and distressed. She disclosed to me that her husband had told her he was going to kill her seconds before he drove her side of the car into a tree. I was only able to spend a few hours with her prior to her release from hospital and during that time she talked of the long history of his controlling and abusive behaviours, along with her fear of him. There was no doubt in my mind that she was a victim of domestic and family abuse (hereafter referred to as DFA). When I spoke to her, she had been in the hospital for ten days and had not been asked any questions about her life at home or her relationship. The only reason I was asked to see her was because she had become emotional during a conversation around her discharge from the hospital. I was asked to step in and discuss her support needs during her rehabilitation, including home help, and transport to and from her outpatient and physiotherapy appointments. She spoke to me about the lack of support she had at home from her husband, and that she was not free to talk about this lack of support amongst family and friends. She discussed her sense of isolation even though she had several family members living nearby. We talked about the gravity of her situation, the fact that the episodes of his abusive and controlling behaviours were becoming more dangerous, and that she knew she was not safe. We talked through a risk assessment and a safety plan. I supplied information on culturally specific family violence support and legal options that she could follow up upon her discharge from the hospital.

I am a qualified social worker with 30 years' experience in the DFA and health fields, across community and acute hospital settings. Most of this work has been working with women and children dealing with family violence and/or sexual abuse. This has been in a variety of practice domains, including counselling, family work, group work, education, and policy work. I understand many of the indicators and red flags that should lead a social worker or health professional to ask questions around the potential use of power and control in a relationship, as all DFA is about power (Hill 2019). I was able to identify other risk factors in the situation for this woman (apart from the fact that she was a woman), including her age, the expectations placed upon her through her culture, her experiences of social isolation, and the nature of her presentation and her injuries.

When I read about the death of this young woman in the newspaper, I thought of all the other women in the intensive care unit of that trauma hospital who I had worked with over the years. The nature of their injuries or other circumstances connected to their presentations had led me to ask them, or if it were not possible to talk to them, to ask their mothers, sisters, aunties, children and friends about their lives. Due to my experience in working with DFA, I was not surprised to hear about the violence, abuse, and control these women were living with prior to their admission to the intensive care unit. What continuously surprised me was the lack of information or any indication of the abuse and control they were living with, in their case notes and files. The words 'domestic violence', 'family violence' or 'intimate partner abuse', either stated or suspected, were absent in previous entries from the first responder handover notes (those of the police or ambulance), the hospital emergency department triage notes and consequently, not written up in the intensive care unit notes. The possibility of DFA was usually not mentioned, even when there was evidence of assault, anxiety, depression, self-harm or other emotional and mental health indications of DFA (Parker 2019). What was clear to me from reading these patient histories, is that many of these women had presented to the emergency department on more than one occasion, and often as the result of the abuse they were living with. I am also mindful that the case-note histories of these women only provided information on the presentations to the emergency department of the hospital where I worked. I did not know where else they may have gone to seek health assistance in other times of need. Hospitals within Victoria do not have a shared data base for emergency department presentations. After asking questions, I became aware that the emergency department at the hospital where I worked, a major Victorian trauma

hospital, did not screen for the possible presence of DFA in the emergency department, let alone routinely ask every woman a simple question about the presence or absence of safety and respect within their relationships. After talking to several colleagues who worked in major hospitals within Victoria and in New South Wales, I established that these hospital emergency departments also lacked DFA screening procedures for women presenting for assistance.

These professional experiences, alongside my own experiences of living with and dealing with DFA, and the responses I received upon presenting to an emergency department, were motivating factors to do this research. At the time I presented for assistance, I was forthcoming about the origin of my injuries, however, the DFA was not addressed. The responses from the health professionals focused only on my emotional state.

As a social worker, I am obligated to work towards upholding human rights and pursuing social justice (AASW 2020a). Social workers work within three core ethical principles, these being respect for persons, social justice and professional integrity (AASW 2020a). Therefore, there is an obligation in this work to focus on the rights of the person and/or their community, in a respectful and empowering way, alongside working towards social justice and addressing systemic barriers that may prevent or inhibit them from reaching their full potential. I saw this research as a means of further fulfilling my obligations as a social worker, including working for change at a systemic level that could lead to changes for vulnerable women.

The impact of DFA in terms of women killed and the known rates of occurrence, has yet to decrease in the 30 years that I have been a social worker and working in this field of practice, despite there having been several federal and state-based enquiries into family violence over the past ten years, including a royal commission. These enquiries have produced numerous recommendations, including pursuing a national legislative framework through which standardised methods of identification and data collection can be facilitated (State of Victoria 2016a). From the available statistics, we know that at least one woman every week is murdered by a current or former partner, and from the age of 15, one in three women will have experienced physical violence and one in four will have experienced emotional abuse (Our Watch 2020). Certain populations of women are more at risk than others in terms of incidence and lethality, including women from Aboriginal and Torres Strait Islander backgrounds, pregnant women, women with disabilities, older women, women from culturally and linguistically diverse backgrounds, women who live rurally or remotely, women who work in the sex industry and women who identify as lesbian, bisexual, transgender,

intersex or queer (Sutton 2013; McGlade 2016; State of Victoria 2016a; AIHW 2021;). In 92 percent of cases, this DFA is perpetrated by an intimate partner, an ex-partner, or a man known to the woman (Parker 2019).

In summary, my research began with the aim to learn more about the ways in which Australian public hospitals screen women for the potential presence of DFA. I wanted to know who was screening, how and why, and the ways in which Australian screening programs compared to international approaches. During this research, I came to understand the perceptions, knowledge, practices and responses of emergency department health professionals, the ways in which these differed from the experiences of women victim/survivors, and the consequences for these women.

Australian research demonstrates that women living with DFA are three times more likely to present to emergency departments than women living in respectful and non-abusive relationships (Power et al. 2011), while in the United States (US), women living with abuse are four times more likely to present at an emergency department than women not living in an abusive relationship (Kothari, C., Rohs, Davidson, Kothari, R., Klein, Loestner and Kutzko 2015). These figures confirm that emergency departments are an important site of intervention to identify and respond to domestic and family abuse. Through the information from the women focus group participants (from here on referred to as women victim/survivors), and managers of the family violence agencies, it is clear these presentations are an opportunity for DFA to be identified, validated, and supports discussed, and offered.

The World Health Organization (WHO) has produced various guidelines for health professionals who work with women subject to abuse and violence (WHO 2001, 2013a, 2005). WHO argues that health professionals have a role to play in identifying violence against women, however, it does not endorse universal screening for DFA, arguing that such an approach creates potential risk (for both the worker and the woman) due to cultural attitudes or local lore about gendered equality in certain communities, or the availability of referral options. This culturally and contextually specific recommendation from WHO has been consistently used to argue against implementation of universal screening for DFA in emergency departments of Australian public hospitals (Hegarty 2015; NSW Ministry of Health 2019). In the following chapter, I examine the reasons, specific contexts, and situations by which WHO makes those recommendations, which are located in the context of developing nations and argue that these specific situations are not applicable in the Australian context.

These arguments contribute important information to the debates around the implementation of universal screening in emergency departments in Australia.

Outline of the thesis

In this chapter I have outlined the motivation and need for this research. In the next chapter I discuss the importance of terminology and my reasons for using the term domestic and family abuse (DFA) throughout this research. I discuss definitions of DFA and the importance of power, control and gender in a definition. I examine the prevalence of DFA internationally and within Australia, explore the impact of DFA on women's health, and argue for screening in public hospitals within Australia. The discussion on screening is developed further in Chapter 3 through the literature review, where I examine different models of screening and screening tools, specifically those used within hospital and health settings. I make the case for universal screening, challenging arguments against the implementation of such a program within the Australian context. This chapter concludes with a discussion on the aims of this research and the research questions.

Chapter 4 introduces and discusses my theoretical and conceptual framework. My position as a feminist critical social worker and my professional and personal experiences with DFA underpin not only the theoretical framework of this research, but also the methods that I chose to ensure that the experiences and voices of the women were central and respectfully represented. Chapter 5 expands on the methodology and methods with a discussion on the ways in which the use of qualitative methods reflects my commitment to principles of feminist research by ensuring that the women participants were satisfied their contribution was evident in this research. My research involved an online survey completed by 35 emergency department social workers, interviews with ten of those social workers upon completion of the online survey, interviews with five managers of family violence agencies, as well as the facilitation of four focus groups of DFA victim/survivors involving 25 participants. Ethical issues and the limitations and tensions between a feminist critical position and public health responses to DFA are also discussed in Chapter 5.

The following four chapters (6, 7, 8 and 9), present the findings. Chapter 6 explores the types of abuse experienced by the women, the impacts on their health and the ways in which they made connections between their health issues and their experiences of DFA. The

women's experiences with health professionals highlight the significant role that health professionals in public hospital emergency departments could play in assisting women who experience DFA.

In Chapter 7, I present information from the online surveys and in-depth interviews with emergency department social workers and managers from family violence agencies. I examine the ways in which the social workers from non-screening environments identify and work with DFA and their understanding of the place of screening programs. This data is compared against information from the social workers with experience of screening environments and then juxtaposed with that from the women victim/survivors.

Chapter 8 explores barriers to disclosure on behalf of the women victim/survivors and barriers to enquiry on behalf of the health professionals. The barriers are analysed through the lens of perpetrator tactics to ensure that the responsibility is placed on the perpetrator and that the discussion does not pathologise or hold responsible, the women victim/survivors. This chapter also examines the consequences of negative social responses to health help-seeking behaviours for women victim/survivors.

In Chapter 9, I examine good practice components of DFA screening programs by integrating literature, the experiences of the women victim/survivors, and information from emergency department social workers and the managers of family violence agencies. This information is critical because it brings together lived experience and professional practice experience, leading to an understanding that good practice requires more than policy and procedural change.

The final chapter, Chapter 10, brings my findings together and argues for a nationally coordinated universal screening program in emergency departments across Australia. This chapter suggests changes that will lead to improvements in the safety of, and responses to, women victim/survivors who present to emergency departments.

Research impact

While undertaking this research, I have had the opportunity to share my findings at several conferences and professional development sessions. Conferences have included the Stop Domestic Violence conferences in 2014, 2016 and 2018; the Nursing Network on Violence against Women conference in 2017; The Australian Association of Social Workers (AASW) National Symposium in 2016; two presentations at the Australian and New Zealand Social

Work, Welfare and Education Research (ANZSWWER) conferences (2015 and 2017); and presentations to several social work practice groups around the country. I shared my findings through a submission to the Victorian Royal Commission for Family Violence (VRCFV) and had the opportunity to speak alongside the Commissioner and Chair of the Royal Commission, the Honourable Marcia Neave AO on ABC 774 radio, following the launch of the recommendations of this Royal Commission. I have been fortunate to be asked to speak at the Victorian Royal Women's Hospital, Strengthening Hospital Responses to Family Violence (SHRFV) presentations days, in 2016 and 2018, and have spoken at several hospital social worker and allied health staff professional development sessions in Victoria, New South Wales, Tasmania, the Australian Capital territory and Western Australia. I have also been able to present my research to various Victorian health agencies as part of their implementation of SHRFV initiatives, including Barwon Health, Winchelsea Community Health and Colac Community Health.

As a result of these activities, I was asked to consult on the establishment of several screening programs in emergency departments of public hospitals, including the Royal Hobart Hospital, the Royal Darwin Hospital, and the Alice Springs Hospital. I have also used the research findings to contribute to the AASW steering committee tasked with establishing a family violence credential and contributed to the content for the compulsory family violence subject for social work degrees within Australia, as set out in the 2020 Australian Social Work Education and Accreditation Standards (ASWEAS).

I have presented to the Federal Government Inquiry into Domestic and Family Violence, which informed the Australian Government's National Plan to Reduce Violence against Women and their Children. In my discussions, I have advocated for a nationally coordinated universal screening program for women who present to emergency departments of public hospitals around Australia.

Chapter 2. Background

In this chapter, I discuss terminology, definitions, and prevalence of DFA, before exploring the known impacts of abuse on the health of victim/survivors. I highlight the importance of language, before examining debates around definitions of DFA and the significance of power, control, and gender in a definition. The chapter concludes with a discussion on screening for DFA in emergency departments of public hospitals.

The importance of language and terminology

Depending on where you live in the world or which state or territory within Australia, some of the terms used to name DFA include ‘domestic violence’, ‘family violence’, ‘intimate partner abuse’ or ‘violence in the home’. There has been much written on the importance of language, with many arguments supporting or contesting different terms (Laing 2001; Braaf and Barrett Meyering 2013; Hill 2019).

When I started this research, I began with the term ‘domestic and family violence’. This appeared to be a commonly understood term that was used within most legal definitions in Australian jurisdictions. It was important to me that my terminology described not only the domestic spaces in which abuse occurs, but also the inclusion of the word ‘family’ to respect and acknowledge Aboriginal and Torres Strait Islander communities and their preference in recognition of ‘family’, implying a range of marital, kinship and community relationships (AIWH 2019). For these reasons, I use the terms ‘domestic’ and ‘family’ in this research because it is not executed by a stranger but enacted by someone in an intimate relationship with that person, usually in a position of confidence and trust to the victim/survivor. In the past decade, there has been an increase in attention and focus on the issue of DFA within Australia, at both state and federal government levels (State of Victoria 2016a; COAG 2019), and with this, a more nuanced conversation on the use of terminology. Khan (2019) argues that language needs to be inclusive of the many behaviours involved in the abuse of power, and Pease (2019) states that coercive control, for example, is not captured by the language of ‘violence’. For many victim/survivors and the general community, the term ‘violence’ represents physical abuse, not necessarily the other subtle behaviours that enable one person to enact power and control over another. Therefore, the perception of ‘violence’ as the main element of DFA has implications not only for victim/survivors in understanding that a

perpetrator's behaviour is abusive, but also for the health professionals who they turn to for assistance.

McKie (2005) argues that the focus on physical violence obscures the ways in which power works in DFA, and this is reflected in other jurisdictions such as the United Kingdom (UK), Canada and some parts of the United States (US) identifying the need for terminology that encompasses a wider range of non-violent, yet controlling, behaviours. Hill (2019) picks up on this argument in her work, demonstrating an understanding that physical violence can be absent or negligible in many abusive relationships. Additionally, as many of the women victim/survivors in this research experienced a wide range of abusive behaviours including physical and non-physical violence, I decided to use the term 'abuse' to capture these experiences.

It is also important to consider language about women who are living with or have lived with abuse. Kelly (1988) argues the need for women's experiences of resistance, coping and survival to be recognised linguistically, noting that the term 'victim' makes acts of resistance invisible (Kelly 1988). The women victim/survivors in this research used both the terms victim and survivor to describe themselves, stating that they felt like both a victim and a survivor, during the relationship and after ending it. The term 'victim' was important to validate and acknowledge the way power and control had been used against and over them, whereas the term 'survivor' signified changes in identity, relationship status and recovery. The women felt they had survived, and many acknowledged that they continued to work towards 'surviving'. For these reasons, I refer to women who are living with or who have lived with DFA, as victim/survivors, acknowledging the violence, abuse and trauma they have experienced and survived, their resistance and the fluid nature of these categories of identity.

Definition of DFA

It is important to this research that a definition of DFA validates the experiences of victim/survivors by 'fitting words to deeds' (Coates and Wade 2004:7). The definition used in this research is inclusive of, and reflective of the experiences of the women victim/survivors, which is important when working from a feminist critical perspective. It is also important that the definition articulates the roles of gender, power, control, and intersectionality.

Gender

Australian and international statistics demonstrate that DFA is a gendered issue mostly perpetrated by men against women, usually within the context of an intimate partner relationship (Laing 2001; Braaf and Barrett Meyering 2013; State of Victoria 2016a; Hill 2019; Pease 2019; AIHW 2021). In Victoria, police data confirms that in 75 to 82 percent of reported DFA incidents, the perpetrator is an intimate male partner (Crime Statistics Agency 2019). This is not to say that men cannot be victims of abuse within an intimate relationship, however, it does mean that perpetrators, regardless of the gender of the victim, are more likely to be male. An analysis of violence and abuse in male victim/survivors demonstrates that there are significant gendered differences in their experiences (Bagshaw 2003; Pease 2008; Hester 2013; Hill 2019). Women are more likely than male victims to be injured, to require medical attention or hospitalisation, to report living in fear and to be killed in this context (Hill 2019; Bagshaw and Chung 2000). Violence and abuse against men is less likely to occur within an intimate relationship, and men are unlikely to suffer similar patterns of injuries to women. Men do not have the same experiences of increasing risk and ongoing fear during or after they have left a relationship and abuse towards men is less likely to include a pattern of power and control (Laing 2001; Braaf and Barrett Meyering 2013). Pease (2019) argues that DFA cannot be seen in isolation from the systemic, structural, and institutional forms of gendered inequality which socially and culturally normalise male violence against women. These macro-level social inequalities enable micro-level strategies of abuse and need to be considered when examining the major differences in the experiences of DFA for male and female victim/survivors (Laing 2001; Taft, Hegarty and Flood 2001; Pease 2019).

There have, however, been challenges to feminist claims that DFA is a gendered issue (Arndt 2016), which continue to perpetuate myths around women being as equally violent as men, or women provoking violence. These challenges reflect beliefs central to the influential Conflict Tactics Scale (CTS) to argue that DFA is not a gendered issue. The CTS was developed by Marcus Straus in the US in the 1970s and revised in the 1990s and lists several types of violent behaviour between intimate partners (Straus, Hamby, Boney-McCoy and Sugarman 1996; Bagshaw and Chung 2000). Through the results of surveys based on this scale, Straus argued that (in heterosexual couples) women commit DFA as often as men. Many researchers argue that the use of the CTS as a tool used to determine rates of DFA is problematic, because the CTS measures single events and ignores the context of situational specific complexities.

These include the meaning or intent of the acts measured, differences between offensive and defensive acts, the assumption of equal power between the parties, and the inclusion of certain acts and exclusion of others (Straus et al. 1996; Bagshaw and Chung 2000). The CTS examines incidents over a 12-month period, not patterns of behaviour over several years, and fails to consider the presence of fear or the use of coercive control (Bagshaw and Chung 2000; Wendt 2016; Hill 2019; Pease 2019). Pease (2019) argues that gender cannot be treated as a variable in this context and that the use of a scale such as the CTS decontextualises and depoliticises gender. It is critical to keep in mind that DFA involves patterns of gendered power and control and, as such, differs from a disagreement or conflict within a relationship where 'power over' is not a consistent theme. With this in mind and knowing that DFA is the private expression of inequitable public gendered power differences, acknowledging the centrality of gender in any definition of DFA is important for this research.

Power and control

The abuse of power, and the ways in which this enables continued control by the perpetrator over the victim/survivor, is central to DFA (Pence 1999; Laing 2001; Stark 2009; Hayes and Jeffries 2015; Wagers 2015; Hill 2019). More specifically, coercive control (Stark 2009), speaks to patterns of behaviour designed to control by instilling fear. Coercive control tactics may or may not involve physical abuse but will include behaviours designed to isolate, degrade, 'gaslight', or exploit victims (Stark 2009). The term 'gaslighting' refers to strategic behaviour aimed at manipulating the mind of the victim/survivor and originates from George Cukor's 1944 film *Gaslight* (Sweet 2019) which portrayed the story of a husband manipulating the levels of gas-lighting within the home, to induce doubt, and eventually insanity, in the mind of his wife. Sweet (2019) goes on to argue that gaslighting is effective when,

...it is rooted in social inequalities, especially gender and sexuality, and executed in power-laden intimate relationships. When perpetrators mobilize gender-based stereotypes, structural inequalities, and institutional vulnerabilities against victims with whom they are in an intimate relationship, gaslighting becomes not only effective, but devastating.

(Sweet 2019:852)

Pease (2019) argues that DFA is the private expression of the public power and privilege granted to men through patriarchy. Therefore gaslighting, as a tactic, is enabled through social norms that uphold gendered inequality. In Australia, gaslighting is recognised as a tool for gaining and maintaining coercive control and as a form of emotional and psychological abuse (DVRCV 2012). Several jurisdictions within Australia recognise the use of coercive control in definitions of DFA including the *Family Violence Protection Act 2008* (Vic); the *Domestic and Family Violence Protection Act 2012* (Qld); the *Family Violence Legislation Reform Bill 2009* (WA); the *Family Violence Act 2016* (ACT) and the *Crimes (Domestic and Personal Violence) Act 2007* (NSW). The *Australian Commonwealth Family Law Amendment (Shared Parental Responsibility) Act 2006* (Section 4 AB) describes DFA as, 'Violent, threatening, or other behaviour by a person that coerces or controls a member of the person's family (the family member) or causes the family member to be fearful'.

Several international jurisdictions have recently recognised the significant role of coercive control in DFA and have moved to criminalise it (Maury 2019; Walklate and Fitz-Gibbon 2019). This move signals a change not only to the ways in which the criminal justice system perceives and responds to DFA, but also assists in broadening understanding of this issue from a focus on physical abuse, to recognising the centrality of power and control. This shift in understanding is important for victim/survivors and for professionals who work with them. At the time of writing (June 2022), Tasmania is the only Australian state to have coercive control listed as an offence in legislation. Other jurisdictions within Australia are considering the issue (Maury 2019; King 2020). Hill (2019) argues that the introduction of any legislation criminalising coercive control would necessitate wide-scale training for professionals, because it would require a shift from conceptualising abuse as a series of

‘incidents’, towards understanding it as a process involving systems of entrapment. Hill (2019) explains that this requires thinking about the actual behaviours and the intent behind those behaviours. The presence of power and control are important factors to include in defining DFA in this research.

Intersectionality

Intersectionality has been described as a metaphor to assist in understanding the ways in which multiple oppressions interact and how these interactions are experienced by those who live with these oppressions (Crenshaw 1991). Any definition of DFA needs to acknowledge and consider intersecting oppressions, through understanding and validating the realities, social locations, and experiences of victim/survivors. For example, inclusion of the word ‘family’ within a definition of DFA and expanding this term to include kinship and community relationships considered ‘family’ within Aboriginal and Torres Strait Islander communities, demonstrates an intersectional cultural approach to defining DFA. Terminology within a definition also needs to ensure that the abuse of power within a relationship does not exclude experiences specific to diverse populations. The concept of intersectionality and the relationship of this to critical feminist research is explored further in Chapter 3.

So far in this chapter, I have discussed the importance of language, naming, and labelling DFA, and elements essential for inclusion in a definition. I have argued that DFA is a gendered issue, connected to the unequal distribution of systemic and individual power. I have also argued that coercive control is a critical element to be included in a definition alongside inclusivity. For these reasons, I am using the definition from the *Family Violence Protection Act 2008* (Vic) as it addresses the gendered nature of this issue, the role of coercive control in DFA, and acknowledges intersectional complexities and meanings inherent in diverse population groups. Section 5 of this Act states:

Family violence is behaviour by a person towards a family member of that person if that behaviour is physically or sexually abusive; or is emotionally or psychologically abusive; or is economically abusive; or is threatening; or is coercive; or in any other way controls or dominates the family member and causes that family member to fear for the safety or wellbeing of that family member or another person; or behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of that behaviour.

Family Violence Protection Act 2008 (Vic)

The Act recognises coercive and threatening behaviours, alongside actions inclusive of economic, emotional, physical, or sexual abuse. The term 'family' under the Act is broad and inclusive of kinship arrangements, same sex relationships and carer relationships. This is central to this research as the women victim/survivors came from a variety of intersecting social locations and experienced a wide range of DFA behaviours, and as such this definition validates and reflects their experiences.

Prevalence

DFA is recognised internationally and within Australia as a significant issue. The United Nations (UN) argues that over 600 million women live in countries where DFA is not regarded as a crime (UNiTE 2011). For countries without legislation recognising DFA, it is difficult to obtain accurate statistical data on the prevalence and prosecution of DFA (World Bank Group 2018). Data from the World Bank Group demonstrates that of the 189 countries included in their review of DFA legislation, 144 have specific legislation relating to DFA. Nine countries have legislation for some forms of violence against partners, while 36 countries have no laws or regulations for DFA (World Bank Group 2018).

The World Health Organization (WHO 2017) estimates that globally, approximately one third of all women have experienced physical and/or sexual violence at the hands of an intimate partner. These estimates are for rates of physical and sexual violence, and do not

include acts of coercive control, or other forms of intimate partner abuse. In Australia, approximately 34 percent of Australian women over the age of 15 years' experience physical or sexual violence at the hands of men and 23 percent of Australian women over 15 are victims of physical or sexual violence perpetrated by a current or former partner (Australian Bureau of Statistics (ABS) 2017). The reported rates of physical and sexual violence against women by their intimate partners have remained steady in Australia since 2005 (ABS 2013).

As noted in the introduction, there are challenges in collecting data that accurately represents the prevalence and consequences of DFA in Australia. Research demonstrates that most women living with DFA do not engage with authorities nor seek assistance from non-government agencies (State of Victoria 2016a; AIC 2019). This has implications for the data collected and reported by the Australian Institute of Health and Welfare (AIHW). Under-reporting remains a challenge, alongside further complications such as hidden reporting, under-recording and inaccurate recording (State of Victoria 2016c; Silvester 2020). Hidden reporting occurs when experiences of abuse are not reported or when an issue arising from an incident of DFA is not attributed to that abuse. Under-recording occurs when agencies or organisations are given information from a victim/survivor or another agency, and that information is not accurately or consistently recorded (State of Victoria 2016c).

Accurate recording of the prevalence of DFA relies on a professional having the ability to correctly identify, record and report abuse. Consistent recording works best with a shared definition and standardised recording and reporting systems (State of Victoria 2016c). Collecting consistent and reliable data within the Australian context is further complicated by the fact that differences exist between state and territory jurisdictions regarding legal definitions of what constitutes DFA, and the ways in which the data is identified and recorded. These challenges demonstrate that the prevalence of this issue in Australia is likely to be far greater than the rates in the reported statistics. Regardless of these challenges, DFA is considered a critical issue in Australia, with profound consequences for victim/survivors, including many impacts on their health (State of Victoria 2016a ; COAG 2019; Hill 2019; Pease 2019).

Impacts on health

The WHO (2005) analysed data from ten countries and found that women who had experienced DFA were,

...significantly more likely to report poor or very poor health than women who had never experienced partner violence. Ever-abused women were also more likely to have had problems with walking and carrying out daily activities, pain, memory loss, dizziness, and vaginal discharge in the four weeks prior to the interview.

(WHO 2005:15)

This study also reported that emotional distress and suicidal behaviour are significantly higher in women who have experienced DFA and that these mental health effects last long after the abuse has ended (WHO 2005). This report argued that DFA has consequences for a range of other women's health issues, including premature death, sexually transmitted diseases, reproductive issues, gastrointestinal issues, sleep disorders, substance misuse and physical injuries alongside mental health impacts already discussed, including depression, anxiety, eating disorders, self-harming behaviours, panic attacks, loss of confidence and low self-esteem (WHO 2005).

In 2013, the WHO facilitated the first systemic review on both the prevalence of violence against women by an intimate partner and the effects on women's physical, sexual, reproductive, and mental health (WHO 2013a). The results were consistent with the 2005 multi-country study and found that women's health was impacted by DFA through physical trauma, psychological trauma, stress, and fear. The use and misuse of barbiturates, benzodiazepines and anti-depressants are also more common in women exposed to DFA (WHO 2013a). These health impacts result in injury, compromised mental health, substance misuse, perinatal and maternal health issues, poor sexual and reproductive health, disability, and death (WHO 2013b).

In 2016, Australia's National Research Organisation for Women's Safety (ANROWS) built on the 2013 WHO research discussed above. Using a systematic review methodology, ANROWS reviewed 43 studies focusing primarily on findings from high income countries similar in socio-economic standing to Australia. This study found that DFA continues to affect the health of women and places women at increased risk of compromised mental health, reproductive health issues and fatality (On, Ayre, Webster and Moon 2016). Other studies

have concluded that women who experience abuse are also at higher risk of self-harm and reproductive and gynaecological problems such as miscarriage, pre-term delivery and babies born with low birth weight (Boyle, Jones and Lloyd 2006; WHO 2021).

Moreover, VicHealth (2004) found that DFA is the leading contributor to ill health and premature death for women aged between 18 to 44 years in Victoria, stating that intimate partner violence,

...has a greater impact on the health of Victorian women under the age of 45 than any other risk factor. The burden contributed by this form of violence is greater than that for many other risk factors, such as obesity, high cholesterol, high blood pressure and illicit drug use

(VicHealth 2005:25)

In addition to the health impacts previously noted, VicHealth (2010) found eating disorders, traumatic and post-traumatic stress symptoms, phobias, dissociative and somatisation disorders, chronic pain disorders, gastrointestinal and digestive disorders, and sleep problems.

The case for screening in public hospitals

I have highlighted that DFA is a gendered form of abuse which reflects broader power structures and relations and I have discussed the prevalence and impacts of DFA on the health of victim/survivors. I now examine the case for screening in public hospitals, and specifically in emergency departments. In advancing the case for DFA screening in emergency departments of public hospitals, I am not suggesting that this should *only* occur in emergency departments or that screening in emergency departments should take precedence over screening in other health settings. Instead, I argue that emergency departments offer a unique opportunity for identifying and responding to victim/survivors of DFA. I begin with a discussion on the role of the health system in working with victim/survivors of DFA, before moving on to explore the role of hospitals and the importance of emergency departments. I

follow this with an argument for screening in hospitals, and specifically, for screening in emergency departments.

Health systems

There is no doubt that the health system plays an important role in responding to women who live with or who have experienced DFA. Research demonstrates that women living with abuse seek assistance from a health professional more frequently than women in the general population (Kothari et al. 2015; Spangaro, Koziol-McLain, Rutherford and Zwi 2020). A systematic review of 37 studies found that between 38 and 59 percent of women presenting to health care providers had experienced abuse from a partner at some stage in their life (Sprague, Goslings, Hogentore, Milliano, Simunovic, Madden and Bhandar 2014). In North America, the key role of health care professionals working with women who are victims of DFA is well documented. For example, in a 2003 Californian review, it was found that 43 per cent of DFA victims sought assistance from a health care professional for impacts on their health (Anglin and Sachs 2003).

The role of hospitals

Hospitals play a key role in responding to women who experience DFA as women present at hospitals for assistance when they are dealing with impacts on their health related to living with DFA (WHO 2013a). In Australia, statistics from the AIHW (2017) reveal that every three hours a woman is hospitalised due to abuse (AIHW 2018). The Australasian College for Emergency Medicine (ACEM) estimates that between 27 and 38 hospitalisations per 100,000 women are due to DFA (ACEM 2020). There are differences in the presentation rates depending on social location, for example, Aboriginal women are 37 times more likely to be hospitalised than non-Aboriginal women, a figure extending to 86 times more likely for Aboriginal women living in the Northern Territory, and up to 95 times more likely for those residing in Central Australia (COAG 2014). These statistics focus only on instances of assault related injuries, and this, alongside the factors previously discussed, represent under-reporting of DFA (State of Victoria 2016c).

Across Australia, different state and territory jurisdictions recognise the important role of hospitals in dealing with victims of DFA and have implemented various programs to

address this (Queensland Government 2016; State of Victoria 2016c; NSW Government 2020). Evidence presented to the Victorian Royal Commission into Family Violence (VRCFV) argued that public hospitals should be resourced to implement a whole of hospital response to DFA (State of Victoria 2016a).

The role of emergency departments

According to the AIHW (2020b), in 2018–2019 there were 693 public hospitals in Australia and, of these, 294 emergency departments providing a 24-hour service. In the same reporting period, there were 8.4 million presentations, involving 22,900 daily presentations (AIHW 2020b). Just over 50 percent (4,145,728) of those presentations were women and girls, and 83 percent (3,429,678) of these were over the age of 16 (AIHW 2020b). With known prevalence rates of DFA at 25 percent for women over the age of 18, this equates to 860,000 potential victim/survivor presentations per day. As previously stated, women living with or recovering from DFA will present to emergency departments three to four times more often than women in the general population and are more likely to present multiple times (Kothari et al. 2015; Power et al. 2011). Based on these figures, it is reasonable to argue that the potential daily number of victim/survivor presentations to emergency departments would be higher than that calculated above as prevalence rates would be higher than in the general population.

Brain Injury Australia (2018) found that in 2017, there were 1240 Victorian hospital emergency department presentations by women for DFA related brain injury assaults, with 588 associated hospital admissions. This report argues that these numbers are an underestimate, as 49 percent of assaults were recorded as caused by an ‘unspecified person’. In a feasibility study carried out by the New South Wales Government, it was estimated that 38 to 40 per cent of women who present to an emergency department will have experienced DFA at some stage in their lifetime and that DFA is severely under-identified in emergency departments (Webster, Pedrose and Lopez 2012, cited in NSW Ministry of Health 2019). Alongside this information, women from diverse population groups are likely to present to emergency departments more often than other women (State of Victoria 2016a; ACEM 2020). The higher prevalence of DFA rates amongst women from Aboriginal and Torres Strait Islander backgrounds has already been discussed, however, older women, women from culturally and

linguistically diverse communities, those in same sex relationships, bisexual, transgender and intersex women, women with disabilities, women from rural, regional, and remote communities, as well as women who work in the sex industry, have higher known prevalence rates for DFA and are less likely to have DFA identified upon presentation to hospital (State of Victoria 2016a; ACEM 2020).

Laing (2003) argues that not only do women living with abuse present for health assistance more often, but their presentations are likely to be for health issues which appear unrelated to, yet are a consequence of, abuse. Similarly, Roberts, Hegarty and Feder (2006) found that 76 percent of women experiencing DFA and presenting to an emergency department, do so for reasons that appear unrelated to abuse, such as acute illness. Other international studies confirm these findings, including Little (2005) who explored presentations to emergency departments in Oklahoma and found that women experiencing DFA presented with stress related issues, including alcohol and drug misuse and homelessness more often than physical injuries related to the DFA. A study in the United Kingdom (UK) estimated that women experience an average of 35 episodes of abuse before seeking assistance, with many of these women having previously presented to an emergency department for reasons that appear unrelated to the abuse (Boyle, Robinson and Atkinson 2004). This information demonstrates that women experiencing DFA present to emergency departments for a variety of health issues related to abuse and the connection is not made between these health issues and the abuse.

Rhodes, Kothari, Ditcher, Cerulli, Wiley and Marcus (2011) found that the majority of victim/survivors who went to an emergency department within a week of a police-reported assault, were not identified as DFA victim/survivors by the health system. This study examined and cross-referenced police data with medical records of women who went to emergency departments (4,306 emergency department presentations) in Pennsylvania over a four-year period. The research found that up to 72 percent of women presenting to an emergency department for health assistance after a physical incident of DFA, were not identified as experiencing the effects of abuse (Rhodes et al. 2011).

In summary, DFA has profound impacts on the health of women victim/survivors and these women are likely to present to emergency departments for assistance at rates higher than other women in the community. The evidence shows that women victim/survivors are more likely to present for reasons other than physical injury/assault and health practitioners

and systems do not make the link between these presentations and DFA. This research reinforces these findings, and contributes new information to this issue, highlighting the central role of emergency departments in identifying and responding to these women and factors which contribute to the non-identification of DFA. The potential to assist and support women victim/survivors is not currently realised in Australian emergency departments (NSW Health 2019; Royal Women's Hospital 2020).

Screening in health settings

The WHO (2020) defines screening in a health setting as the systemic application of the use of simple tests to identify populations and individuals at risk of a range of health problems. Patients presenting to various health settings in Australia are already screened as part of the general triaging processes and are asked questions about their consumption of tobacco and alcohol, their use of prescribed or illicit substances, and if they have a history of heart disease and/or diabetes (American College of Emergency Physicians (ACEP) 2016). These questions are asked regardless of the presentation of the patient and aim to identify known risk indicators for certain types of cancers, high blood pressure, high cholesterol, diabetes, substance misuse, osteoporosis, sexually transmitted diseases, and mental health conditions (ACEP 2016). Screening is technically a preventative strategy which aims to identify, prevent, mitigate, regulate, educate and support as well as reduce public health costs (ACEM 2020). Although DFA is not a disease, it significantly impacts on the health of victim/survivors. Screening for the presence of DFA, as with screening for other health issues, also assists in early identification, support, and action. Screening in a health care setting to determine the potential presence of DFA is defined as the, 'systematic involvement of healthcare workers in the detection of intimate partner violence among clients who may or may not present with direct signs of victimization/abuse' (Lawoko, Sanz and Castren 2011:2).

Screening is often viewed as a secondary preventative intervention for dealing with DFA, with law enforcement responses categorised as primary interventions (Thurston, Tutty and Eisener 2004). Peak bodies in the US, including the American Medical Association, the American College of Obstetrics and Gynaecologists, the American Academy of Nurse Practitioners, the American College of Emergency Physicians, the American Academy of

Family Practice, and the Emergency Nurses Association, all call for universal DFA screening in health settings with female patients (Kothari et al. 2015).

Australian research also argues for screening for DFA in hospitals (Hegarty 2015; Spagnaro 2017). Laing (2003) found that women are likely to present to health services and their general practitioner before family and friends or before having contact with domestic violence crisis services. Hegarty (2012) reinforces this finding, noting the importance of general practitioners asking about women and children's safety and sensitively validating disclosures.

Sutherland, Bybee and Sullivan (2002) state that identifying abuse at the earliest possible stage can be vital in terms of supporting a woman to leave a violent relationship. This report argues that the signs of abuse are not always visible signs, as women present to health settings with a wide range of issues. Therefore, health professionals who rely only on the presence of suspicious injuries miss the opportunity to offer assistance. Sutherland et al. (2002) state that when victim/survivors are misdiagnosed, the underlying cause of the health issue remains undetected, which can not only place a woman in greater danger but can also lead to treatment that enables further control and abuse by the perpetrator.

Validation from a health care professional plays an important role in empowering and educating women victim/survivors (Spangaro and Zwi 2010; NSW Health 2011; Reisenhofer and Seibold 2012). Moreover:

The experience of screening shaped their constructions of abuse, giving name to it, re-connecting with others through the care and back up offered by health workers and connecting to narratives of competence.

(Spangaro and Zwi 2010:9)

This research found that validation can often be the catalyst for a woman victim/survivor beginning to believe that a different life may be possible for herself and her children. Health professionals have an important role in this, and screening is one method to enable this (Gerbert, Abercrombie, Caspers, Love and Bronstone 1999; Laing 2003; WHO 2013a). Thurston et al. (2004) argue that initiating a discussion on DFA sends the message to a

victim/survivor that DFA is unacceptable, and that a hospital is a safe place for disclosure at that time or in the future.

Screening in emergency departments

Emergency departments are a significant site for the potential identification and support of women victim/survivors for several reasons including accessibility, affordability, and confidentiality. Regarding accessibility, Braaf and Gilbert (2007) compared Australian and international data from health settings, domestic violence agencies, hospitals, and police, to identify peak times for incidents of DFA. Their findings highlight a higher rate of DFA incidents after usual business hours, during holiday seasons and on public holidays. In Australia DFA incidents rise during the Christmas/New Year period, Easter, and over long weekends such as Anzac Day, the Queen's birthday, Melbourne Cup, the football grand finals and during the summer period. Incidents were also found to peak during weekends and after hours when families were together (Braaf and Glibert 2007; State of Victoria 2016b). Many general practitioners and other health services are not open during these peak periods, whereas most emergency departments are open 24 hours a day and may be the only accessible options for a woman victim/survivor seeking assistance during those times. The VRFCV argued that there are higher rates of DFA for women living in rural, regional, and remote areas, where there is also less access to health services (State of Victoria 2016b; AIHW 2021). Regional and rural hospitals are likely to be one of few accessible sites for many women victim/survivors in these areas.

Regarding affordability, for many women, a public hospital emergency department may be their only option. Financial or economic abuse is estimated to be present in up to 87 percent of DFA situations (Corrie and McGuire 2013). Presentations to emergency departments of public hospitals are free for patients who are Australian residents or who reside in Australia within specific visa conditions under the Australian Medicare scheme (Services Australia 2022).

In relation to confidentiality, the VRFCV (2016) found that women victim/survivors were often uncomfortable disclosing to family doctors if the perpetrator was also a patient of that doctor. This was found to be a particular problem for women in rural and remote areas.

Emergency department health professionals are more likely to be unknown to both the victim/survivor and perpetrator (State of Victoria 2016b).

As is demonstrated in the discussion above, emergency departments are an accessible and affordable health site for assistance for women who experience DFA. However, Richardson, Coid, Petruckevitch, Shan Chung, Moorey and Feder (2002) found in their review of 258 UK medical records that most women's experiences of abuse are not documented in their medical records. Comparing their findings to US research, they concluded that fewer than 10 percent of women experiencing DFA are identified at the time of presentation to an emergency department. Other research demonstrates that without a process in place to ask about DFA, as many as 72 per cent of women who attend an emergency department will not have their experiences of abuse identified (NSW Ministry of Health 2019; ACEM 2020). As research previously reported shows, many presentations appear unrelated to abuse and, in these situations (without screening), the health professional is generally unaware of the presence of DFA (Roberts et al. 2006). Lawoko et al. (2011) concluded in their evaluation of screening in Sweden that healthcare professionals report that universal screening increases the identification and management of DFA. An international review of screening programs in emergency departments and antenatal clinics found that screening increased identification of DFA in eight out of nine studies (Ramsay, Richardson, Carter, Davidson and Feder 2002).

Conclusion

In this background chapter, I have discussed terminology and provided a justification for my decision to use the terms 'domestic and family abuse' and 'victim/survivors'. I have considered the importance of a definition that recognises gender as central to understanding DFA, alongside the analysis of power and control and the significance of viewing this through an intersectional lens. I have examined known DFA prevalence rates, and the issue of under-recording and under-reporting, and argued that the health system has a role to play in identifying and responding to women who experience DFA. I have argued that screening in emergency departments is vital for several reasons, including that women victim/survivors attend emergency departments of public hospitals at a greater rate than women in the general population, that emergency departments are often the only accessible service for many of these women, and that DFA is not being identified in many of these presentations.

In the next chapter I turn to the literature review where the focus is on key aspects of screening for DFA in Australia and in the international context. I explore literature around screening models and the extent of their use before discussing the outcomes of these programs. I also consider the arguments against universal screening for DFA.

Chapter 3. Literature review

In this literature review I begin with an exploration of DFA health and hospital screening programs, including those used in emergency departments within Australia and internationally. I examine screening tools and the importance of these, alongside models and known impacts. The chapter concludes with a discussion outlining the reasons why it is important to implement universal screening in emergency departments in Australia. As previously stated, women experiencing DFA attend emergency departments more often than other women and identification of DFA in those presentations does not reflect the known prevalence rates within the community (Kothari et al 2015). Every time DFA is not identified for a victim/survivor, it is a lost opportunity to offer support and attend to safety.

Before proceeding, it is worth clarifying the various terms used in relation to DFA screening. At the time of writing, in June 2022, there were several models of screening programs used in health care settings, within Australia and internationally. As previously discussed, screening involves the systematic use of simple tests or questions across health populations to identify potential risk factors (WHO 2020). In Australia, screening programs are currently based around 'selective screening' models. Examples of these include the 'case finding' model in NSW and the 'sensitive enquiry' model in Victoria (NSW Ministry of Health 2016; Royal Women's Hospital 2020). These selective screening models require health professionals to ask questions of women who attend specific areas of health service (such as pre- or post-natal, drug and alcohol or mental health services), if clinical indicators are present (for example signs of physical abuse), or within other program constraints including limited hours of operation or age-range limits on women eligible for screening. Selective screening for DFA in Australian hospitals involves asking patients about present or past relationships and follows a set procedure for treatment and support if DFA is identified (Phelan 2007; Spangaro et al. 2020). Further detail on these models will be discussed later in this chapter.

O'Doherty, Taft, Hegarty, Ramsay, Davidson and Feder (2014) explored different options for screening programs for DFA and defined 'universal screening' for DFA as a process of applying a set of standard questions to all women who present for health assistance, regardless of whether they present with known risk factors or clinical indicators. Universal screening is performed by all health professionals (as opposed to a select few) at all times of the day, in a particular health setting (O'Doherty et al. 2014).

In New Zealand (NZ), the Violence Intervention Program (VIP) is an example of a universal screening program. It requires health professionals to screen all women who present to an emergency department and is carried out 24 hours a day. The VIP model, however, uses the term 'routine enquiry' to describe the program, arguing that this terminology distinguishes it from other 'universal health screening' carried out within the hospital setting. The reason stated for this distinction is that the other screening relies on a tick box approach, whereas the VIP model focuses on introducing a conversation (NSW Health 2016; Gear, Koziol-McLain, Henry, Garrett, Wilson and Janicot 2020; Royal Women's Hospital 2020).

The extent of screening

Screening for DFA is carried out in many countries around the world including NZ, Canada, the UK, the US, and Australia (Anglin and Sachs 2003; Breiding, Black and Ryan 2008; Power et al. 2011; Koziol-McLain and Gear 2012; Spangaro 2017). In some instances, for example NZ, the screening is part of a whole of Government approach, whereas in others, including Australia, individual departments, territories, regions, or states determine the ways in which these practices are administered and the criteria for deciding when and how the screening will take place (Anglin and Sachs 2003; Breiding et al. 2008; Koziol-McLain and Gear 2012).

International screening programs

Over half of the States within the US have legislation mandating universal screening (Durborow, Lizdas, O'Flaherty and Marjavi 2010; ACEP 2017). DFA has been identified as a major health issue in both the US and Canada, and since 1992, there have been recommendations from national committees that hospitals develop policies and procedures to identify and refer victims. The American Medical Association and the American College of Obstetricians and Gynaecologists recommend universal screening for all female patients in emergency health settings (Anglin and Sachs 2003; Breiding et al. 2008). The importance of screening to identify DFA within the US was also supported through the introduction of the Affordable Care Act (ACA) in March 2010. This legislation mandates that health insurance plans cover screening and that it is also accessible for adolescent and adult women without health insurance, who may be socially or economically disadvantaged (Stidham Hall, Fendrick,

Zochowski and Dalton 2014). The report stated that this inclusion was important, as identification of abuse can lead to improved health and prevent further abuse (Stidham Hall et al. 2014). Finally, the US Preventative Services Taskforce (USPSTF) recommends universal screening for women of 'child-bearing' age (USPSTF 2013).

Screening in emergency health settings in Canada differs between regions and territories. In 2000, two key health stakeholders initiated the development and implementation of a comprehensive response for victims of DFA in emergency health settings within the Calgary region (Thurston et al. 2004). In contrast, in 2003, the Canadian Taskforce on Preventative Healthcare argued that there was no convincing evidence for the implementation of routine screening for women during pregnancy (Wathen and McMillan 2003).

In the UK, the Department of Health recommends that health professionals 'routinely enquire' about DFA with all female patients and introduced guidelines for health professionals to assist with this. While this does not equate to mandated universal screening, health professionals were advised that abused women are more likely to present to hospitals, require medication, and present with issues other than physical injuries (Laing 2003; Boyle et al. 2004; Department of Health 2005). Guidelines published through the National Institute of Health and Care Excellence (NICE) recommend 'selective screening' for patients in health areas where there is evidence to suggest an elevated risk of DFA, including alcohol and drug services, sexual health, and antenatal services (NICE 2016). This is an example of selective screening as women are only screened where there are known indicators of elevated risk.

Sweden follows a similar pattern to that of Canada and the UK, in that although the Government recognises DFA as a significant health issue, screening is encouraged, but not universally mandated (Lawoko et al. 2011). In an evaluation of emergency department practice in Sweden, 50 percent of emergency department health practitioners had screened for the possibility of DFA among their female patients during the previous three months, with female practitioners more likely to screen than their male counterparts and midwives screening less than nurses and other allied health staff (Lawoko et al. 2011). This is significant as pregnancy and post-birth is a known high-risk time for DFA, and most women presenting to midwives would be pre- or post-natal (Baird, Creedy, Brandjerdpor and Gillespie 2020). Lawoko et al. (2011) argue that, given these findings, 'encouraging' health practitioners to screen 'routinely' may not be effective in high-risk areas of health. In 2016, the Swedish

Government released the National Strategy to Prevent and Combat Men's Violence Against Women. One of the four objectives of this strategy focused on improving the detection of violence through a screening model incorporating 'routine enquiry' by health professionals, on the presentation of clinical indicators. This model operates within emergency departments; however, as screening only occurs if the health professional identifies potential indicators, it is a selective screening model (Government Offices of Sweden 2016).

My review of the literature indicates that NZ is the only country implementing national 'universal screening'. In 2001, the New Zealand Ministry of Health, through the District Health Boards, began a family violence health prevention project which included screening for DFA for all adult women (over 16 years of age) presenting to health services, including emergency departments at public hospitals (Koziol-McLain and Gear 2012). The VIP model provided staff training, built networking structures between domestic violence agencies and hospital settings, and had evaluation procedures built into the program from the beginning (Koziol-McLain and Gear 2012). I will discuss the impacts of this program later in this chapter.

Screening programs in Australia

In Australia, the National Plan to Reduce Violence Against Women and their Children 2010–2022 (COAG 2010) aims to address the issue of DFA, through connecting and coordinating the actions and work of various government departments and services, community groups, organisations, and jurisdictions throughout the states and territories of Australia (COAG 2010). At the time of writing, the next stage of the Plan was subject to consultation (COAG 2022). The existing plan centres action through six national outcomes, which have been implemented over a twelve-year period, in four separate stages. The six national outcomes of the Plan were: to work towards communities being safe and free from violence; to build respectful relationships; to strengthen Indigenous communities; to improve services to meet the needs of women and children; to ensure effective judicial responses; and to work towards perpetrators being held to account for their actions (COAG 2010). The outcome on improving services to meet the needs of women and children (Outcome 4), specifically addresses improving the early identification of violence, and discusses the use of screening tools for antenatal, maternal and child health services as well as the development of a national risk assessment framework for the health sector. This demonstrates that the government

supports selective screening, as it is promoted for specific health areas, not for every woman who attends a health service. While this Plan signalled the federal government's recognition of DFA as a prominent issue, it also drew attention to the independent, jurisdiction-based administration of related programs (Mitchell 2011).

Australia's National Research Organisation for Women's Safety (ANROWS) was tasked through the Plan, to develop the National Risk Assessment Principles (NRAP). Completed in 2018, this set of principles provides an understanding of risk and management, but does not replace the frameworks, practices and tools currently used in different jurisdictions across Australia (Toivonen and Backhouse 2018). The consequence of this is that policy to address the health impacts of DFA across Australia remains fragmented and disconnected. Addressing this issue and identifying DFA in a hospital context is left to the states and territories and individual hospitals to deal with the issue in separate ways that are not nationally coordinated. This fragmentation also occurs between and within states and territories. For example, some jurisdictions have shared hospital systems and patient records, such as in Tasmania and in the NT, while others, as in NSW, share a data base for screening, whereas Victoria has independent hospital data capture systems unique to each regional health board (State of Victoria 2016a). These disconnected health data and recording systems make it difficult to facilitate and evaluate state-wide and national activity, outputs, and initiatives (McKay, Hegarty, Taylor, Chapman and Cameron 2021).

Some Australian hospitals have implemented family violence response programs, however, due to discontinuous funding and other resourcing issues, many struggle to be sustained (Young, Hayhurst and Page 2003; Power et al. 2011; Spangaro 2017; McKay et al. 2021). For example, in 2006 a three-month trial was rolled out to screen for DFA in the emergency department of Flinders Medical Centre, a major public hospital in Adelaide, South Australia. Despite an increase in identification and referral, the program was discontinued due to lack of recurrent funding (Power et al. 2011). Similarly, in 2009, a pilot project implemented by the emergency department of Monash Medical Centre, a major public hospital in Melbourne, Victoria, found an increase in identification of women victim/survivors of DFA. However, this pilot project was discontinued as hospital administration were concerned that once identified, women's safety could not be assured (Coombe 2009).

In Victoria, the Strengthening Hospital Responses to Family Violence (SHRFV) project was initiated in 2014, beginning with the Royal Women's Hospital and Bendigo Health. This

program has now expanded and occurs in 88 hospitals throughout Victoria (Royal Women's Hospital 2020). This program promotes a 'model of sensitive enquiry', which is a selective screening model asking questions of women if indicators of DFA are detected. The program states that there is an emphasis on sustainability in terms of striving for systemic change within hospital culture, however at the time of writing (June 2022), ongoing state government funding has not been guaranteed (McKay et al. 2021).

In 2008, Queensland Health introduced selective screening for DFA in antenatal and post-natal health settings. This program has expanded every year since that time and there are also plans to introduce a referral program for paramedics to assist victims of DFA. Screening in emergency departments is not part of this plan (COAG 2010). In 2017, the Royal Brisbane and Women's Hospital in Queensland introduced a 24-hour social work service in the emergency department to address increasing rates of DFA (Dick 2017). While this program recognises the need to address the issue, not all staff screen and not all women are screened, therefore it is not a universal screening program.

New South Wales Health introduced the Domestic Violence Routine Screening Program in targeted health programs in 2001. As previously discussed, this case-finding program is a selective screening model with screening occurring only in areas of known increased risk (NSW Health 2016). More recently, in 2019, NSW Health commissioned a feasibility study which led to the implementation of screening programs in emergency departments of three hospitals in NSW (NSW Ministry of Health 2019). Following on from this, the NSW government released the NSW Health Strategy for Preventing and Responding to Domestic and Family Violence Plan 2021–2026. This plan identifies emergency departments as a priority setting to address the health impacts of DFA, but the language of the plan reflects targeted identification based on known indicators of risk, rather than universally screening all women who present to an emergency department (NSW Ministry of Health 2021).

Unlike the national VIP model in NZ, Australia does not have any 'universal screening' programs at the time of writing (June 2022), nor any consistent national methods to screen for DFA. Neither does Australia have a national training program to build capabilities in health professionals in this area. As this review demonstrates, screening programs are fragmented across states and territories, and utilise different tools and methods to identify DFA.

Screening tools

Screening tools are one component of a comprehensive approach to DFA screening in health care settings, however, the tool itself plays an important role in screening outcomes, and an important role in the collection of standardised data (O'Campo, Kirst, Tsamis, Chambers and Ahmad 2011; Koziol-McLain and Gear 2012).

There have been several reviews and compilations of screening tools for use in detecting DFA in health care settings (Nelson, Nygren, McInerney, and Klein 2004; Basile, Hertz and Back 2007; Feder, Ramsay, Dunne, Rose, and Arsene 2009; Nelson Bougatsos and Blazina 2012; NSW Ministry of Health 2019). Basile et al. (2007) found 34 screening assessment tools with a focus on questions that were considered acceptable by women victim/survivors, all with fewer than 20 questions to assist with the practical reality of working in a busy and time constrained environment of an emergency department. Tools listed in this study for specific use within an emergency department included the Hurts, Insult, Threatens and Screams (HITS) scale, the Abuse Assessment Screen (AAS), the Minnesota Tool, the Ongoing Abuse Screen (OAS), the Ongoing Violence Assessment Tool (OVAT), the Partner Violence Screen (PVS), the Patient Satisfaction and Safety Survey (PSS), the STaT, and the Universal Violence Prevention Screening Protocol (Basile et al. 2007). The questions on the tools were a combination of direct, indirect, and subtle enquiries. Direct questions ask women if they have been hit and request that they mark the position of the injury on a diagram of a body. Indirect questions rely on the ability to build rapport and have a conversation. Basile et al. (2007) found that these tools varied in reliability, validity, specificity, and sensitivity, however, when testing for these characteristics the CTS was used as the gold standard by which to judge the criteria. As previously discussed, the CTS measures conflict in a relationship, does not look for patterns of power and control and assumes gender symmetry in DFA.

Screening tools such as HITS, OVAT, HART and WAST (described above) are actuarial tools, that have been psychometrically tested and validated to identify and weigh the factors which can predict the likelihood of whether a woman is experiencing DFA (ACEM 2020). These tools can be used in either selective or universal models. Using the HITS tool as an example, women are asked a series of four questions around actions from their partner, such as, has their partner ever hit or physically hurt them; insulted them; threatened them; screamed/sworn at them. The answers to these questions are then rated according to the

frequency of the behaviours for each of these questions, for example: never = 1 rarely = 2, sometimes = 3, fairly often = 4 and frequently = 5. A woman with a score of over 10.5 indicates the presence of DFA (Sherin, Sinacore, Xiao-Qiang, Zitter and Shakil 1998). The NSW Health (2019) feasibility study discussed previously trialled the HITS tool, reporting that it was short and simple and the best in terms of diagnostic accuracy, validity, and reliability (NSW Ministry of Health 2019). It needs to be noted that the HITS tool focuses on current partners; however, for use in the NSW feasibility study, health professionals administering the tool were encouraged to ask beyond a current partner (NSW Ministry of Health 2019).

These tools emphasise aspects of DFA that fit with community understandings and beliefs around DFA, including highlighting incidents, rather than patterns of control, physical abuse and concentrating on current relationships. Focusing on current relationships is problematic as it fails to consider the heightened risks associated with separation (Webster et al. 2018). Emphasising physical abuse can minimise or neglect other forms of abuse, such as coercive control. Hill (2019) argues that many women victim/survivors may not recognise that they are living with or have lived with abuse if physical or verbal abuse is not present. Therefore, in many circumstances, asking women if they have been hit or screamed at may elicit a negative response, and will not lead them to identify or understand their experiences of psychological, financial, reproductive and other non-physical forms of abuse. The inability of these tools to assist in identifying coercive control is significant, as research demonstrates that coercive control is estimated to be present in up to 80 percent of situations where women victim/survivors sought health assistance, and in a recent review of domestic violence related homicide in NSW, coercive control was present in 99 percent of cases (Stark 2012; Coroners Court NSW 2020; Topsfield 2020). The tools listed above also consider frequency of abusive behaviour as a measure of risk, where women are asked about behaviours in the past 12 months. This can also be problematic, as frequency does not always correlate with severity (Toivonen and Backhouse 2018).

Screening tools, however, are only one component of a comprehensive screening program aiming to address identification and support for women experiencing DFA. Coben's (2002) Delphi Instrument explores factors necessary to bring about cultural change across all hospital systems (infrastructure) in a screening program. Coben argues that change needs to occur across all systems, including attending to the knowledge of the health professionals themselves (Coben 2002). The Delphi Instrument measures the commitment from a hospital

by auditing several factors, including the existence of a steering committee (with intervention and collaboration of community agencies) to oversee the development of policies, procedures, a screening tool, training of staff, attending to the physical environment and working towards sustainable funding. This instrument also counts the universality of a program as a measure of cultural change within a hospital. This, alongside a discussion on the use of specific questions for the tool, will be explored further in Chapter 9 when discussing good practice in screening programs.

Models and impacts

As previously stated, numerous pilot programs have been trialled in Australia, and there are several programs currently operating. I now explore these and their known impacts, comparing findings to those from the universal VIP model in NZ.

The three-month pilot project at Flinders Medical Centre in South Australia was based on the ecological model, drawing from work by Thurston and Eisener (2006) who emphasised the need for a whole of hospital systems approach (Thurston and Eisener 2006; Power et al. 2011). In this project, attention was paid to capacity building amongst staff through ongoing professional development aimed at increasing knowledge around DFA, using the screening tool, and responding to disclosures (Power et al. 2011). The screening tool used in this program was based on the Domestic Violence Intervention Tool (DVIT), asking women who presented to the emergency department, 'Has a partner or significant other person ever done any of the following: made you feel afraid; hurt you physically or thrown objects or constantly humiliated or put you down?' (Power, Bahnisch and McCarthy 2011:542).

Staff were given an ABCDE response resource card, as a prompt to: 'Ask alone, Be supportive, Call on resources, Document, and Ensure safety', alongside phone numbers for relevant support and referral options (Power, Bahnisch & McCarthy and 2011:542). Information was repeated on wall posters to remind staff of important information including definitions of DFA, screening tool questions, ways in which to respond, and referral information.

The screening program was for all women over 16 years of age. Screening did not occur if the woman was in acute distress, or if partners or other family members were present. The program was limited in that the screening was not available to women after

hours, on weekends or on public holidays, therefore this was not universal screening. The questions asked were also limiting in that they were centred around current relationships and focused on fear and physical abuse. Regardless of these constraints, in the three-month trial period of this program, there was a 213 percent increase in identification of DFA in women presenting to the emergency department and a corresponding increase in referrals to social work services. Of this increase in referrals, approximately half of the women identified were diagnosed with mental health issues at the time of presentation to the emergency department. Eight-five per cent of the women referred to the social work department had no previous contact with a social worker, or other professional, in relation to their situation. Despite these results, this program was discontinued due to lack of ongoing funding.

In 2002, a pilot screening project in the NT was trialled across two hospitals for a period of three months. Attention was also paid to building capacity within staff with the professional development program, informed by a knowledge and attitude survey undertaken at the beginning of the project (Young et al. 2003). This survey found that 22 percent of health professionals had some DFA knowledge content in their qualifying degrees or in training undertaken post-graduation. The screening tool in this project consisted of a questionnaire designed by the working group, based on the DVIT tool. Although there were prompting questions to assist staff with facilitating the conversation, the questions also concentrated on physical abuse and incidents that occurred within the past year (Young et al. 2003). The project evaluation found that screening 'significantly increased the level of DFA identified, and the level of help offered to those disclosing' (Young et al., 2003:4). During this trial, 63.1 percent of women at one hospital and 72.2 percent at a second hospital had DFA identified. Other significant impacts of this project included newly established protocols with community agencies, leading to improved relationships between the hospitals and those services, and a 50 percent increase in the numbers of restraining orders requested from police stationed within the emergency department. This is important as Aboriginal women are 11 times more likely to be killed as a result of DFA, 86 times more likely to be hospitalised in the NT because of DFA, than non-Aboriginal women, and report that police often do not take allegations of DFA seriously (Young et al. 2003; AIHW 2006; COAG 2014; Gleeson 2022).

Examples of current screening programs in use in Australia at the time of writing include the SHRFV program in Victoria and the NSW Health program. As previously discussed, both are based on selective screening, and do not promote universal screening. The SHRFV

program is a whole of hospital approach based on the Kaiser Permanente systems model in California and involves striving for culture change within the hospital through commitment and support from leadership and governance structures, alongside the development of policies, procedures, and guidelines (O'Doherty et al. 2014; Royal Women's Hospital 2020; McKay et al. 2021). The program also includes support for staff through mentoring and personal support, alongside building capacity through training and development of partnerships with organisations and workers in the family violence sector (Royal Women's Hospital 2020). There are limitations with this model of enquiry, in that it relies on the health professional having sufficient understanding of indicators of DFA to initiate an enquiry (Royal Women's Hospital 2020). The SHRFV program has recently been evaluated and findings demonstrate that organisational change in terms of development and implementation of policies, procedures and commitment from leadership is strong, however, identification rates and responses to women dealing with DFA were difficult to obtain due to the lack of consistent and comparable data and the lack of data sharing between Victorian hospitals (McKay et al. 2021).

The screening program implemented through NSW Health screens women in health areas flagged as high risk (NSW Health 2016). Evaluations have been completed since 2004 and, unlike Victoria, this program has benefited from consistency with a state-wide system of data collection and record keeping. These evaluations have demonstrated that of the women deemed 'eligible' for case-finding screening in mental health services, in 2015, an average of 51.5 per cent of eligible women were screened, with a disclosure rate of 16 per cent. In drug and alcohol services, an average 78.7 per cent of eligible women were screened, with a disclosure rate of 19 per cent (NSW Health 2016). Not all women deemed 'eligible' were screened, however, these evaluations have led to a review of best practice evidence for responses to DFA, concluding that system-level interventions are necessary in order to successfully implement protocols for DFA intervention in health services (Spangaro 2017). Due to concerns around the screening tool used in the case-finding model (in that it was not a validated screening tool and lacked precision in identifying DFA), a new tool was devised for the six-month project, facilitated within the emergency departments of three hospitals (NSW Ministry of Health 2019). As previously discussed, this project utilised a version of the HITS tool which included questions on the behaviour of partners, alongside questions on physical abuse, insults, threats, and verbal abuse. This program was not considered to be universal

screening, as the criteria for screening was limited to women between the ages of 16 and 45 years and screening was not offered to those who required treatment in under 30 minutes of presentation (NSW Ministry of Health 2019). Within those limitations, only between 10 and 13 percent of eligible women were screened across the three participating sites, with 17.7 percent scoring 10 or more on the screening tool, indicating the presence of DFA.

The VIP program in New Zealand began in 2004, with evaluation and reporting systems built into recording and data collection procedures from the implementation of this program. Hospitals are randomly audited through the District Health Boards (DHBs), for screening compliance throughout the year, to check for compliance among other domains (Fanslow and Kelly 2016; McLean, Koziol-McLain and Howson 2017). The VIP model includes the appointment of coordinators at the DHB level, and ‘champions’ within the system to support staff, alongside resources such as family violence intervention guidelines, a website, posters, cue cards, pamphlets and technical advice. The model also encompasses networking meetings and national training programs for health care providers as well as external evaluation with input from women victim/survivors. The screening model used was adapted from the Delphi instrument (discussed previously), which measures cultural responsiveness. The screening tool was considered appropriate for working with Māori, however, the authors state that further critical analysis is needed to better understand and address the sites of racism within health system responses to family violence (Koziol-McLain, Howson, Valentin Shun and Garrett 2019).

Annual evaluation of the VIP since 2004 has shown that screening rates have steadily increased, which has corresponded with an increase in disclosure rates. At the beginning of the program, evaluation reports demonstrated that 20 per cent of women were screened; by 2017, this had increased to a 93 percent screening rate overall. However, the 2019 evaluation reported a drop in the percentage of women screened, with only 56 percent screened in that reporting year, which has been the catalyst for further investigation (Gear et al. 2020). Regardless, universal screening within the VIP has led to a higher percentage of women being screened and identified than in any of the programs used within Australia.

The case for universal screening

In Australia and internationally, there are many who argue against the implementation of universal screening in emergency departments. Arguments include the WHO recommendation against universal screening, contending that it is not cost effective and creates a burden on health professionals. I now address these arguments.

As previously stated, the WHO argues that health professionals and health organisations play a vital role in identifying and supporting women who are victim/survivors of DFA, however universal screening in health settings is not endorsed (WHO 2013a; WHO 2017; WHO 2020). Many who argue against universal screening cite WHO guidelines to justify their position (Hegarty 2015; McCaw 2018; VEGA 2018; Royal Women's Hospital 2020). The rationale laid out by the WHO is specific to the structural, cultural and geographical conditions in which many WHO humanitarian health programs operate, including safety concerns for victim/survivors and health professionals in jurisdictions that do not legislate against DFA or prioritise women's safety and equality, and communities where there is no community infrastructure to support a woman following disclosure (WHO 2017; WHO 2020). The NZ government, when implementing the VIP, considered that these were not valid arguments for the NZ context, as NZ has a steady socio-economic position and aspirations for gender equality (Koziol et al. 2012). I would argue that Australia is in a similar economic position as NZ, and within Australia, all levels of government espouse a commitment to addressing gendered inequality and increasing respect towards women (COAG 2019; Family Safety Victoria 2020). The WHO guidelines, regarding structural, cultural and geographical issues that impact on the ability of some jurisdictions to implement universal screening, are not applicable to the Australian context.

Another argument cited by the WHO against universal screening is a comparison of the costs and resources required to sustain universal screening against selective screening models, where scarce funding and energy can be directed to known high-risk areas for DFA (WHO 2013; Garcia-Moreno, Hegarty, d'Oliveira, Koziol-McLain, Columbini and Feder 2015). KPMG (2016) found that, even when taking into consideration gaps in available data on prevalence rates and developments around more nuanced understanding of behaviours that constitute DFA, the cost of DFA within Australia in 2015–16 was estimated at 22 billion dollars. KPMG (2016) argued that it was difficult to estimate the second-generation economic impacts on children living with DFA, or the longer-term psychological impacts on victim/survivors.

Laing (2001) also argues that it is difficult to estimate the true economic costs of DFA, as it is hard to calculate the tangible, intangible and lost opportunity costs that occur due to DFA. I have already argued that selective screening models in hospitals fail to identify victim/survivors at rates comparable to known DFA prevalence within the community. Therefore, the cost-benefit argument against the introduction of universal screening in favour of selective screening models needs to consider the continuing tangible and intangible costs for those victim/survivors, other individuals, families and community when DFA is not detected or addressed as a result of using selective screening models.

The NZ VIP model was established as part of a government commitment to address the alarming rates and economic burden of DFA (Koziol-McLain et al. 2019). Annual evaluation and monitoring of the VIP has produced reliable data on the prevalence of DFA in NZ, information on the gendered nature of DFA and evidence that universal screening changes the ways in which the community and health professionals understand the role of hospitals. This program has led to an increase in identification rates and strengthening relationships between hospitals and family violence and other community agencies (Koziol-McLain et al. 2019). This program is evidence that, with a commitment to adequate resourcing and response for both hospitals and community referral programs, universal screening can identify and support more women and work towards cultural change within health organisations.

Other arguments against implementing universal screening centre on the effects on health professionals, including the potential for them to become overwhelmed in an already busy and crisis driven environment, as well as the emotional burden of responding to disclosures, especially for those who may have their own experiences of DFA (Hegarty 2015; VEGA 2018; Royal Women's Hospital 2020). I will address these arguments separately.

Reasons stated in the NSW pilot project for the low rates of screening reflected the 'time-poor' reality of working in an emergency department. Participants in the evaluation of this project nominated several factors contributing to the low rates of screening, including high numbers of patients as well as systemic issues, such as a lack of integrated processes within the program itself, for example, paper copies of the screening tool, a reliance on staff to identify women in the target groups rather than initiating the screening tool for every woman, and reduced access to social work services (NSW Ministry of Health 2019). Addressing some of the structural and systemic problems identified in the evaluation would

alleviate many of these issues and pressures on staff. However, high numbers of patients are a constant in many emergency departments, and it is noteworthy that this is not used as an argument against other routine screening programs. Taket, Wathen and MacMillan (2004) argue that screening for DFA should be seen as of equivalent importance to other screening used to address serious health issues. They state that 'asking all women as a routine part of history taking, just as health professionals regularly and repeatedly ask patients about their smoking behaviour, alcohol use, weight and exercise' (Taket et al. 2004:7), should be a standard part of procedure. Many of the screening tools previously discussed in this thesis were designed with only four questions in order to consider the potential time constraints of a busy emergency department.

Hearing disclosures of DFA, and asking questions around the issue, carries an emotional burden for those listening (Herman 1997). For emergency department workers, there are many circumstances, experiences and presentations that are difficult and create an emotional burden. Many comprehensive screening programs, regardless of the models used, recognise this and incorporate personal support and clinical supervision for staff as an integral part of the program (Gear 2020; MacKay et al. 2021). McLindon, Humphreys and Hegarty (2018) observe that support for staff is an essential component of all screening programs and programs need to address the specific needs of staff who have lived experience of DFA. I argue that it is important to educate, validate and support all women regardless of whether they are a patient or a health professional.

Another argument against universal screening in emergency departments is that it may not lead to a woman leaving the perpetrator (Hegarty 2015; VEGA 2018). As previously discussed, the purpose of a screening program is not for a woman to leave the perpetrator. Separation may not be her safest option (Toivonen and Backhouse 2018). Screening can validate women's experiences, promote help-seeking behaviour through receiving a positive social response, and reinforce to her that she is entitled to a healthy, non-abusive relationship (Thurston et al. 2004; Braaf and Sneddon 2006; Keel, Chapman, Wilson, Hegarty and Cameron 2021). Taket et al. (2004) cite other evidence to support the value of screening, including women reporting less difficulty in obtaining resources and an improved quality of life following identification.

A final argument against universal screening is that tools designed to work on assessing physical diseases may not pick up on the nuances necessary to understand a social

phenomenon such as DFA (Pease 2019; Taket et al. 2001). Pease (2019) argues that any intervention to deal with the issue of DFA needs to ensure that wider social relationships are considered. This is an important argument, as many health professionals lack knowledge about the influence of social contexts, and the role of the medical model in facilitating the agenda of patriarchy, in their understanding of DFA (Daniels 1997; Richardson et al. 2002; Roberts et al. 2006; Moulding 2016; State of Victoria 2016c). Roberts et al. (2006) examined the lack of DFA specific training in the qualifying degrees and attitudes of health professionals working in emergency departments and found that ‘practitioners assume the broader community values about domestic violence’ (Roberts et al. 2006: 7). This is consistent with the findings from Young et al. (2003) in their evaluation of the NT project when examining knowledge and attitudes of health professionals. The VRCFV examined DFA specific training for health professionals in graduate and post-graduate degrees and post-qualifying professional development and found that undergraduate and post-graduate training in the health professions ‘lacks any mandatory content in intimate partner violence’ (State of Victoria 2016a:38). This finding led to four recommendations that specifically address this lack of training, including that the Australian Association of Social Workers (AASW),

Amend the Australian Social Work Education and Accreditation Standards to require that a ‘working with family violence’ subject be required as a component of the core curriculum in all social work undergraduate degrees

(State of Victoria, Recommendation 208, 2016:102)

As mentioned in the introduction, I have advocated and worked towards the AASW's introduction of compulsory family violence content to all degrees to ensure that social work graduates gain this knowledge (AASW 2020b).

The previous chapter demonstrated that DFA significantly impacts on the health of victim/survivors and that emergency departments are a unique point of access for a range of reasons (Phelan 2007; Spangaro 2017; Koziol-McLain et al. 2019). This chapter explored different models of screening and demonstrated that universal screening identifies more women victim/survivors of DFA than selective screening models, however, there is a reluctance to embrace universal screening within the Australian context. This chapter also

challenged the arguments against the introduction of universal screening in the Australian context. The aim of this research was to contribute to the knowledge, understanding and practice of screening programs for DFA in emergency departments of Australian public hospitals, centring the experiences of women victim/survivors in the process. I now discuss the aims and research questions that guide this research.

Aims and research questions

To contribute to the knowledge, understanding and practice of screening programs for DFA, this research explored what happens for women victim/survivors when they present to an emergency department, why this happens and how their experiences could inform improvement of the practices of hospital systems and health professionals. Alongside the experiences of the women victim/survivors, this research examined knowledge, insights, and reflections from emergency department social workers, as well as workers with expertise in the DFA field.

The questions guiding this research were:

- What is the nature of screening for domestic and family abuse in emergency departments of Australian public hospitals?
- Why is it important to universally screen for DFA in emergency departments of Australian public hospitals?

To answer these questions, this research explored three sub questions:

- What are the experiences of women victim/survivors of domestic and family abuse upon presentation to emergency departments of public hospitals, and what consequences emerge for these women?
- How do social workers and other emergency department health professionals identify and respond to domestic and family abuse?
- What are the important factors to consider for good practice in the implementation of universal screening programs for domestic and family abuse in emergency departments of public hospitals?

Conclusion

Universal screening for DFA in emergency departments by health professionals who are trained and supported increases identification and disclosure and supports women who experience DFA (Roberts, Lawrence, O'Toole and Beverley 1997; Krimm and Heinzer 2002; Laing 2003; MacKay 2008; Power et al. 2011). Importantly, universal screening can identify women who present with a range of symptoms beyond physical assault, which is the case for the majority of women dealing with DFA. Without screening, it is unlikely that these women would have DFA identified, named, explored, nor any safety plans or supports offered (Roberts et al. 2006; Kothari et al. 2015; Spangaro et al. 2020).

My review of the literature has explored the case for universal screening for DFA in emergency departments within the Australian context. I have discussed different models, screening tools and programs both in Australia and internationally and examined the outcomes of those programs. I have also acknowledged and challenged the arguments against the implementation of universal screening in emergency departments of Australian public hospitals and stated the reasons why these are not applicable for the Australian context and the ways in which challenges can be addressed in the implementation of such a program. I have concluded by outlining the research aims and research questions. In the next chapter, I outline the theoretical framework of this research, including my own experiences of living with DFA, and of working with many victim/survivors, and the ways in which these experiences influenced this research.

Chapter 4. Theoretical framework

My professional practice as a social worker is based within the theoretical perspective of feminist critical social work, and this, alongside my own personal experiences of DFA, influence both the theoretical positioning of this work and the research methods. In this chapter I discuss the ways in which feminisms inform my position and emphasise the importance of the gendered lens over and throughout my critical social work positioning in this research. I elaborate on the ways in which this feminist critical approach informs the methodological position of this research, including the requirement for reflexive consideration of my location as the researcher. I preview ethical challenges encountered around this, while conducting the research. This chapter also examines the potential tensions in basing this research theoretically within a feminist critical framework, while arguing for public policy intervention in the lives of women who are victim/survivors of DFA. I assert that public health policy and a feminist critical framework can coexist and inform each other.

My background and experience

My position as a feminist critical social worker and my personal experiences of living with and surviving DFA, underpin the theoretical framework of this research. I have been a social worker for over 30 years and much of my practice during this time has been working with women and children whose lives have been impacted by DFA. This work has been conducted in various settings including family service agencies, community health centres and acute hospital settings. I have worked with women and children in crisis and recovery, on an individual basis and collectively through the facilitation of support groups. My work has been at the micro, meso and macro levels, working with women, advocating for organisational change, and contributing to improved policy in and education about DFA. For the past 14 years I have also taught undergraduate and post-graduate social work students in this area of practice and facilitated training to my peers. I bring extensive practice and theoretical experience and knowledge to this research.

As a social worker, working from a feminist critical position, my practice framework has required me to adopt an intersectional approach, acknowledging the importance of social location, multiple identities, structural disadvantage and understanding the compounding effects and often complex oppressions of these factors in the lives of those I work with.

Working within this feminist critical framework has also meant that I work for structural reform, informed by my work with individual women and their children. To explore these concepts and their relationship to this research, I begin by discussing critical social work theory before moving on to feminist theory, and the importance of a gendered analysis in understanding and conceptualising DFA. I then unpack my experiences of DFA and discuss the influence and contribution of this, to this research.

Critical social work theory

The term 'critical' in social science theory implies a challenge to the status quo (Leavy and Harris 2019). Healy (2014) states that critical social work draws on critical social science theories, arguing that 'macro social structures shape social relations at every level of social life', and that it is these social structures that lead to oppression and discrimination (Healy 2014:185). Examples of two such macro social structures relevant to this research include the ways in which dominant patriarchal social structures and systems influence and manipulate gendered roles and relations, and the ways in which medical model discourses and structures within patriarchy mediate the gendered narrative, diagnoses, and treatment of 'disease and dysfunction'. For example, the construction of expected gendered trauma reactions in women experiencing DFA has consequences when women's behaviour falls outside of these gendered expectations. Medical model discourses pathologise these unacceptable trauma responses compounding the trauma through diagnoses of mental illness and pharmacological treatments, which then impact risk, safety and agency in parenting (Herman 1997; Moulding 2016; Humphreys, Healy and Mandel 2018).

Fook (2012) describes critical social work as committed to working towards social change from an understanding of the inequalities inherent within macro structures and how they oppress certain individuals, groups, and communities. Allan (2009) argues that one of the central values informing a critical social work perspective is commitment to social justice and an emphasis on working towards individual, social, cultural, and structural empowerment. Critical social work, therefore, refers to practice that not only makes visible macro social structures and the consequences of these, but also obligates the worker to address these structural disadvantages at all levels, including the individual level. This is relevant to this research because this research interrogated the ways in which hospital

emergency departments respond to women experiencing DFA, the reasons behind these responses, the role of macro structures on these responses and the impacts on the women victim/survivors. This research is committed to addressing the influence of those macro structures on women's lived experiences through suggestions for improvement based on the findings, which are informed by the women's perspectives.

It could be understood that the focus on macro structures places critical social work within modernist ideas of power and identity. Healy (2014) argues, however, that critical social work can also include some aspects of post-modernism, namely challenging and disrupting discourses and oppressive narratives and including lived experience to challenge existing understandings of self and others. Healy (2014) outlines four characteristics of critical social work theory which identify both modernist and post-modern influences, including: a commitment to solidarity with those who are oppressed; insight (and acting upon that insight) into the power differences existing within and between relationships; identifying and having an understanding of the ways in which social, cultural, political and economic conditions determine opportunities for people and their communities; and ensuring that oppression is addressed by working to change these unjust processes and structures. This research emphasised and explored the ways in which gendered and medicalised discourses and practices impact not only on a victim/survivor's understanding of their experiences, but also on the ways in which their presentations to emergency departments were constructed and acted upon by health professionals, and the policies and subsequent practices they are bound by.

Working from a critical social work perspective requires the researcher to challenge both traditional power relations and the privileged position of professional knowledge (Healy 2014). In acknowledging and advancing the lived experiences and expertise of the women victim/survivors, alongside articulating, and challenging the oppressive effects of the macro-systems involved, this research sought to challenge and disrupt power dynamics between victim/survivor and perpetrator, researcher and researched, health professional and perpetrator, health professional and patient, and the organisations and systems in which they operate.

As mentioned previously, critical social work theory requires insight, reflection, and action to address power dynamics within and between relationships. During the research process, I reflected on the various experiences and locations I occupied, including researcher,

victim/survivor, professional colleague, cis-gender heterosexual woman, and social worker, as well as the varying levels of power that sit within and across each of these categories. I was mindful that I wanted to remain honest and transparent with research participants, and during focus group discussions, shared my victim/survivor status with the participants, however, owned my work and privilege as a white social worker and my role as researcher alongside my experiences as a survivor. Acknowledging these multiple aspects of my identity and interrogating the ways in which they influenced power dynamics within and between the different cohorts of participants was essential to the critical theoretical positioning of this research and will be explored in more detail in the following chapter.

Leavy and Harris (2019) discuss the power of language in understanding and constructing identity, stating that the use of specific language promotes certain knowledge. This is an important consideration for my research. Traditional professional discourses around DFA and health frame knowledge and understanding of victim/survivors' emotional distress to abuse in ways that pathologise women's lived experiences (Moulding 2016). This is an example of a medical macro structure contributing to the oppression of individuals. To address this, the language used by the women victim/survivors to describe and interpret their experiences, behaviours, feelings, and outcomes, is prioritised throughout this research. For example, the women preferred the term 'abuse' to 'violence' to describe their experiences, as the term 'violence' implied physical assault which did not capture many of the non-physical perpetrator behaviours they experienced. The language and associated meanings of 'violence' had left women unaware that they were living in a relationship legally considered DFA. Another example was the use of the words 'safe' and 'fear' in conversations around potential questions that could be asked of women upon presentation to emergency departments. Many existing screening tools described previously in this thesis ask women if they feel 'safe' or if they are 'afraid' of anyone. The women victim/survivors stated that these words were 'too' strong, or some did not think they were 'unsafe', and others did not feel 'fear' all the time, and therefore they might have said 'no' if asked if they were afraid or unsafe and would have responded more positively to being asked if they worried about any aspects of their current or past relationships. The women stated that they may have had a conversation about what was worrying them, not knowing they would be disclosing experiences of coercive control or abuse. Privileging the words, expressions and meanings of the women victim/survivors prioritises their discourses, lived experience and meanings, and

in doing so, demonstrates aspects of both feminist research practices and critical social work principles used in this research. Reflecting on use of language as a professional power signifier was also important and attention was paid to language in the information communicated to participants for the different research stages, with different forms of expression used for different participant cohorts. This is explored further in the following chapter on methodology and methods.

Understanding the meaning within language and discourse was important with all participants in this research. For example, it was necessary at times to deconstruct the language used in the interviews with social workers, through challenging and inviting participants to reflect on the use of certain terms and phrases, to uncover less obvious discourses and instances of professional power. During some interviews with emergency department social workers, it became apparent that language reflected beliefs and internalisation of myths that were victim blaming (i.e. 'if it's bad enough, she would leave'), excused perpetrators (i.e. 'he had a lot on his plate with her mental state') or showed overtones of colonial blindness and a lack of knowledge of the issue (i.e. 'up here in the Territory, the Aboriginal women give as good as they get'). Upon hearing this, I gently challenged the statement by asking for further clarification on what they meant, seeking evidence to support the statements, and discussing the potential consequences of these ideas for women victim/survivors.

Pease (2009) states that social work is a value-laden profession concerned with locating, naming, and challenging inequality, and oppression. Critical social work is a praxis that integrates a critical social theory perspective into the social work project. This research, and the methodology employed, aimed to locate, name and challenge current micro, meso and macro discourses and practices within emergency departments that contributed to the ongoing oppression of women victim/survivors of DFA. Critical theory was one of the two theories on which this research was based. I now discuss the use of feminist theory as a theoretical concept on which I based this research. Feminist theory sits within a suite of critical theories, not only drawing attention to the role of power in relationships, but also centralising gendered experiences of oppression and inequality and highlighting gender as a pivotal concept in understanding DFA (Healy 2014; Moulding 2016; Leavy and Harris 2019).

Feminism and feminist theory

My positioning as a critical social worker and my practice over the years connects with and is strengthened by my feminist understandings of DFA. Feminism is a 'broad-based philosophical perspective' (Tong 1989:1), which incorporates a range of ideologies. It is informed by concerns with cultural, political, and social practices that reproduce gender inequality, alongside other influences and social locations that enable experiences of oppression, such as class, race, geo-locations, physical ability, and sexuality (Leavy and Harris 2019). I acknowledge that there are a multiplicity of feminist theories and feminist practices.

According to Healy (2014), feminist social work theory is a modernist construct, however, there are post-modern and post-structural forms of feminism within contemporary feminist thought. These 'feminisms' underpin the theoretical base of this research and inform the methodology. Feminist theory is important to this research for several reasons including that: feminism has been pivotal in theorising DFA and positioning this as a serious public issue demanding structural change (Hill 2019); feminism calls attention to power within relationships, including within the research process (Leavy and Harris 2019); and intersectional feminism acknowledges, explores, and understands the ways in which gender and other multiple oppressions are experienced. The concept of intersectionality has influenced feminism (in particular, white feminism) to interrogate and understand multiple oppressions experienced by women from diverse social locations (Crenshaw 1991).

Feminism

Feminist theory derives from the feminist movement, described as a movement to end 'sexism, sexist exploitation and oppression' (hooks 2000:1). Describing feminism as a movement assists in understanding that there is a variety of feminist thought and positioning within 'feminism'.

Feminism evolved from the early suffrage movement in the late nineteenth and early twentieth centuries, reflecting the social locations of the western, colonial, middle class women who fought for voting and equal rights for white women (Leavy and Harris 2019). Contemporary feminisms have developed and evolved, allowing for a diversity of opinion and positioning under its banner (Tong 1989). The second wave of feminism in the 1960s and 1970s challenged the traditional roles of women, but it was not until the third wave in the late 1980s and 1990s that the concept of intersectionality was introduced through the work

of Kimberlé Crenshaw. Crenshaw's work arose out of frustration with the limitations of 'white feminism' (Crenshaw 1991; Leavy and Harris 2019). As stated in Chapter 2, intersectionality is a metaphor to describe the ways in which multiple oppressions are experienced (Crenshaw 1991). Crenshaw (1991) drew attention to and mapped intersecting social locations, exploring the ways in which these contribute to complex experiences of gendered discrimination and oppression. Post-modern feminism continues this evolution. Shepard and Dziengel (2016) argue that while feminism is a modernist construct with a grand narrative (gendered oppression) and centred on a particular identity of 'woman', post-modern feminism challenges binary understandings and categories of 'woman', celebrates 'other' and works to deconstruct the gendered narrative that supports this (Tong 1989).

Boyle (2019) proposes the term 'continuum thinking' when exploring the range of ideas and opinions within feminist thought and I use this concept in my understanding of the evolution of feminism and feminist theory and how this pertains to DFA in this research. Boyle (2019) takes this concept from Liz Kelly's (1988) work on the continuum of sexual violence, and argues that as with experiences of sexual violence, a continuum provides a way forward in enabling feminists to identify underlying commonalities and connectivity when exploring links between gender and violence. Boyle states, 'Continuum thinking' can offer important interventions which unsettle binaries, recognise grey areas in women's experiences and avoid 'othering' specific communities' (Boyle 2019:19).

Boyle's (2019) 'continuum thinking' allows for the development and progression of feminist thought which has been necessary for feminism to move towards more nuanced and inclusive understandings that give voice to the experiences of women from multiple social locations and assists in acknowledging diversity and highlighting the need for inclusivity. The concept of continuum thinking also allows for some aspects of post-modern feminism to guide this research, while at the same time allowing me to argue that the concept of 'gender' remains central in my understanding of DFA. This is important, as working from a gender-neutral position would be to work in a way that is contradictory to a feminist analysis of DFA.

There are several broad and unifying principles under the feminist banner, common to all feminist thought. These include offering an analysis that centres on critiquing patriarchy and gendered-based inequality and the ways in which this is enabled and reproduced, working towards emancipation from gender-based oppression, promotion of choice and freedom from traditional stereotypical gender-based roles, and prioritising women's rights as

human rights (Dominelli 2002; Morley and Macfarlane 2008; Buchanan and Jamieson 2016). In other words, feminism presents a lens through which we can understand and analyse the ways in which patriarchal privilege devalues and makes invisible the multiple experiences, voices and identities of 'woman' and the consequences of this (Orme 2013).

Theorising domestic and family abuse

Feminists have long argued for DFA to be taken seriously as a public issue and have politicised and theorised the issue through the lived experiences of women victim/survivors (Scutt 1983; Hill 2019). Pease (2019) states that feminist theories characterise DFA as planned and repetitive forms of coercive control, consistent with the ways in which traditional gender roles are reinforced. This reinforcement leads to culturally accepted behavioural norms consistent with these traditional gendered role expectations which, if not acknowledged and addressed, can have oppressive consequences. Feminism has positioned gender as central to DFA, arguing that a feminist theoretical perspective acknowledges the unequal power positions assigned to heteronormative gender identities and challenges the societal structures and discourses that allow and reproduce these norms (Pence and Paymar 1993; Wendt 2016).

The WHO (2009) describes 'gender' as socially constructed characteristics ascribed to women, men, girls, and boys, which become accepted identities within a society. While acknowledging that the category of gender is socially constructed, this research also acknowledges that privilege and oppression is promoted and sustained within this construct as those social norms are embedded within social institutions and the associated practices. Pease (2019) argues that DFA is the result of the private expression of this public gendered norm. This research interrogates how this occurs within health system responses to women victim/survivors of DFA, and the consequences of this. This research is not dismissing multiple gendered constructs and identities of 'woman' or the multiple ways in which individuals experience or express gender, however, for the purposes of this research it is understood that gender-blind language and practice, specifically in health systems and health system responses to women victim/survivors of DFA, has critical consequences for those victim/survivors, including blaming, individualising, pathologising and labelling individual women.

Moulding (2016) argues that feminist informed approaches position women's distress within the gendered power relations that 'frame their lives' (Moulding 2016:190). This means

that feminist informed approaches understand and interpret many manifestations of women's distress as being a result of the impacts of living and dealing within these gendered power relations. This is particularly important to this research, as the interpretation of these manifestations of women's distress within a health setting are often bereft of understanding this broader gendered context. Mainstream health services sit within the medical model, where practice is based around diagnosis and medication on the assumption of gender neutrality. This blindness to the health manifestations and consequences of gendered oppression, leads to practice that is deficit based and contributes to further oppression (Moulding 2016). Roberts et al. (2006) discuss the medical model as one that is determinist in nature and one where individualised treatment is emphasised (Humphreys and Thiara 2003). They argue that this model and approach to health is simplistic, with consequences for a woman victim/survivor of DFA by placing the responsibility for her presenting behaviour within her own dysfunction. Therefore, using feminist theory in this research will mean a focus not only on a gendered understanding of DFA but also on challenging the health system and responses to the manifestations of women's distress that result from DFA.

Morley, Ablett and Macfarlane (2019) state that feminist theory promotes the experiences of women and seeks change through structural reform, addressing social and political disadvantage and challenging inequitable societal arrangements. This is important to this research as working from a feminist position means that I worked alongside women to understand and promote ways to address the consequences of the inequitable gendered social arrangements they experienced through DFA and subsequent interactions with the health system. It also means I am committed to examining the ways in which emergency departments, and those that work within them, identify and support women victim/survivors of DFA and to advocate for change if this system is undermining the safety and wellbeing of these women.

Aspects of post-modern feminism also guide the theoretical principles, and therefore the methodology, of this research. Post-modern feminism (as with post-modern critical theory) embraces the 'plurality of truth' (Wendt 2016:12), deconstructing traditional assumptions and interrogating the power relations within those assumptions (Healy 2014). Post-modern influences include the deconstruction of dominant discourses, honouring subjectivity by positioning people as experts of their own lives and self-reflexive practice on behalf of the professional (Healy 2014). In this research, as previously discussed, the inclusion

and privileging of the women's language and terminology, and the meaning within this language, challenges medical and social work discourses around DFA and victim/survivor identity, and the power that is inherent within these discourses. Post-modern influences in feminist thought argue for the acknowledgment and inclusion of diverse identities, allowing for the contribution of the subjective experiences of these multiple identities and the ways in which oppression is borne within them (Fraser 2008; Morley and Macfarlane 2008). This research also works to deconstruct the medical discourses that have positioned women victim/survivors of DFA as 'problematic' or 'deficient', alongside an examination of the consequences of gender-neutral/blind practice with DFA victim/survivors.

Morley and Macfarlane (2008) argue that it is important to incorporate feminisms (including post-modern concepts) into critical social work as it can assist in reconstructing possibilities for individual and community agency, it values a variety of ways of knowing, and it acknowledges and allows for complexity of context and identity. While positioning myself as a feminist critical social worker, and employing feminist ontology, epistemology, and methodology in this research, I am aware that aspects of the model of public health policy intervention that this research is exploring could be seen as contradicting feminist critical theory, and I explore this next.

Contradictions in arguing for state intervention

This research, based on feminist critical theory, not only interrogates the consequences of emergency department practices for women experiencing DFA, but is also committed to advocating to change oppressive practices. This could be understood to be incongruent with the feminist principle of working towards facilitating increased agency in the lives of women victim/survivors (as stated previously) and therefore at odds with elements of feminist critical practice. This is a valid concern as state intervention and public health policy in dealing with DFA have often directly or indirectly, held women responsible for their situation, for the risk to themselves and their children, or for any action needed to address their situation (Humphreys and Thiara 2003; Stanley and Humphreys 2015). Forms of state intervention designed to 'assist' women in DFA situations have often led to increased surveillance of those women and become a form of oppression with punitive and disempowering consequences for those women and their children (Bumiller 2010; Stanley and Humphreys 2015; Buchanan 2016; Laing 2016; Moulding 2016). Herman (1997) referred to this punitive and

disempowering response as creating secondary traumatisation in women and children. Bumiller (2010) argues that increasing the role of health professionals to identify the presence of DFA will lead to an 'uncritical acceptance of punitive solutions and the development of an apparatus of social control in the name of preventing domestic violence' (Bumiller 2010:182).

Daniels (1997) examines many of the tensions for those advocating to ensure increased safety for women and children through changes in state intervention and argues that the ability to participate and work within the limits of state sanctioned policy is a valid and reasonable way for feminists to pursue their goals. Daniels (1997) claims that feminists must hold the state accountable as it is the state and its institutions that reproduce and sanction the conditions that enable continued violence, abuse and oppression, and that working to confront, challenge and change these conditions is a legitimate feminist activity. State intervention leading to punitive and disempowering consequences for women victim/survivors of DFA is not an argument against state intervention per se. However, as Daniels (1997) argues, state intervention facilitates the agenda of patriarchy. An important contribution of a feminist critical intervention is to make this visible, and to understand the complex processes by which this occurs, alongside ensuring that suggestions for a way forward contribute to the empowerment, education and support of women experiencing DFA. This research makes these practices visible and advocates for change.

My position as a feminist critical social worker over the past 30 years in DFA, leads me to understand that we need a multi-pronged approach to address this issue. My emphasis on empowerment and reflexive practice informs my work as a feminist critical researcher and influences the theoretical underpinnings and methods in this research.

My personal experiences

As a social worker working in the field of DFA for over 30 years, I have had access to theories, knowledge and information that explain gendered inequality and the resultant systemic discrimination. This understanding informed my practice when working with victim/survivors of DFA. For 18 years of this time, I was also living with DFA, and I have been recovering from this for the past 12 years. With all the knowledge and theory I had access to, the power of an individual over me kept me confused, silent, ashamed, and unable to articulate my experiences for many years. This silence and control were compounded by the fact that the

perpetrator was also a social worker, who espoused critical social work theories in his practice and feminist ideals in his life to those in our professional and personal social circles. I will discuss the steps I took to interrogate the impact of my own experiences on this research in the following chapter, however, it needs to be said at this stage that the stigma I felt in working as a social worker while living with DFA heavily influenced my decision not to disclose my experiences of DFA when interviewing other professionals for this research. Aside from seeking to keep the interviews focused on professional conversations and practice, I wanted to avoid the judgement and stigma I had encountered from some in the social work/family violence field, towards colleagues who publicly discussed their own lived experiences. Beckett argues that the social work profession falls into the trap of promoting slogans which can become 'reductionist assertions' (Beckett, 2006:172) or acts of tokenism. I would argue, based on my experience, that the growing emphasis on the inclusion of 'lived experience' in social work and other fields can be tokenistic and, as such, lead to the potential to 'other' the individual who shares their lived experience. In doing this research, I wanted to be considered by my colleagues as a serious research student, with experience as a professional in the DFA field. I did not want to be seen or treated as the 'other' and did not want the interviewees to discuss their views and ideas with me through the lens of themselves as 'worker' or 'professional' versus myself as 'service user' or 'victim/survivor'.

My past experiences have led me to understand that many social worker/family violence professionals have difficulty in acknowledging and accepting multiple identities (i.e., in this instance, those of professional and DFA victim/survivor being the same person). Workers who demonstrate victim-blaming or victim-deficit narratives in their practice invoke feelings of shame and stigma in a colleague who is also a victim/survivor, which has the effect of silencing a professional with experience of DFA. This demonstrates both an inability to conceptualise post-modern notions of multiple identities (in that a professional can also be a victim/survivor), and an assumption of inherent, unequal power differences between professional and victim/survivor. This is also a missed opportunity, where practice could be enriched through experiential insight, especially when considering the statistical reality of the role gender plays in the likelihood of being a victim/survivor of DFA, and the implications of this when considering the gendered composition of those in the social work, family violence and health professions.

At the beginning of this thesis, I discussed my motivation for this research and centred this on my experiences of working as a crisis social worker in a trauma hospital. While this was my main motivation, I cannot separate this from my own experiences of help-seeking behaviour for health issues because of the abuse I lived with. I sought assistance for health-related consequences of the abuse on several occasions but did not disclose until the final presentation. At that time, the health professionals framed my emotional distress as mental illness. The conversation from that point, and suggested treatment revolved around my deficits, not focusing on my distress being a consequence of the perpetrator's tactics or behaviour. This was not labelled as DFA or written up in my case notes as DFA, and no risk assessment or safety planning was discussed. The only referral and support offered to me was for mental health treatment, which I declined because I was not the one with the mental health problem. Upon reflection, I understand that the responses were based on ignorance and led to increased risk for both myself and my children. Rather than this being a limitation, I believe my experiences add value and validate this research.

My experiences (both personal and professional) have enabled me to communicate with other social workers working in hospital systems, those working in DFA support agencies, and very importantly, they enabled me to support and communicate on a more personal level with the women victim/survivors. The importance of this last point, and the ways in which I reflexively managed and balanced my lived experiences to interrogate and respond to potential unconscious bias, are explored later in this chapter. I also believe that my experiences have assisted me in working as an insider/outsider in this research (Leavy and Harris 2019) and deepened my commitment to ensure that the voices and perspectives of the women were respectfully acknowledged and portrayed in a way that accurately represented their experiences. In this research, both my professional and personal background have guided the theoretical and conceptual framework of this research.

Feminist research as praxis

Denzin and Lincoln (2018) argue that there are three interconnected activities that define the research process, the ontology or epistemology on which the research is based, the theory informing the methods employed, and the analysis of the information gained through the process. Feminists, post-structuralists and post-modernists have questioned traditional

positivist paradigms (Stanley and Wise 1990; Dominelli 2002; Denzin and Lincoln 2018), arguing that research is filtered through a lens that reflects the social location of the researcher, and therefore these paradigms have privileged and positioned the experiences of cis white heterosexual men as 'typical', and erase diversity. In failing to recognise diversity, traditional research paradigms disregard the significance and consequences of power relations mediated by gender and other social locations (Stanley and Wise 1990; Dominelli 2002).

As previously discussed, feminist ontology centres gender as pivotal to one's identity and to the ways in which society enables and reproduces privilege and oppression through social structures and systems (D'Cruz and Jones 2014). Therefore, the range of feminisms that inform feminist research, while encompassing many standpoints, have shared principles and characteristics. These include a focus on gender and gendered inequality, with an understanding that class and race determine material differences, and that feminist research works to privilege the lived experiences of women. Feminist research focuses attention on the processes of the research and the relationship between the researcher and the researched (Skinner, Hester and Malos 2012; D'Cruz and Jones 2014; Denzin and Lincoln 2018). Further, feminist research requires the research to challenge oppressive systems and advocate for structural and individual change, alongside the researcher working to reflect on their influence and impact within the research (Skinner et al. 2012; Healy 2014).

In conducting this research, I incorporated several strategies to reflect on the ways in which I impacted on and influenced the research process. My own experiences of DFA, of having been shamed, silenced, denigrated, gaslighted, manipulated, abused and disempowered whilst having to live in a state of confused hyper vigilance, self-blame and fear, played an important role in the processes of conducting this research as both a challenge and an asset. As a victim/survivor, I am in a unique position to understand the separation and fragmentation between the ways in which DFA is understood and categorised in the legal and professional sense, and the disconnection of this from one's lived experience. This, alongside being 'othered' by professionals and reflecting on the power differentials and assumptions that enable this 'othering' (as previously described), allowed me a unique connection with other women victim/survivors. However, I was also aware of the potential for this to contribute to unconscious bias in both the research process and the analysis of data.

Denzin and Lincoln (2018) discuss the ways in which the 'personal biography' of the researcher (i.e., class, age, gender, race, culture, etc.) contributes to the lens through which they conceptualise, configure, and perform the research. Therefore, with Crenshaw's concept of intersectionality in mind, I was aware that my experiences of DFA and other components of my 'personal biography', while having some connections and commonalities with other women victim/survivor participants in this research, were unique to me, and did not speak to the diverse experiences of all victim/survivor participants. I was mindful of the need to be constantly reflexive and alert to this in order not to generalise and elevate my own biases and ideas, with both the women victim/survivors and the social work/family violence professionals. To mitigate this risk, alongside working with my academic supervisors, I employed an external supervisor during recruitment, data collection, transcription and analysis. At first, this external supervision was to assist me to draw out my assumptions, biases, and blind spots as well as assisting me to develop a structure that enabled me to critically reflect on my reactions to content from the discussions and information both from the women victim/survivors and the other participants. This gave me the space and the tools to analyse and reconstruct these thoughts, feelings, and reactions. It soon became apparent that external supervision was also a necessary self-care tool while conducting the research. Although I had been separated from the perpetrator for many years, it was still difficult to hear 'myth-laden' responses from social work colleagues and not connect these to my own circumstances. I also used external supervision to talk and work through my feelings, thoughts, and reactions to the experiences of the women victim/survivors. Many of the experiences of abuse, perpetrator tactics, impacts on the women and children and professional responses were similar to my own. Hearing these stories and tapping into fear, frustration and injustice again triggered the reoccurrence of nightmares for me over many months. The space in these supervision sessions for reflection was therefore very important both personally and professionally.

Conclusion

In this chapter I have argued the importance of feminist critical theory as the underlying theoretical position for this research. Feminist critical theory emphasises a gendered structural analysis of DFA and of the macro systems which enable and contribute to the

oppression of women victim/survivors. I explored the use of Boyle's (2019) continuum thinking to articulate the developments of feminist thought and highlight the importance of an intersectional lens in conceptualising this issue and conducting this research.

This chapter also explored the contribution of my professional experiences as a social worker and my personal experiences as a victim/survivor. I have examined these influences over my theoretical positioning within the research, and the need to interrogate power in relationships and potential bias in the research process. Keeping in mind the theoretical framework of this thesis, in the next chapter I outline the methodology and methods employed to answer the research questions and outline the ways in which feminist critical theory influences and directs this methodology.

Chapter 5. Methodology and methods

This chapter outlines the methodology and methods utilised in this research, presents the ways in which I examined and addressed the power differentials within the research process, and outlines the steps taken to support the women victim/survivors throughout the research. I also describe the processes involved in data analysis and explore ethical considerations, limitations, and challenges.

Methodology

The methodology utilised in this research is influenced by feminist critical theory which draws primarily on modernist ideas with contributions from certain aspects of post-modernist thinking. For example, a central narrative of this research posits that DFA perpetrated towards women is the result of unequal gender power relations in society, upheld through social structures and beliefs. This is a modernist construct as it relies on a concept of gender and gendered experiences of oppression (Healy 2014); however, this research also assumes that the women victim/survivors are not a homogenous group and while there are commonalities and similarities in their broad experiences and those related to, and resulting from seeking health assistance, there is also diversity and difference. The intersections of their experiences of colonisation, gender, race, culture, age, socio-economic status, and sexuality contributed to differing and complex consequences and impacts for each of these women. This research, and the methodology employed, explored and respected those intersecting experiences, firstly through allowing space and time in the focus group discussions to explore the ways in which those intersections impacted experiences and mediated consequences, and secondly, through asking the women to read through the transcribing of the focus group discussions to ensure accuracy of expression. Finally, thoughts and ideas from the women were privileged in the discussion in this thesis, contributing to my suggestions for good practice universal screening programs in emergency departments.

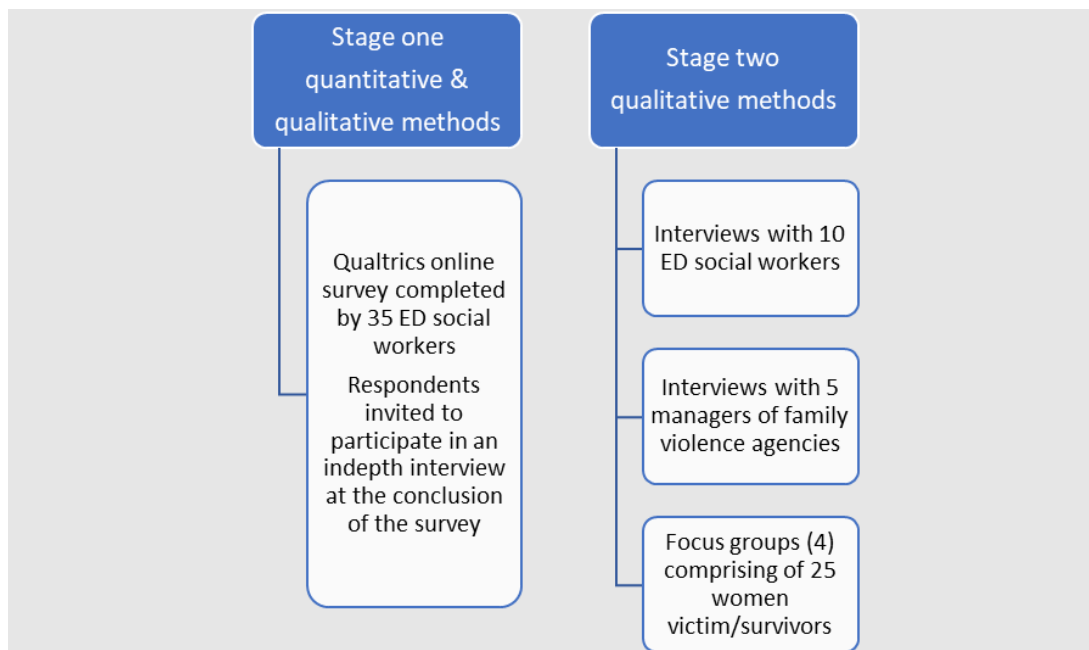
In choosing the methodology and methods, it was important to ensure that strategies of inquiry and methods of data collection aligned with a feminist critical theoretical paradigm. As well, I kept a clear focus on answering the research questions. Feminist researchers favour multiple research methods to achieve these elements, including surveys, focus groups, analysis of large-scale data sets and interviews (Skinner et al. 2012).

To gain a breadth of information I used qualitative methods in interviews and focus group discussions with women victim/survivors and with those working in the field. I also distributed an online survey to emergency department social workers across Australia. Although an online survey has its limitations, the use of open, closed, multiple choice and short answer questions within the survey resulted in a rich mix of data, allowing me to conduct descriptive statistical and qualitative analysis. D’Cruz and Jones (2014) describe quantitative methods as pertaining to quantity or number, and qualitative methods as producing data that explores values, processes, experiences, understandings, narratives, language and meaning. The online survey sought similar outcomes in that although it provided profile and demographic information, it also contributed to documenting the experiences, understandings, narratives and meanings. Another advantage of online surveys is that they are relatively low cost and convenient for respondents (Neuman 2006; Leavy and Harris 2019). In the context of a limited budget and the busyness of the hospital environment, an online survey offered respondents the convenience and flexibility of undertaking the survey at a suitable time.

The use of both qualitative and quantitative methods is a way of understanding ‘how things “are” for people – both empirically and experientially’ (Wadsworth 2010:83). Therefore, the use of a multi-method approach in this research assisted in exploring not only the breadth of what was happening in emergency departments across Australia, but also the underpinning knowledge, evidence and rationale as well as mapping the consequences for women victim/survivors, and their insights into improvements.

Data collection occurred in two stages, over a period of fifteen months, with two separate human research ethics approvals granted. O’Leary (2017) explains that a variety of methods support phased stage research as they allow for comparison and triangulation of various perspectives when analysing the data. This was true for this research. Conducting the research in two stages enabled the utilisation of several different methods of data collection and analysis, directed at different stakeholder groups, which solicited numerous and sometimes contradictory understandings of what happens for women victim/survivors in presentations to emergency departments and the potential reasons for this. The chronology of the data collection is outlined below (see Figure 1 below: Two research stages).

Figure 1 Two research stages



Stage one

The first stage involved the development and distribution of an online survey to 105 social workers from public hospital emergency departments across Australia, with 35 completing the survey. The use of an online survey (rather than interviews or focus groups) expanded the sample size (Neuman 2006; Denscombe 2008). The online survey sought to understand past and current experiences of using screening and components of different models. This survey also obtained data on how staff in emergency departments conceptualised and identified DFA where there was no screening program in place, and to understand how these workers responded to and supported women victim/survivors in those instances. In addition, the survey explored workers' knowledge and understanding of screening programs as a means of identification of DFA. I produced a snapshot of emergency department screening practices and rationales, which built out the picture obtained from in-depth interviews with emergency department social workers that followed on from this online survey, by influencing lines of inquiry used in the interviews and in the focus groups (Leavy and Harris 2019). For example, the online survey asked respondents to articulate how they and/or their department identified DFA in the absence of a screening program. The respondents provided descriptions

of specific presentations or clinical indicators which indicated the potential presence of DFA, many of which were identical to presentation experiences described by the women victim/survivors in the focus groups.

This stage received ethics approval through the RMIT University Human Research Ethics Committee (see Appendix 1: Notice of Ethics approval number 36/14) in October 2014 and was considered low risk as the participants were adults who had the capacity to give free and informed consent to participate and responses were anonymous.

Online survey

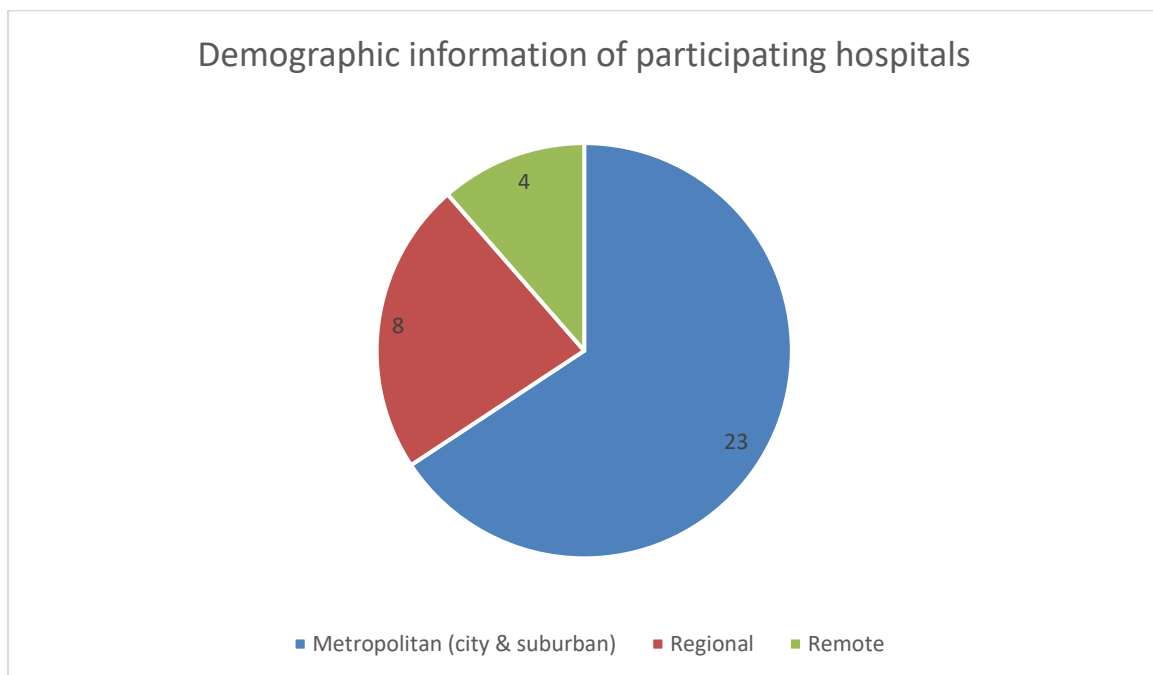
The Qualtrics software allowed me to trial and test survey questions and to monitor the real time status of completions. This was important in terms of being able to follow up with a reminder email to the social work department when necessary. The survey was anonymous, which protected the identity of the hospital and social worker and addressed the ethical requirement for confidentiality and any concerns that the workers may have had regarding potential identification of themselves or their hospital. This anonymity allowed workers to respond more openly when discussing the issue and the ways in which their department worked in this space.

The survey contained a mixture of open, closed, and short answer questions. The closed questions were designed to gain measurable and demographic information such as type of hospital, location, size, and screening processes. The short answer questions provided further information on the ways DFA was identified in female patients, and the processes after identification. The survey also included an invitation for respondents to participate in a one-to-one interview, as part of stage two of the research. This online survey was piloted by myself, my supervisors and two hospital social work colleagues. As a result of the pre-test some questions were adjusted prior to the distribution of the survey.

To reach as many emergency department social workers as possible, I conducted an internet search of the 289 public hospitals with emergency departments listed in the AIHW hospital statistics report (AIHW 2014) to ascertain whether there were social work services in those hospitals. To increase the potential reach for emergency department social workers, I also submitted a request to the AASW research committee, for details of the study to appear in the AASW online e-bulletin. This online bulletin was emailed to over 30,000 AASW members throughout Australia. The only inclusion criteria were that the hospital had both an

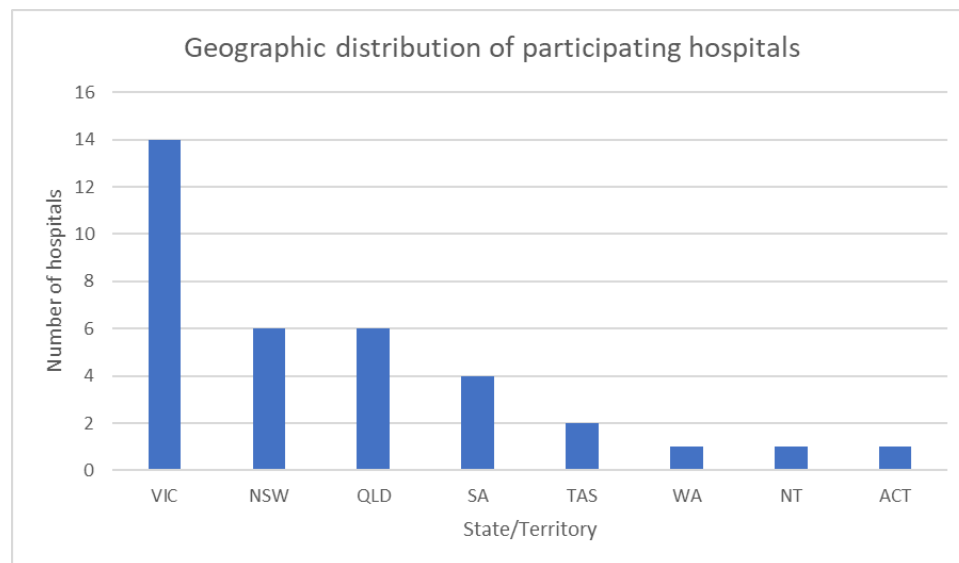
emergency department and a social work service. As a result of these methods, I identified 135 potential social work departments in hospitals that also had emergency departments and in March 2015 sent an email to these departments (see Appendix 2: Sample email to social work department). The email explained who I was and included a brief explanation of the research project along with a request for the email to be forwarded to the social worker assigned to the emergency department. This email was accompanied by the participant information form for this stage of the research (see Appendix 3: Participant Information Form – online survey). It was then left to the emergency department social worker to reply to the email if they wished to participate in the survey. Of those 135 first email requests, I received 105 responses from social workers who expressed interest in participating in the online survey. I then contacted those social workers via email and included the participant information form and link to the online survey (see Appendix 4: Sample email to Qualtrics Survey participants & Appendix 5: Qualtrics online survey questions). I kept a respondent audit register during the month that the survey remained open and sent two reminder emails to those who had not completed the survey during this time. The completed surveys came from hospitals across Australia and used AIHW categories of metropolitan (city and suburban), regional and remote locations. These categories aimed to ensure a variety of hospital size and geographic location (see Figure 2 below: Demographic information of participating hospitals).

Figure 2 Demographic information of participating hospitals



Of the 35 returned surveys, two social workers identified their hospitals as specialist women's hospitals, 31 were categorised as generalist, and two were reported as 'other' with no further explanation. Thirty-three respondents identified as social workers, with the remaining two respondents describing themselves as having a social work background with position titles such as emergency department manager or care coordinator. Thirty-one respondents identified as female and four as male. Every state and territory were represented (see Figure 3 Geographic distribution of participating hospitals).

Figure 3 Geographic distribution of participating hospitals



As can be seen, many participants worked in Victorian hospitals, and I attribute this to being more well-known in Victoria than the other states and territories. The results of these online surveys are discussed further in the later chapters of this thesis.

Stage two

Stage two utilised data from semi-structured interviews and focus groups. Bryman (2015) describes qualitative approaches as encompassing a wide range of interviewing styles, including the semi-structured interviews I conducted with emergency department social workers and managers of family violence agencies, and the focus groups with women victim/survivors of DFA. These qualitative methods built on the information gathered in stage one, as well as bringing in the voices, experiences and knowledge of women victim/survivors. This stage received RMIT University Human Research Ethics Committee (see Appendix 6: Notice of Ethics approval number 19459) in August 2015.

It was important that the methodology used in this research, based on feminist critical theory, privileged the experiences and voices of the women victim/survivors, alongside locating the subjective experiences of all participants within broader cultural understandings of DFA (Leavy and Harris 2019). To achieve this, focus groups comprising women

victim/survivors were used, with attention paid to accurate and respectful representation of their experiences, through clarifying vague or ambiguous contributions and giving the women an opportunity to read through the transcriptions of the sessions prior to use in this thesis. I used semi-structured interviews with emergency department social workers and managers of family violence agencies, to gain a deeper understanding of the information collected through the surveys (D'Cruz and Jones 2014).

Interviews with emergency department social workers

Twenty-four of the 35 social workers who completed the online survey nominated to be interviewed at the conclusion of the survey. Of these 24 social workers, ten were selected based on representing a wide variety of hospitals throughout Australia. Emails were sent to all those who nominated for an interview, thanking them for making themselves available. For those who were not selected for an interview, the email stated the reasons (e.g., too many already from that state/territory, or too many large hospitals in the sample already) and for those who would be interviewed, emails contained an invitation to nominate a time for a telephone interview. This invitation also attached the Participant Information Form (PICF), (see Appendix 7: ED Workers Participant Information Form), and interview questions. Factors taken into consideration for involvement in the interviews included the geographical location of the hospital for state and territory representation, and a mixture of metropolitan (suburban and city), regional and rural hospitals, as well as different 'categories' of hospital (i.e., general or women's specialist hospitals). See Table 1 below, ED worker interviews: hospital location and demographic.

Table 1 ED worker interviews: hospital location and demographic

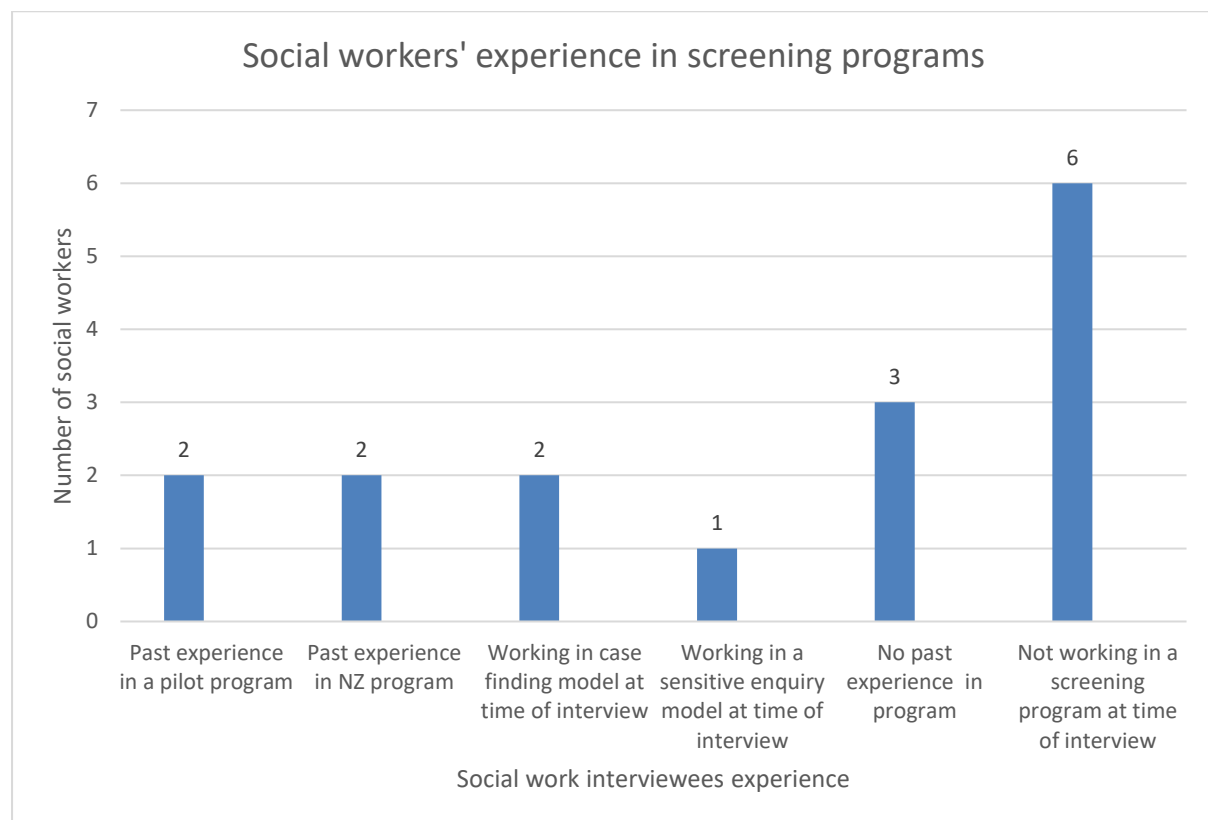
State or Territory	Hospital demographic
Tasmania x 1	Metropolitan hospital
Queensland x 2	Regional hospital Metropolitan women's hospital
South Australia x 1	Metropolitan hospital
New South Wales x 2	Metropolitan hospital Regional hospital
ACT x 1	Regional hospital
Northern Territory x 1	Metropolitan hospital
Victoria x 2	Metropolitan hospital Metropolitan women's hospital

The use of an interview guide ensured that the interviewees were asked the same questions, enabling comparison in analysis and the development of themes, as well as creating space for participants to contribute to the interview as they saw relevant. Sending the questions prior to the interview also allowed the interviewees some time to reflect on the information before the interview (see Appendix 8: ED Workers Interview questions). Also attached to the email with the interview questions was a copy of the verbal consent form that I explained would be introduced at the beginning of the interview (see Appendix 9: Verbal consent sheet for ED social workers). The selection also included social workers from two women's hospitals, with the expectation, informed by the literature, that these hospitals would have a higher concentration of victim/survivors amongst their presenting cohort, given their patient population.

Varying levels of experience in DFA and screening were represented in the sample (see below, Figure 4: Social workers' experience in screening programs). Two of the ten had experience in hospitals with screening programs that had ceased, three were currently working in screening programs, two in case-finding models and one in a model of 'sensitive inquiry', while two had worked in screening programs in New Zealand. The final worker was developing a program for their hospital emergency department. By choosing social workers from different geographic locations and hospital types along with diverse levels of experience,

knowledge, and practice, I anticipated rich and varied information would be shared. As can be seen in the figure below, some interviewees had multiple experiences which accounts for why this figure totals more than ten participants. For example, the two social workers who had experience in the New Zealand VIP were working in screening programs in Australia at the time of interview.

Figure 4 Social workers' experience in screening programs



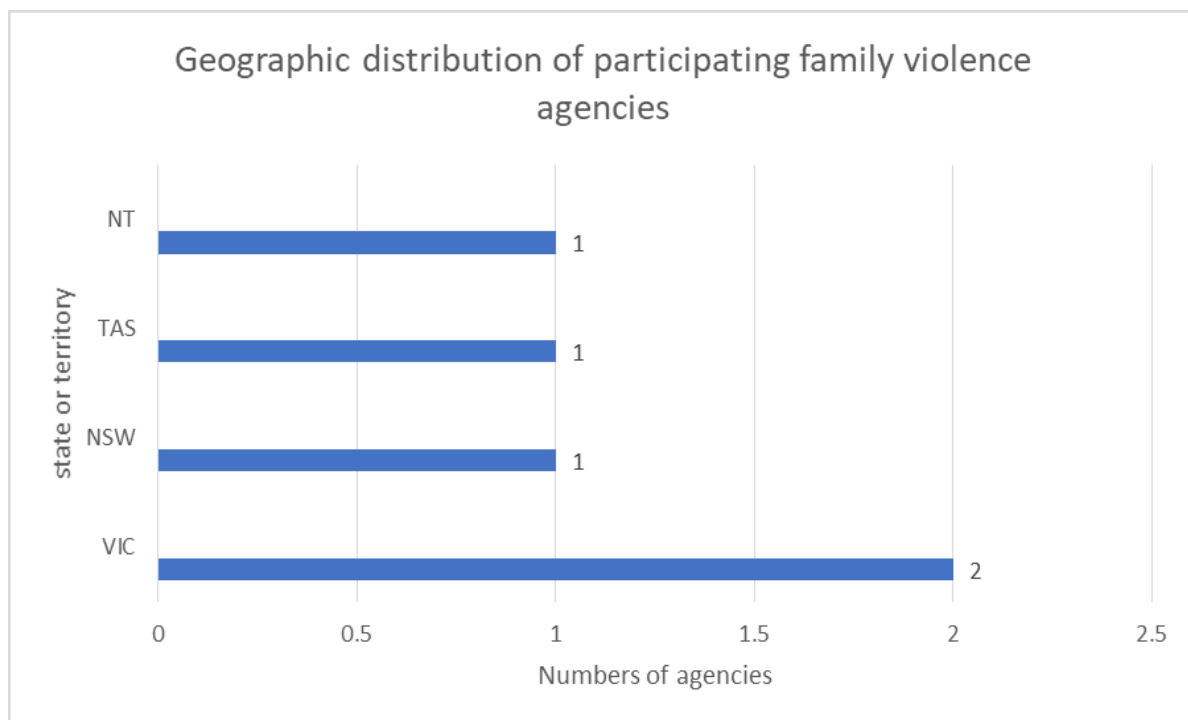
The interviews were scheduled for a time convenient to the interviewees, with three of the interviews rescheduled due to work demands on the social workers. It would have been possible to conduct face to face interviews with the Victorian social workers, however, to ensure consistency, all interviews were conducted via telephone. At the beginning of the interviews, participants were thanked for participating in the research, and research protocols concerning consent, recording of the interviews and storage of information were discussed. The verbal consent forms were introduced prior to the commencement of the interview to ensure that consent was understood and received. It was explained (and included in the participant information form) to the participants, that interview recordings would be saved on my password protected RMIT University computer and then deleted from the

recording device. At the beginning of the interviews, I also acknowledged that because DFA is a gendered issue and between one third and one quarter of women experience intimate partner abuse at some stage in their lifetime, I was aware that this may be an issue for some of those I was interviewing. I encouraged them to take their time, reminded them they could stop, and spoke to them of community support should they need this. No social worker nor any of the managers of family violence agencies disclosed personal experiences of DFA during the interviews or asked for the interview to pause or stop.

Interviews with managers of family violence agencies

In addition to the ten emergency department social worker participants, five managers of family violence agencies were interviewed. To select the latter sample, I conducted an internet search of each state and territory. The selection criteria included both peak bodies for women's family violence services or a state-wide family violence service for a particular state or territory. Emails were sent to ten managers of these organisations, covering all Australian states and territories, with the PICF attached to the email (see Appendix 10: PICF for managers of family violence agencies). Five of those managers agreed to the request for an interview. Phone interviews were scheduled, a copy of the questions and consent form were sent (see Appendix 11: Interview questions for managers of family violence agencies), prior to the interview (see Appendix 12: Managers, verbal consent form). As there were only five managers who consented, all were interviewed. Managers came from Victorian, Tasmanian, NT and NSW family violence agencies, each with state-wide jurisdiction. As can be seen in this distribution, the managers interviewed did not represent all states and territories across Australia, with SA, the ACT, Queensland and WA not included. (See Figure 5 below: Geographic distribution of participating family violence agencies).

Figure 5 Geographic distribution of participating family violence agencies



Focus groups with women victim/survivors

Feminist critical research challenges structural oppression and does this through privileging the language and lived experiences of women, paying attention to process and taking a reflexive stance to address power differentials (Skinner et al. 2012; D'Cruz and Jones 2014; Healy 2014; Denzin and Lincoln 2018). To hear the voices and include the lived experiences and reflections of women who were living with or dealing with DFA at the time of presenting to an emergency department, I conducted four focus group discussions with 25 women. O'Leary (2017) describes focus groups as an organised and directed discussion examining a specific topic or concern. Focus groups allow participants to bounce ideas and experiences off each other, which can give rise to deep discussions that may not occur through one-to-one interviews (Leavy and Harris 2019). Criteria for inclusion as a focus group participant was restricted to women who were separated from the perpetrator and who were connected to an existing facilitated support group. There were two reasons for these criteria, the first was to ensure as far as possible that the women were not still living with the perpetrator, as their participation in this research could have placed them at greater risk. The second was my assumption that women involved in a support group would have an established connection and avenue of support with other women in the group and/or the group facilitator. I was

mindful that these factors would provide some support and a sense of safety for the women, minimising anxiety that they may experience as a result of participating in these sensitive discussions.

The benefits of support group participation for survivors of DFA have been well documented and note that these groups offer women victim/survivors the opportunity to meet and talk with other women, immediately challenging the isolation tactics employed by perpetrators (Goldberg Wood and Roche 2001). Alongside an educational component of survivor support groups, the sharing of stories and experiences allows women victim/survivors to deconstruct internalised self-blame in relation to their experiences of abuse. At the same time, support groups assist women to reconstruct their understandings of their experiences of abuse and highlight perpetrator responsibility. These groups also promote a sense of connectedness and empowerment around the structural and political implications of their personal experiences. Disruption and resistance to the ways in which women view themselves (and their understanding of socially constructed ideas and beliefs related to DFA) are extremely powerful components in the recovery process (Poels and Berger 1992; Goldberg Wood and Roche 2001).

Although the inclusion of women's voices in this research was important, it was equally important that alongside their reflection and discussions, their participation did not add to their trauma and anxiety. I was hopeful that their contributions to the research created a sense of being valued and contributing to some positive and constructive work. Buchanan and Wendt (2017) argue that one of the clear intentions in conducting feminist research is to ensure it is valuable for women, and it is not enough to simply just involve women. Roof (2012) states that it can be empowering when women victim/survivors understand they have important knowledge to contribute to the research process. To add to this, when their contribution is valued by a researcher who pays attention to and validates what they say, it can be beneficial for the victim/survivor. Therefore, it was very important to ensure that feminist research principles were employed here, with a focus on reducing as much as possible the power imbalance between myself as the researcher and the women as the researched, as well as communicating with warmth and respect, providing information and resources, assuring confidentiality, assisting them to have some sense of control and choice throughout the discussion, validating their experiences and framing their contributions as important and necessary (Buchanan and Wendt 2017). As previously stated, critical social

work theory also incorporates a commitment to addressing oppression at all levels, therefore it was important to use a structural lens throughout the focus group discussions, to ensure that the conversation included a focus on structural contributions to the women's experiences, and not on individual deficits. For example, during discussions where women discussed the guilt they carried at not leaving the perpetrator sooner, I focused the conversation on the many barriers that exist. The women discussed the lack of safe, supportive and affordable housing, lack of legal protection and income security, alongside gas-lighting tactics of perpetrators which left many not knowing they were in a DFA situation. I also included time at the end of the focus group discussions for reflection to explore their participation as a potential act of resistance. I will expand on this later in this chapter.

To recruit women participants, I contacted support group facilitators through the Domestic Violence Resource Centre Victoria (DVRCV) support group directory and then through a state-wide survivor/advocacy program with an 'Invitation to participate in research' flyer (see Appendix 13: Invitation to Participate in Domestic Violence Research). This invitation used less formal language than the PDCF, to appear as inviting and non-threatening as possible, alongside attempting to ensure that I was addressing the power differentials conveyed through professional and research language. In this initial email to the group facilitators, I also included the verbal consent sheet (see Appendix 14: Verbal consent sheet for women participants), alongside the questions to guide the focus group discussions (see Appendix 15: Questions to guide the discussions in the focus groups). I explained in the email that I would have a conversation with the women about the consent sheet prior to the commencement of the focus group discussions. I sent this information through as I wanted to ensure that the women were as prepared as they could be prior to the focus group discussions.

The focus group discussions were scheduled to run for 90 minutes, including time for introductions, an explanation of ethical issues and a short debrief at the end of the conversation (see Appendix 16: Debrief guide). The group participants were given the option before the commencement of the focus group, for the support group facilitator to remain in the room as a support for the women during the discussion. All groups agreed that this would be preferable. The focus group discussions went for longer than planned, at approximately two hours each, with a break for refreshments (provided by me) at the halfway mark. In two of the four groups the women did not want to stop talking, and refreshments were brought

back to the group to continue conversations. The women appeared comfortable with each other, with their familiar support group meeting space and with their support group facilitator.

At the time of participating in the focus group discussions, all the women were living in Victoria. I made the decision to hold focus groups in Victoria due to financial limitations around the cost of travelling interstate. However, during the discussions it was revealed that nine of the 25 focus group participants had lived outside of Victoria during the time they were living with DFA. Five women lived in rural areas at the time of the abuse, which added complexity for them when seeking assistance, including having to travel long distances to access services in areas where the perpetrator was not known. The implications and consequences of this for those women will be discussed further in Chapters 6 to 9.

Data collection and analysis

There were several forms of data collection and analysis employed. The online survey software generated a report providing descriptive statistical information on hospital location, type and size, professional background of the respondent, and presence and duration of any screening protocol. To analyse the qualitative information from the short answer questions on the surveys, I used descriptive and values coding, identifying similarities and differences to develop themes related to identification and indicators of DFA, and knowledge and attitudes towards screening in emergency departments (Leavy and Harris 2019). Saldana (2013) describes values coding as focussing on power issues and disparities or conflicts in data. This was useful to make sense of the disparities between the women's experiences of treatment in emergency departments and the social workers' expectations of their responses. This information was also used to inform and supplement questions for the interviews and focus groups that followed on from the surveys.

The interviews with the emergency department social workers and managers of the family violence agencies, and the focus group discussions, were initially recorded and transcribed by myself, giving me the raw material to work with. Transcripts of focus group were emailed to the support group facilitators for distribution to the participants in the focus groups, to ensure that the women were satisfied they had been truthfully and respectfully

represented and that they were confident they could not be identified (Leavy and Harris 2019). I did not receive any requests for adjustments or changes to the transcriptions.

I followed O’Leary’s (2017) process of reflective analysis, which after collecting and organising the raw data, involved coding the transcripts, searching for patterns and interconnections, then mapping and building themes from these before moving on to analyse and interpret the meaning of these themes. This then led to the findings, and enabled conclusions to be drawn (O’Leary 2017). I chose to manually code transcripts, as opposed to using a computer software program, because I did not want to prematurely ‘typify’ any information. Denzin and Lincoln (2018) discuss the risks of premature typification when using software programs and argue that the creative and interpretive nature of this process is political process and viewed through the social locations of the researcher. As has been previously discussed, research based within a critical feminist paradigm calls for the researcher to understand and acknowledge their own biases and social location ‘lenses’ and address the ways in which these may be impacting on the research processes (Healy 2014). Having physical copies of the interview and focus group transcripts allowed me to manually code themes, and then reflect on the interpretation I was placing on this information to examine and critically interrogate my own social locations, experiences and related influence.

Using feminist critical theory meant that oppressive practices and systems could be made visible in the research process (Skinner et al. 2012; Healy 2014). Therefore, I had to be vigilant when analysing and coding data to identify any narratives signifying structural oppression and challenge these in my analysis. For example, in the interviews with the emergency department social workers, one interviewee stated that women in family violence relationships did not disclose because many had grown up with child protective services in their lives (ED worker, large metropolitan hospital, QLD). It was important to ensure that this was not coded as a ‘barrier to disclosure’, but that the oppressive underlying narrative signalling a victim-blaming myth was explored. Due to the quantity of raw data from the interviews and focus groups, I analysed each stakeholder group’s data separately and then identified patterns across and between the groups. For example, one theme was that the women victim/survivors were not aware that many of the perpetrators’ behaviours were examples of coercive control. Connected to this was another theme where the majority of the women victim/survivors did not link their health issues to coercive control, as they were unaware that they were living with abuse. Many of the emergency department social workers

demonstrated that they had limited understanding of the signifiers of coercive control and the connection between this and the presenting health issues for women victim/survivors.

The mapping of these themes assisted in developing an understanding of important and recurring characteristics, some consistent with literature and research, and others leading to new insights. The themes identified through data analysis form the basis of Chapters 6 to 9.

Ethical considerations

Human research into emotionally laden and sensitive issues, as is the case with research into DFA, can involve challenges and risks to participants and to the researcher, who has the responsibility to represent information and data in a respectful and truthful manner (WHO 2001; Buchanan and Wendt 2017). Further, critical feminist research dictates a number of ethical considerations.

Feminist research requires us to balance embodied standpoints, commitments to social and political justice, and respect for the dignity of all those affected by our research practice.

(Leavy and Harris 2019:95)

As previously noted, two Human Research Ethics Committee approvals were granted for the separate stages of the project. During the research process, I was mindful of adhering to ethical conduct outlined through the NHMRC guidelines, the WHO recommendations regarding the ethical conduct of research in DFA and the AASW Code of ethics. These guidelines focus attention on ensuring research is ethically just, has merit, facilitates safety and respect for participants and considers the potential risks and benefits for both participants and the general community (WHO 2001; NHMRC 2007, 2018; AASW 2020a). I now discuss the steps I took to address these issues.

Respect for participants

Ethical guidelines state that research must incorporate respect for participants, ensuring they are free to decide to participate; that the research is just, in that it has merit; that the researcher acts with integrity; that it demonstrates justice in terms of fair selection of participants and a fair distribution of benefits and burdens; and that it enacts beneficence by considering risks and benefits for participants alongside the general community (NHMRC 2007, 2018).

This research has merit because it has potential benefits for all participants, working towards reducing harm and increasing safety for women experiencing DFA, and improving the conceptualisation of DFA in hospitals and advancing screening practices. The research gave women victim/survivors, workers and managers an opportunity to contribute to the advancing knowledge about screening for DFA (WHO 2001), including a greater understanding of the role of coercive control and the ways in which this impacts the internalised belief systems of victim/survivors and practitioners, and the response of health systems.

In my dealings with participants, I only asked questions relevant to the research and conducted the surveys, interviews and focus groups with honesty, openness, and reliability to promote research integrity (NHMRC 2007, 2018; AASW 2020a). I was open and honest with participants around the aims of the research and what their participation would entail in terms of time and commitment. I was also conscious to ensure that I was on time for all interviews and focus group discussions, demonstrating respect for participant's time, and rescheduled interviews when requested. I came to this research through my professional work as a feminist critical social worker, therefore, I practiced from a recognised social work knowledge base. I also acknowledged potential conflicts of interest with participants by advising hospital social workers of the aims of the research and my previous social work roles in hospital settings and ensured that the women victim/survivors were aware of this and my experiences of DFA (AASW 2020a).

Buchanan and Wendt (2017) state that when carrying out research with women concerning their experiences of DFA, there are benefits when this is conducted by clinically trained female interviewers, with experience in working with trauma responses. My professional social work practice experience and associated ethics assisted me by ensuring this research was conducted with integrity as I have a firm knowledge base and a commitment

to upholding the human rights of research participants (AASW 2020a). I believe that this professional experience, combined with my personal experiences, enhanced my ability to communicate in a supportive, respectful and trauma informed manner. Alongside this, I was aware of the need for reflection and reflexivity in my research practice and processes (Leavy and Harris 2019). As previously discussed, I attended to this through external and academic supervision, as well as continuously reflecting on my own position within this research process by situating my personal, professional, intellectual self during the different stages of this research. I was aware of my many roles in the research process, from researcher to facilitator, educator, colleague, collaborator, and advocate, and I was constantly aware of the need to negotiate these as I progressed through this research.

Confidentiality

Confidentiality, what that meant and how it would be maintained, was discussed with all participants prior to the commencement of online surveys or interviews/discussions. The emergency department social workers were identified by state and demographic type of hospital (i.e., metro, regional, rural). Workers were advised of this through reading the participant information at the beginning of the online survey or during the initial discussion on confidentiality in the interviews (also on the participant information form) and agreed to proceed with this knowledge. The focus group participants also had information regarding confidentiality sent to them prior to the scheduled group sessions, and I then read this information and discussed it with them, prior to commencing the focus groups. The women had previously talked about confidentiality as part of their support group rules, so were familiar with the concept. All research participants were advised prior to the interview/focus groups that I wished to record the interviews, but that this was negotiable, depending on their permission. Participants were advised this was for my benefit to assist with accuracy of recalling discussions and that this information would be transcribed, saved on my RMIT password protected computer and deleted from my phone. All participants consented to interviews and focus groups being recorded. The women victim/survivors chose their own pseudonyms at the beginning of the focus group discussions, to assist in protecting their identity.

Participant safety

Research on DFA must be conducted with respect to ethical and safety considerations, therefore, it was ethically important to ensure that all participants felt physically, emotionally, culturally, and professionally safe during their involvement in this research (WHO 2001; NHMRC 2007, 2018; AASW 2020a). However, physical safety for those with whom I conducted phone interviews was difficult for me to ascertain. These participants chose the time for the interview, therefore had the ability to consider where they would take the phone call and look to their physical safety while participating. For the women victim/survivors, the focus groups were held in familiar locations (where they met as a support group) and amongst potentially supportive group members, with their group facilitator in attendance.

I worked towards the professional safety of the workers by ensuring that the hospitals or agencies in which they worked were identified only by state and type and gave the emergency department social workers the choice as to how much information they disclosed on the survey and whether they wanted to participate in an interview. I also discussed the possibility of workers having lived experience of DFA and reminded them of supports available.

I was mindful that participation in this research may have some distressing effects because of the subject matter, and I worked to establish safety for the participants at the beginning of the interviews and focus groups (WHO 2001). To assist in the reduction of any distress, I had information on hand for referral and support options if necessary. For the women victim/survivors there was also a conversation at the beginning of the focus groups to ensure they understood options for support, should they decide not to continue with the discussion. Having a plan to manage any potential distress was a crucial factor in addressing my ethical responsibilities for emotional support and to ensure duty of care for the women. The focus group participants had the opportunity to connect with their support group facilitator, or to follow up with myself the following day, should they need further support. Pamphlets for a 24-hour support line were also available. I was aware that I would be asking the women to recall what they had and, for some, still were, dealing with and times where their health had been compromised because of this, alongside their experiences of help-seeking behaviours. During the discussion, they may have reflected on times when that assistance was not forthcoming or when they may have felt judged, disbelieved, and not validated. Recalling this, and the circumstances leading to this, had the potential to be

distressing for both that woman and others in the room. I worked to ensure as much as possible that the conversations did not re-traumatise the women and were empowering the women. There was time for sitting with distress, and with silence and much validation for the women and their feelings from myself and the other women, throughout the discussions. This is also an important principle of critical feminist social work when working with those who have experienced trauma (Herman 1997; Wilkin and Hillock 2014). Therefore, throughout the focus group discussions, I utilised practice principles which included hearing their story, drawing out and reinforcing their acts of resistance and their agency in their survival, and in their protection of themselves and their children (Herman 1997; Coates and Wade 2004). During the focus group discussions, I ensured that we took breaks, had snacks and drinks, and that the conversations were not rushed, in order to communicate respect for their contributions. As previously noted in this chapter, there was also a mini debrief as the sessions ended, to finish in a reflective and positive manner. This debrief was semi-structured around four questions, leaving time for women to share their thoughts or stay silent. Women were asked to reflect on both the positive and difficult parts of the discussion and what signs of hope or hopeful thoughts they would take from the conversation and participation in this research. This was important to ensure that the women were leaving the discussion feeling emotionally safe.

I assured the interviewees and focus group participants that their responses, experiences, and the language they used to reflect on these would be incorporated into the findings. This was especially important for the women victim/survivors as a way of enabling their voices to be heard. The interviewees and women participants were eager to contribute to making a difference on this issue. Several times during the focus group discussions the women stated that this was the reason they were contributing to this research. As explained by Sonia, a 28-year-old mother of two:

I know that I want to make a difference. This should not be happening still to women today when they go for help. Why do you think I am here?

This is important to the ethics of this research, as for research to have merit it must have some benefits for the participants (WHO 2001; NHMRC 2007, 2018).

To respect the experiences of all the participants I assured them that the questions they had seen prior to participation were to be used as a guide, but they were also free to take the discussion in directions they wanted and to say the things they needed to say. Therefore, at the end of all group discussions and interviews, I asked if there was anything further, they thought would be useful. References to these further conversations are discussed in Chapters 6 to 9, where the women victim/survivors explain the consequences of not having the abuse identified in a timely manner and the serious knock-on effects on help-seeking with other systems. A focus on legal systems was never part of this research but was very important to the women victim/survivors in this research.

To create an emotionally safe and trusting space, I drew on my practice experience as a feminist critical social worker, working from a trauma informed position in the field of DFA. I have experience listening to and supporting distressed, anxious and fearful people, alongside my own experiences as a victim/survivor. I offered support, empathy and understanding of the many ways in which trauma presents in conversations and throughout reflection. Feminist trauma-informed practice has at its core, a feminist analysis of DFA. In practice this means that it is based on the understanding that the gendered social context of women's lives shapes not only the likelihood that women will encounter gendered abuse at some time during their lives, but also the ways in which the impact of this abuse is constructed by those they reach out to for support (Wilkin and Hillock 2014). This was important in terms of support for the women participants because feminist trauma-informed practice challenges perspectives that medicalise and individualise trauma and trauma responses, moving away from pathologising victim/survivors and towards normalising responses to abuse. Feminist trauma-informed practice attends to personal discomfort and heightened anxiety, while drawing out strengths, acts of resistance and connecting the personal to the political through consciousness raising (Weeks 2003; Wilkin and Hillock 2014; Moulding 2016). This practice knowledge assisted me to create a safe and trusting space, challenge victim-blaming narratives, validate the experiences and strengths of the women participants and celebrate their acts of resistance (including framing their participation in the focus group discussions as an act of resistance), alongside transparency about my own experiences to the women, which were important aspects in attending to emotional safety for these participants.

As well as physical, professional, and emotional safety, it was important to attend to the cultural safety of the participants (WHO 2001; AASW 2020a). To achieve this, I worked to

convey acknowledgement and respect for the significance of culture and social location and the role this played for professionals and women victim/survivors. Although I used respectful and culturally appropriate language, alongside recognising the ongoing consequences of colonisation throughout my discussions and conversations with the participants, cultural safety and sensitivity calls for more than this. Therefore, in choosing the social worker interviewees and the women participants I was mindful of ensuring the inclusion of participants from diverse backgrounds. For the social workers, as previously stated, this diversity was reflected in terms of geographical region, type of hospital and demographic diversity. For the women victim/survivors, I paid particular attention during the discussions to note the contributions of all participants, in order that I could draw out the voices of those from diverse backgrounds, especially if they were struggling to find a space to contribute.

In conversations with women from CALD backgrounds, attention was paid to the ways in which marriage, motherhood, DFA and separation were positioned in their cultures and what this meant for their experience and recovery. Several women commented favourably on this aspect of the focus group discussions. For the two women who had been abused in same sex relationships, I ensured that time was available in the discussions to allow them to express the complexities in this for them, and discussion on some of the perpetrator tactics that were specific to same sex relationships, and the consequences of this when seeking assistance. There was also time for them to explore the added pressure on them to present their relationship as a healthy relationship. For the two Aboriginal women, again I ensured there was time within the group discussion to acknowledge the consequences of colonisation on family and community, the pressure on them to remain in the relationship, and the extra judgement around their role as mothers from various health professionals. My experience in these focus groups was that once the acknowledgement of diversity and the intersection of this on specific experiences of DFA was raised in discussion, the women were supportive, empathetic, and respectful to the conversation and the individuals involved. This assisted towards cultural safety for many in the focus group discussions.

Attention to power

Another important ethical consideration when undertaking feminist research includes reflection on and addressing power dynamics between the researched and the researcher and ensuring that the research works to challenge inequitable gendered social structures

(Skinner et al. 2012; Buchanan and Wendt 2017). Ethical considerations of feminist research direct the researcher to reject the prevailing academic distinction between the researcher and the researched (Skinner et al. 2012).

At the onset of arranging the distribution of the online surveys and the beginning of the interviews with the workers and experts in the field, I was upfront about my professional experiences. At the beginning of the focus group discussions when introducing myself, I was also upfront with the women about my experiences, both professional and personal. As previously discussed, I made the choice not to talk about my personal experiences with the social worker and manager interviewees for many reasons, including that I was not asking these workers about any personal experiences, whereas I was asking the women victim/survivors to discuss their very personal stories and felt that telling them that I too was a victim/survivor of DFA demonstrated that I was attempting to lessen the power differential between the researcher and the researched. I did not disclose my experiences as a way of validating my role, but more out of a sense of transparency and wanting to connect and share, given that I was asking this of them. To do this, I acknowledged at the beginning of the focus group discussions that although I had my own experiences, I was not part of their support group, and I was here as a researcher. However, I did emphasise that it was both because of my professional experiences working in hospitals and personal experiences of living with abuse, that led me to want to do this research. Regardless of these experiences and the work to acknowledge and address power, I was still conscious about the power differentials between myself as the researcher and the participants. I was in a position of power regarding the research topic and its design, and I am a white, western, cis-gender, heterosexual woman with the opportunity to pursue a university education. My position as an academic, a social worker working with DFA and in hospital settings for many years, and my own experiences of DFA, may have been quite intimidating for some research participants.

My social work practice experience assisted in my communication with all research participants, enabling deep and active listening, using skills such as paraphrasing, reflecting content and feeling, summarising to move the conversations forward and being respectful of pauses or silences in the conversation to allow others to reflect on their thoughts and feelings. This enabled me to connect well with most of those I interviewed. There were instances, however, when I needed to critically interrogate my reactions to what I heard, paying attention to both my emotions and my physical responses to the information and discerning

why I responded the way I did. For example, when a social work interviewee spoke of women victim/survivors as being non-protective parents, I needed to explore whether my reaction was a result of feeling defensive about the lives of my own children, or because this mother-blaming is often a symptom of a worker's internalised belief system that protects perpetrators from the consequences of their actions by making them invisible and blaming victims (Buchanan 2016). The emotional labour of the reflexive practice because of my insider/outsider status was often heavy, but important to acknowledge and work through to enable honest and ethical reflection as a researcher.

I believe I have worked to ensure participants in this research were not exploited or burdened, and have paid attention to my responsibilities around information, safety, support, protection of confidentiality, as well as to the processes, relationships, and power dynamics. I have also ensured that additional ethical considerations of conducting feminist research have been considered, reiterating that it is not only necessary to include and respectfully represent the voices and experiences of all participants, but it is necessary to ensure that marginalised voices are heard, and that the research process benefits and empowers those who participate (Skinner et al. 2012; D'Cruz and Jones 2014; Buchanan and Wendt 2017).

Limitations and challenges

There are a number of limitations and challenges to the research. First, the recruitment of potential respondents for the initial online survey posed some difficulties in terms of finding the appropriate social workers in emergency departments. In some cases, the original emails were not passed on to the emergency department social workers and in some hospitals, there was a lack of permission (or a lack of timely permission) to proceed through the various levels of hospital administrative bureaucracy in order that the social workers were given permission to complete the survey. The lack of information available on the presence (or not) of social work departments within public hospitals was also a limitation as this necessitated an internet search and could have resulted in missing some valuable survey feedback. Although I distributed 105 online surveys, I only received 35 completed surveys. Nulty (2008) explores return rates of online surveys in a comparison of response rates to online and paper surveys and found that online surveys typically receive a response rate lower than that of a paper survey. McPeake, Bateson and O'Neill (2014) explored the use of electronic surveys in hospital

settings and stated that respondents may not be comfortable with sending information over the internet and may be time poor. Both issues could have been a factor in the low response rates. However, of those who completed the surveys, the uptake for participation in a further interview was very encouraging. The main challenge associated with the emergency department social worker interviews was finding a time to conduct the interview which would not interfere with the busy and sometimes crisis driven schedule of the emergency department social workers. To address this, several interviews were re-arranged to fit with participants' schedules.

Second, the interviews with the managers of the family violence agencies were limited by the fact that many of the states and territories around Australia had one state-wide family violence service. Of the ten state-wide peak bodies and agencies that I contacted, only five managers were available or willing to participate in an interview, two of which were from Victoria (one peak body and one state-wide agency). The limitation here is that recommendations from the VRCFV featured heavily in the responses.

Third, and the most challenging limitation in the collection of data for this research, was recruiting the women victim/survivor participants. To ensure that there was as much support as possible, the recruitment centred on women who were already connected to a support group. Understandably, many support group facilitators were not willing to pass the invitation along to attendees, citing duty of care responsibilities. After gaining access to one support group through the facilitators, I then contacted the coordinator of the survivor/advocate program through a state-wide family violence agency in Victoria and put the request to meet with the existing survivor/advocate groups to this body. Although recruitment was initially a challenge, gaining women victim/survivors through the survivor/advocate groups was a benefit in that many of the women came from diverse social locations and several (nine in all), had experiences of seeking health assistance in other states at the time of living with the perpetrator.

Fourth, research documenting potential limitations with the use of focus groups as a research method includes issues such as dealing with the dominant voices and opinions of one or more group members, constructing the 'other', and the reproduction of normative discourses (Smithson 2000). There were participants who dominated early discussions within the focus groups, however, my background in group work facilitation was helpful as I was able

to thank those women for their input and ask to hear from some of the other women, encouraging those who were having difficulty in finding space for their contributions.

Smithson (2000) discusses the challenges of potential 'group think' that can occur in focus groups and the resulting reduction of normative discourses. In this research, the challenge was in being alert to the presence of normative social discourses that blame or pathologise victim/survivors of DFA. I have had experience in doing this through facilitating DFA support groups in my work, therefore was alert to this happening, and addressed these when they occurred. Challenging these narratives was also necessary in some of the interviews with emergency department social workers.

The final challenge in conducting this research was having my own personal experiences of DFA. As a social worker who has worked in the field and as a victim/survivor myself, I come with experience and preconceived ideas about the significant role played by all health practitioners. I saw this more as a strength than a limitation but was conscious of the need to critically interrogate my preconceived ideas and reflect on how my experiences influenced the meanings I made and presented. As previously stated, to mitigate this risk I employed private external supervision for various stages of this research. The other challenge around having experience as a victim/survivor was that I had to incorporate self-care strategies and techniques, especially after the focus group discussions with other women victim/survivors. Not surprisingly, some of their experiences were similar to mine, and after hearing so many stories I was sometimes left with a sense of heaviness. The external supervisor assisted with this as well. Alongside supervision, and incorporating self-care strategies, I know working toward macro-level change in oppressive structures has been one of the ways I have been able to continue with my work over the past 30 years. Working for change in the ways hospital emergency departments and health professionals respond to women victim/survivors, has been significant in overcoming the personal challenges while conducting this research.

Conclusion

In this chapter I have outlined my methods and methodology used in both stages of this research and the reasons for this. I have explored the ways in which I addressed ethical considerations including confidentiality, respect and safety for participants, attention to

power alongside the limitations and challenges presented in conducting this research. The next chapter begins the presentation of my findings, commencing with the first theme, related to the ways in which the majority of the women victim/survivors were unaware they were living with DFA and the therefore, the connections and impacts of this on their health. The chapter highlights the need for health professionals to assist women victim/survivors to identify the presence of DFA and link this with presenting issues and health impacts.

Chapter 6. 'Joining the dots': Domestic and family abuse and health impacts

The title of this chapter comes from a comment made by Sue, a 40-year-old mother of two children and one of the focus group participants. Sue talked of the impacts of DFA on her health and this not being raised by health professionals she consulted:

Yeah, for me anxiety and low iron levels in my blood. I'm only 40 and exhausted. I know it [DFA] was a huge stressor on my system. None of the doctors or others have made that connection with me, I've joined the dots myself. Everyone was looking for every other reason, every other common reason.

This chapter discusses the experiences of women focus group participants, beginning by outlining the types of abuse they suffered and the subsequent impacts on their health. I then explore responses women received from health professionals. Using a feminist critical lens, the chapter concludes with an examination of the consequences of the health professionals' responses.

The women victim/survivors all reported presenting for assistance to at least one health professional during the time they were living with or recovering from abuse. This included general practitioners, maternal and child health nurses and a range of health professionals working in emergency departments. Fifteen women presented to more than one health setting during this period of their lives. At the time of participating in the research, the women stated that they had subsequently developed some understanding of the relationship between DFA and their health (both physical and emotional) and the ongoing impacts that continued to affect them during recovery. The women were all separated from the perpetrator at the time of contributing to this research, however many were still subject to ongoing abuse, often in the form of controlling behaviours by the perpetrator.

The recommendations from the VRCFV highlighted the importance of recognising and understanding the ways in which abuse impacts on the health of victim/survivors and emphasised four important stages where support is needed for women and their children, these being prevention, early intervention, crisis response, and recovery (State of Victoria

2016a). The experiences of the women victim/survivors support these findings in that they presented for health assistance throughout their relationships and after separation.

During the focus group discussions, the women recalled their experiences of seeking assistance for health issues, and speculated whether, had the connections between their health and DFA been made earlier, their journey could have been different. They spoke of the ways in which the impacts on their health became critical for them post-separation, which is also considered in this chapter.

The women had much in common with each other, and yet were also diverse in their experiences and social locations. They had lived with DFA for periods ranging from 18 months to 23 years. Twenty-three of the 25 women had children under the age of 18 (a total of 16 children) and were still in communication with the perpetrator around parenting requirements. Nine were from non-English speaking backgrounds, two had been in same sex relationships, two identified as Aboriginal, and the remaining 12 women were of non-Indigenous heritage. The women ranged in ages from 25 to 45 years. There were differing levels of education and socio-economic status, with three women having university degrees and professional careers (one being a health professional), while others spoke of not having had the opportunity to finish secondary school. Drawing on the principles of feminist research, I explore the ways in which these intersecting social locations contributed to their experiences of abuse and to gendered discrimination and oppression when seeking assistance for the health impacts of DFA.

Categories of abuse experienced

The women experienced multiple forms of DFA, as defined by the *FVPA 2008* (Vic), including physical, sexual, verbal, emotional, social, economic, reproductive, spiritual, and religious abuse. There were categories of abuse that overlapped, for example many stalking behaviours were facilitated using technology; as will be explained in greater detail in this chapter, and, in some instances the women asked for these categories to remain separate, and in others, they are discussed separately due to the unique consequences of that form of abuse.

During the discussions, the women revealed abuse not articulated in the legislation that did not fit neatly into the categories outlined by the *VRCFV*. For this reason, I have also included three new categories of abuse in this chapter, being reproductive abuse, systems

abuse and parental/maternal abuse. These are important additions as behaviours within these categories capture how perpetrators used social gendered norms to weaponise health, legal and child welfare systems against women.

Physical abuse

The *FVPA 2008* (Vic) states that physical abuse can involve a direct assault on the body as well as use of weapons, assaulting children, and deprivation of necessities like sleep and food. Four of the women experienced multiple forms of physical abuse, including: assault or threat of assault with a weapon; strangulation; attempted drowning; deprivation of necessary bodily functions; destroying the woman's possessions; and being forced to consume drugs and alcohol (including in one case, the perpetrator prescribing drugs and forcing her to take them). Maria, a 38-year-old mother of four children, described her experiences of physical abuse, 'He tried to drown me, held guns to my head, I was hurt and bashed'.

The 2017 National Community Attitudes towards Violence against Women Survey (NCAS) stated that physical abuse is the most clearly understood form of DFA in the community, however, this understanding is centred on physical acts, not threats to act (Webster, Diemer, Honey, Mannix, Mickle, Morgan, Parkes, Politoff, Powell, Stubbs and Ward 2018). Maria, and the other three women who experienced physical abuse, did not understand at the time that threats against them were also physical abuse. The women who were physically abused reported believing the perpetrator's claims that it was their own behaviour that compelled him to enact violence.

It is significant to note that physical abuse was the least common form of abuse reported by the women, however, it continues to be the most readily understood form of abuse within the community (Webster et al. 2018). Stark (2012) states that the emphasis on understanding DFA as physical in nature leads to trivialising or dismissing patterns of control and resultant oppression, and the impacts on the victim/survivor (Laing 2001; Stark 2009; Hayes and Jeffries 2015). This has implications in terms of the ways in which a victim/survivor presents for assistance and responds to questions asked in a screening environment. Before a woman can disclose that she is in an abusive relationship she needs to recognise what is being done to her. Women victim/survivors in this situation interpreted their relationship or their own behaviour as 'the difficulty', instead of the DFA and the perpetrator's behaviour as

the problem. It can take some time for women victim/survivors to gain an understanding that the perpetrator is responsible for this behaviour and that this is abuse (Fraser 2003; Hill 2019).

Sexual abuse

The *FVPA 2008* (Vic), defines sexual abuse as unwanted or pressured sex, causing pain to sexual parts of the body, sexual degradation, or sexual criticism from one partner toward another. Eight of the women described various experiences that fell within this definition, including non-consensual sex either through direct communication, fear of the consequences should they refuse and criticisms of the woman's body and/or her sexual performance. Three women spoke of feeling obliged to have sex when the perpetrator wanted sex, or when the perpetrator pressured them by citing religious or cultural expectations. Stark (2012) states that circumstances such as these indicate the presence of coercive control. In the discussions it was clear that the women who submitted through fear were not aware, at that time, that they were being sexually abused. They stated that they were confused about consent because they 'did not say no'. Rhiannon, a 37-year-old woman with two children said, 'I didn't know. If I had said 'no' he would have been very cruel and made sure it hurt'.

The WHO (2005) cites the contribution of culture to commonly held attitudes about men's right to use and access their partners' body when and how they wish. This report argued that these cultural attitudes may also override a woman's understanding that she is being sexually abused, especially in cultures where there are taboos around talking about sex or sexual abuse, or in circumstances where there is cultural shaming of women's bodies. Feminist critical theory asserts that all cultures demonstrate forms of gender-biased beliefs and narratives that protect the perpetrator and blame the victim (Buchanan and Jamieson 2016; Milligan 2020). This was evident in experiences described by the women which are not specifically listed in the legalisation but recognised as sexual abuse (Victoria State Government 2018). These included 'outing' as punishment to family and friends for the women in same sex relationships (discussed further under emotional/psychological abuse); three women who had their credit cards used by the perpetrator for his sexual pleasure (i.e., strip clubs, sex workers, pornography), and one woman whose perpetrator distributed naked photos of her, to their joint work colleagues without her knowledge (they were police officers, working at the same station).

Technology facilitated abuse

The *FVPA 2008* (Vic) states that technology facilitated abuse involves the use of technology for persistent communication, threats, unauthorised posting of content on social media, monitoring behaviour, and intercepting calls and messages (State of Victoria 2016b). A few women (n=7) described various forms of technology facilitated abuse including some listed above under sexual abuse, alongside examples such as receiving excessive numbers of intimidating and/or threatening text messages (one woman counted 360 messages in one day), and the perpetrator changing the woman's passwords without her permission or knowledge (which had consequences in terms of accessing devices or online platforms including bank accounts). Two women described having sexually explicit photos of themselves distributed, and for one of the women, this was in the context of a fake (naked) Facebook profile created in her name, with invitations sent to male members of her CALD community. Kate, a 27-year-old woman with two children explained:

He had created a new profile of me without me knowing, put my head on pictures of a naked woman, said I was a slut and available and invited the men in the community to be 'friends' with me on this page.

There were also behaviours that fitted into the category of technology facilitated abuse not described in the legislation, including control over internet access through the daily removal of the modem by the perpetrator and the use of tracking devices to follow the movements of women and their children.

Stalking

Stalking is defined as behaviour that can include following a victim/survivor, keeping them under surveillance, loitering outside their place of residence or work, interfering with their property, or acting in any way which could cause physical, or emotional harm to the victim (*Crimes (Stalking) Act 2003* (Vic) s21A; *Criminal Law Consolidation Act 1935* (SA) s 19AA). As previously discussed, technology is often utilised in stalking behaviour. Examples of stalking experienced by the women included many of the behaviours described above using

technology. Several women (n=5), talked of this behaviour increasing upon separation, including instances where the perpetrator broke into their homes, leaving evidence to ensure that the women knew who had been there. One woman had her property damaged during a break-in, another recalled that the perpetrator left large kitchen knives lined up on her kitchen bench as a 'message' to her, and Sonia, a 28-year-old woman with two children recounted:

The IVO was still in place, he wasn't allowed to go to our house, but I found a pot of coffee on the stove and a cup in my bedroom with the indent on my pillow from his head still evident. He left it there on purpose.

Sonia went on to discuss how the police refused to help her and advised her not to become 'paranoid'.

Emotional and psychological abuse

The *FVPA 2008* (Vic) defines emotional or psychological abuse as behaviour that harasses, torments, intimidates or is offensive to the other person, including threatening to disclose a person's sexual orientation; blaming the victim for any abuse; undermining the self-worth of the victim; using emotional blackmail; humiliation and degradation; destroying property; and making threats against the victim, her family, or pets. Verbal abuse including derogatory taunts is also included within this category of abuse. All the women experienced behaviours within this category of abuse, including threats of suicide from the perpetrator, threats against themselves, their children, and their family of origin. Hill (2019) argues that abuse of trust and personal knowledge by a perpetrator towards their intimate partner results in emotional damage and is a unique feature of this type of abuse.

One woman recounted the perpetrator blaming her when he killed the family pet, telling her she should have done what he asked and that she 'was next'. Two women experienced abuse in a same sex relationship, and both were threatened with disclosure of their sexual orientation to family and friends. Judy, 32 years of age, described this emotional abuse:

She would not talk to me for weeks, or she would shout at me. She told me she would tell my family and friends about us, and she did. She would threaten to kick me out of the house, knowing I had nowhere to go.

The women also experienced verbal abuse, including being called dehumanising names such as 'pig', 'dog', 'slut', 'cow', and/or being called 'fat', 'hopeless', 'unlovable' and 'a drama queen'. One woman talked of how she began hating the sound of her own name due to the way he 'spat it out' at her.

[Economic/financial abuse](#)

The *FVPA 2008* (Vic) defines economic abuse as withholding or the threat to withhold necessary financial support, and denial of the financial autonomy that a person might otherwise have. Corrie and McGuire (2013) argue that economic abuse is often hidden, minimised, and misunderstood.

Examples of economic abuse described by the women included three women being denied the ability to work outside the home, and another three women stating that the perpetrator used their joint credit card for his sexual gratification. Several of the women were denied the information necessary to make informed financial decisions for their future, including one who was listed as a director in her partner's company (and therefore responsible for his debts) without her consent or knowledge. Two women recounted the perpetrator borrowing against their shared mortgage without consent or knowledge and another discovered the perpetrator had manipulated and colluded with the bank to close her back account, to which he was not a signatory. Five of the women had debt because of fines and credit card expenditure incurred by the perpetrator. Sue, 40 years of age and with two children, discussed how hard it was with little financial independence:

The moment I moved in I was told to shut down my bank account and all our money was in a joint account, and from that moment I had to ask, (and) if I used funds, I was interrogated on why I spent money.

Diverse social locations gave rise to complicated and intersecting forms of financial abuse for some of the women, including dowry threats against one woman and her extended family.

Social abuse

The *FVPA 2008* (Vic) situates social abuse within the category of emotional/psychological abuse, because it affects the emotional wellbeing of the victim/survivor. I acknowledge that this often overlaps with other forms of abuse, however, I am choosing to discuss this in a separate category because the women believed this type of abuse was central to controlling behaviour and had a profound effect on their ability to seek support. The *FVPA 2008* (Vic) describes social abuse as behaviour designed to isolate a victim/survivor from family and friends and from activities outside the home such as sport, volunteering, or paid employment. Several of the women (n=6), described being forbidden to contact or socialise with family, friends, and work colleagues, as well as being disconnected from social media, having car keys confiscated, and being locked inside the house while the perpetrator was at work. Two of the women were taken interstate, away from their support systems, while one who had left her career and migrated to Australia to be with her partner, was forced to house her family in a nearby motel when they came to stay, ensuring that there was less time to spend with them which meant obscuring the abuse and, making it obvious they were unwelcome. As Caroline explained, 'I kept having to make excuses, the house was too small, she needed her space and quiet. They had come all that way'.

Reproductive abuse

This form of abuse, or reproductive coercion as it is sometimes known, is still emerging as a category of DFA. The *FVPA 2008* (Vic) is relatively silent on this form of abuse however, once again, the women asked that this be included to reflect their experiences, as this was a common experience (n=14). Reproductive abuse is defined as behaviour that obstructs or attempts to obstruct the autonomy of a person to make decisions and choices about their reproductive health (Grace and Anderson 2018). Examples include sabotaging contraception, pressure to become pregnant, or to terminate a pregnancy (Marie Stopes Australia 2018).

The women described behaviours including being forced to take the contraceptive pill, have an intra-uterine device fitted and one woman threatened until she had the Depo-

Provera contraceptive injection. Two women spoke of having terminations they did not want, while another was prevented from having a termination. Two women were denied timely medical intervention during pregnancy, and another whose perpetrator told her to take herself to hospital when she went into labour. The women spoke of experiences where the perpetrator-controlled pain relief during labour and/or enforced early discharge from hospital only hours after giving birth. Lina described how this happened for her:

I had gone into labour in the middle of one of his explosion phases. His control over pain relief, telling the midwives I was determined not to have any, was designed to hurt me as much as possible at that time.

Women also spoke of perpetrator control over breastfeeding, one woman not being allowed to breastfeed, another being told that she must breastfeed, while a third was belittled for not being able to breastfeed. Several of the women discussed the ways in which the perpetrator used the post-birth period as an opportunity to tell family, friends, and health professionals she was suffering from post-natal depression, when this was not the case. This is an example of perpetrators weaponising the gendered social norm that labels post-birth distress in women as a mental illness.

Spiritual/religious abuse

The *FVPA 2008* (Vic) describes spiritual/religious abuse as behaviour that prevents a person from connecting with their cultural or spiritual ceremonies and practices and/or the use of religious or cultural beliefs to justify abuse and control of another person. Some of the women (n=6), experienced spiritual abuse, including being prevented from observing religious practices (e.g., fasting) after which the woman was shamed to family and community by the perpetrator. Robyn, 33 years of age with three children, recalled the perpetrator using the religious leader to reinforce his 'rules', 'We were very involved in the Catholic Church. He had the vicar come and talk to me about my role as a wife and mother'.

Both Aboriginal women had experience of the perpetrator (who, in both situations were non-Aboriginal men) mocking their cultural beliefs, with one prevented from attending

any women's business or travelling back to country following the death of kin. These experiences, alongside the dowry related threats experienced by one woman, are examples of the ways in which intersecting social locations enabled complex forms of control.

Systems abuse

This category of abuse is not in the *FVPA 2008* (Vic), nor is it in any Australian family violence legislation (Australian Law Reform Commission 2011). Mandel, Mitchell and Stearns-Mandel (2021) argue that unchallenged gender bias within systems, enables continued perpetrator manipulation and control of victim/survivors. In other words, systems often facilitate the agenda of patriarchy (Daniels 1997), through enacting gender-biased practices, easily weaponised by perpetrators (Heward-Belle et al. 2018; Mandel et al. 2021). The women described the ways in which many of the systems they turned to for assistance (medical/health, legal, housing and child welfare), supported the perpetrator to continue control over them and their children.

Medical/health systems

The women recounted experiences where the perpetrator manipulated medical systems and those who worked within them by suggesting her presentation was proof of her deficient mental state, with that suggestion taken as fact by professionals. Examples included perpetrator inflicted injuries being re-interpreted as self-inflicted injuries, distress at perpetrator abuse being labelled as mental illness, post-birth distress categorised as post-natal depression and delayed medical attention (due to perpetrator intervention) framed as evidence of her mental ill-health.

Legal systems

Manipulation of the legal system by the perpetrator was a common theme discussed in the focus groups. As stated previously, prior to the conclusion of every focus group discussion the women were asked if there was anything further that they would like to add, and in every group, women raised the ways in which the perpetrator used legal systems to extend control over them and/or their children. The women felt particularly aggrieved that a legal system designed to support victim/survivors could be so easily manipulated by a calm and clever perpetrator. They spoke of the 'trauma' when calling police for assistance, only to then be

labelled as the aggressor after the perpetrator manipulated and colluded with police. These women also experienced difficulties in obtaining intervention orders, with five women recalling instances of the police failing to act on breaches of orders. Caroline, who was in a same sex relationship, discussed the barriers she encountered when trying to get protection from police, who would not take her abuse seriously due to the perpetrator being another woman. This is an example of the intersecting oppressions for women from diverse social locations.

Other examples of legal system abuse included the perpetrator being awarded custody in the family court on the grounds that he remained in the family home, in circumstances where the woman and her children were homeless due to his abuse; the perpetrator refusing counselling for children post-separation; and using a woman's mental health plan (as a result of the impact of his abuse) to argue she was an unfit parent. Melinda, 31 years of age, with two children, explained:

The Courts were trying to give custody to someone who was drunk, even in Court. He had no interest in the kids before he left, they were six and three, but lots of interest in them afterwards, just to have some influence over me.

Five of the women reported that they made the decision to remain in the relationship until the youngest child was 15 as a protective measure for their child as they could not be assured that the legal system would recognise the risk for the child should the perpetrator weaponise this system.

Child welfare systems

Exposure of children to DFA is framed as an issue for child welfare authorities (Heward-Belle et al. 2018). Within this framing, there has been an increasing body of research arguing that child welfare services hold mothers accountable and to a higher standard of parenting than fathers and instead of the perpetrator being held responsible for his abusive behaviour, mothers are held accountable for the exposure of children to DFA (Stanley and Humphreys 2015; Heward-Belle et al. 2018). The women recalled the perpetrator using this knowledge to threaten the intervention of child welfare authorities, in response to any discussion of

separation. One of the Aboriginal women participants recalled her general practitioner also threatening the intervention of child welfare authorities should she remain with the perpetrator. Seen in the historical and contemporary context of colonisation alongside the known rates of removal of Aboriginal children through Australia's child protection systems (Child Family Community Australia 2020), this was a powerful threat for this mother.

Housing systems

The VRCFV states that access to affordable, secure, and sustainable housing is one of the three pillars necessary for recovery from DFA, alongside financial security, and health and wellbeing (State of Victoria 2016a). Lack of alternative accommodation options was a reality for all women victim/survivors in this research. The women recounted experiences of being held responsible for rental arrears when the perpetrator refused to pay his share of the rent upon leaving the premises and being held liable for perpetrator damage to the property, which also impacted their ability to secure future housing. The women recalled that the lack of housing alternatives influenced their decisions to remain with the perpetrator. Kate, a 27-year-old with two young children, recounts:

Once I was dumped in a refuge in a different town and they took my forms of communication off me and I was isolated and couldn't talk to anyone – no support at all, I ended up going back.

Parental/maternal abuse

Parental abuse of the non-offending parent includes behaviour aimed to control, isolate, and undermine the ability, confidence and right to parent (Hooker, Kaspiw and Taft 2016). This is particularly important within systems that hold mothers more accountable than fathers, as previously discussed (State of Victoria 2016a; Heward-Belle et al. 2018). Hooker et al. (2016) describes various tactics and behaviours used by male perpetrators to take advantage of this inequity, including by direct means (i.e., taking the children away from the mother) and indirect means (i.e., maternal alienation). The women in this study had experience of both direct and indirect means of parental and maternal abuse, including being told that the

children no longer loved them, that they thought she was ‘stupid’ and ‘mental’, alongside his encouragement for the children to use his derogatory language when talking to her. The women spoke of perpetrators attacking them for their parenting decisions and having their decisions over-ridden, alongside being constantly compared to other ‘better’ mothers (including the perpetrator’s mother) and told they were a ‘useless mother,’ in front of the children. Katrina, a 45-year-old woman with four children, attempted suicide when she thought her children felt the same way about her as the perpetrator:

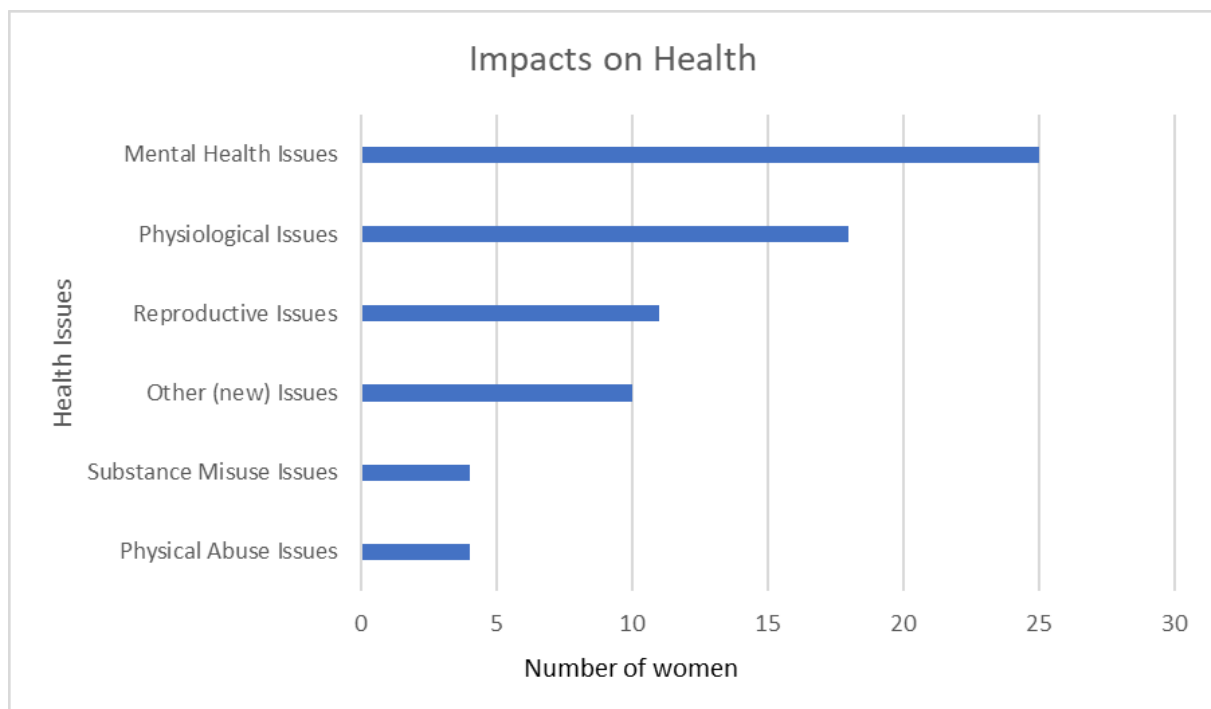
He had been telling me for months that my children didn't love me anymore, that I was the cause of all their problems, saying that in front of the children.

Impacts on the women’s health

The behaviour, tactics and forms of abuse experienced by the women demonstrate ways in which the perpetrator enacted and maintained control over the victim/survivor. I now discuss the impacts of the different forms of abuse on the women’s health.

The emotional, psychological, and physical impacts of DFA on the health of victim/survivors have been outlined in chapter 2. Figure 6 (below), Impacts on health, illustrates the range of impacts that the women victim/survivors attributed to living with and recovering from DFA. The numbers in this table reflect multiple health issues experienced by women and which were often linked and/or cumulative.

Figure 6 Impacts on health



Mental health

The women discussed their experiences of compromised mental wellbeing as a result of living with the abuse, describing themselves as having 'mental health issues'. Moulding (2016) discusses mental health in the context of DFA as 'women's violence related emotional distress' (Moulding 2016:188). Her exploration draws attention to the fact that medical discourses on mental health claim to be gender neutral, when they are in fact, gender-blind. Gender-blind discourses separate the causes of mental ill-health from gendered abuse and ignore gendered power relations or bias in historical and contemporary understandings of the female relationship to mental illness, diagnosis, and treatment (Herman 1997; Moulding 2016). These omissions and the failure to conceptualise symptoms through a gendered lens, lead to individually pathologising women who are dealing with the impacts of abuse. Therefore, this research, based on feminist critical theory, will in any discussions on mental ill-health as a result of DFA, recognise the impact of the social conditions of women's lives, and understand this as a functional emotional response to gendered abuse.

The impacts of the abuse on the mental health of the women were experienced in various ways, including through disassociation, panic attacks, hypervigilance, memory loss, self-harming, suicidal ideation, deep grief, anger, and flashbacks. The women explained that

they were diagnosed with a range of mental illnesses by a number of health professionals. Diagnoses included anxiety, depression, post-natal depression, obsessive compulsive disorder, panic disorder, relationship adjustment disorder, bipolar disorder, and post-traumatic stress disorder. In total, the women identified 46 different mental health diagnoses, made in isolation to the abuse they were experiencing at the time of presentation to a psychiatric or medical professional. Eight of the 25 women had mental health plans as part of their ongoing recovery, at the time of the focus group discussions.

Substance use and misuse

Four women disclosed substance misuse as an impact of living with abuse. They discussed overuse of prescription drugs and drinking to excess and believed they would not have had these issues had they not been abused. One woman stated that she overused prescription drugs to cope with the constant demands of the perpetrator, while two women spoke of being pressured to drink with the perpetrator, and feeling they had to comply. These women stated that they did not consume alcohol prior to the relationship with the perpetrator. Thirty-seven-year-old Rhiannon reported that she had been drinking to the point of suffering seizures requiring medical attention while she was living with the perpetrator. She explained:

I was pretty healthy when I met him, and I was a real drinker within about five years into it. I wasn't a drinker, but quickly became one, he didn't like to drink alone.

Rhiannon said that it was her concerns for her children and their future that helped her reduce her drinking.

Physiological health

Eighteen of the women participants discussed physiological impacts related to their experiences of abuse, which included digestive system issues, chronic constipation, menstrual problems, gall bladder concerns, insomnia, somatic disorders, exhaustion, and fatigue. Katrina, aged 45, talked about the impact of the abuse on her body, and how this contributed to other health issues:

One thing he would do to me was sleep deprivation, very high levels of this. I was also locked inside the house and wasn't allowed outside to exercise, so my body had become very weak in relation to muscle strength. I had huge menstrual problems, low iron levels, and glandular fever as a result of being so low. This was all during my thirties and I had never been so sick in my life.

Another woman described a sore jaw and headaches from constant grinding of her teeth. She explained that a dentist informed her the grinding was a sign of stress, which she then attributed to living with abuse and post-separation abuse.

Reproductive health

Eleven of the women participants discussed impacts of the abuse on their reproductive health, including the distress, anxiety, and grief they felt at having reproductive choices taken away from them by the perpetrator. This included choices around contraception, decisions during pregnancies, labour, and early mothering. The women discussed impacts from the abuse, such as hormonal imbalances, endometriosis, menstrual issues, and irritable bowel syndrome. One of the women disclosed that the perpetrator prevented her from accessing health care while pregnant. In her third trimester she was diagnosed with gestational diabetes and held responsible by health professionals for putting the health of her baby at risk. Lina recounted how a physical attack from the perpetrator caused a placental abruption, resulting in an early induced labour. She explained that the abuse continued throughout her labour and created fear and anxiety for her at a time when she was being told to 'calm down' for the sake of the baby:

I had my daughter in the birthing centre and my husband beat the living hell out of me in the bathroom while I was in labour. Nobody listens to a screaming woman in the labour ward.

Women spoke of their distress at being abused immediately post-birth, feeling responsible for the safety of their new baby, and constantly exhausted through anticipating and dealing

with outbursts of aggression and trivial demands from the perpetrator. Five women talked of their exhaustion and distress post-birth, resulting from the abuse, and how this was labelled as post-natal depression by the perpetrator, which was then believed by family, friends, colleagues, and health professionals. This is an important example of the perpetrator using gender-blind medical model discourses to his advantage to control the victim/survivor.

Physical health

Many of the examples discussed above impacted on the physical health of the women, however, the four women who experienced physical abuse, identified impacts on their body directly because of physical abuse. These included bruising, fractured bones, concussion, tightness in the throat and difficulty breathing because of strangulation. Many of these impacts required medical attention, however two women were prevented from receiving medical attention by the perpetrator for a number of physical assaults, their injuries left untreated, causing long-term pain and permanent disability.

'Other' impacts on health

Ten of the women participants identified other impacts on their health that were framed in ways not previously seen in the literature, including adrenal issues, 'burning or acidic tears', toes bending backwards, weight-loss and thyroid issues. Three women (each from a different focus group), talked of the abuse affecting their ability to breathe properly. This may have been connected to anxiety; however, the women phrased this in the context of 'breathing shallowly' for years. They spoke of not realising this was happening at the time and discussed the difference to their health by learning how to breathe again. Kylie, a 32-year-old Indigenous woman with three young daughters, talked of how her non-Indigenous perpetrator used everything he knew about her childhood to hurt, undermine, and control her, including the tragedy of losing her father to suicide at an early age. Kylie stated she would get extremely upset, would hyperventilate and was constantly anxious. She recounted that:

When I left him, I had to do a lot of work with myself and my kids, so that they would start to respect me. I have had to learn how to breathe again. Now with the singing and the yoga, I have learnt how to breathe again and connect with my brain and to relax. Now my trees are growing, my flowers are everywhere.

Two of the women recalled being diagnosed with alopecia and after leaving the relationship they connected this to the stress of living with abuse. Robyn, aged 33 and with three children, had been married to the perpetrator for 15 years and recounted, 'My hair was falling out and that miraculously grew back even thicker after I left the relationship, so I attributed that to the abuse'.

Health impacts post-separation

Post-separation is often regarded as a time of increased risk for victim/survivors due to ongoing and often increasing abuse from the perpetrator and the scarcity of services and failure of systems designed to protect and support women and their children during recovery (Fury, Sullivan and Bybee 2000; Dunkley and Phillip 2015; State of Victoria 2016a). The women discussed many examples of post-separation abuse from the perpetrator, which they described as affecting their sense of agency, independence, and safety, invoking fear for themselves and their children and leaving them unsure of what would happen next. The impacts on their health because of this included exhaustion from hypervigilance, anxiety, gaps in concentration and memory, nightmares, post-traumatic stress disorder, panic attacks, flashbacks and difficulty sleeping.

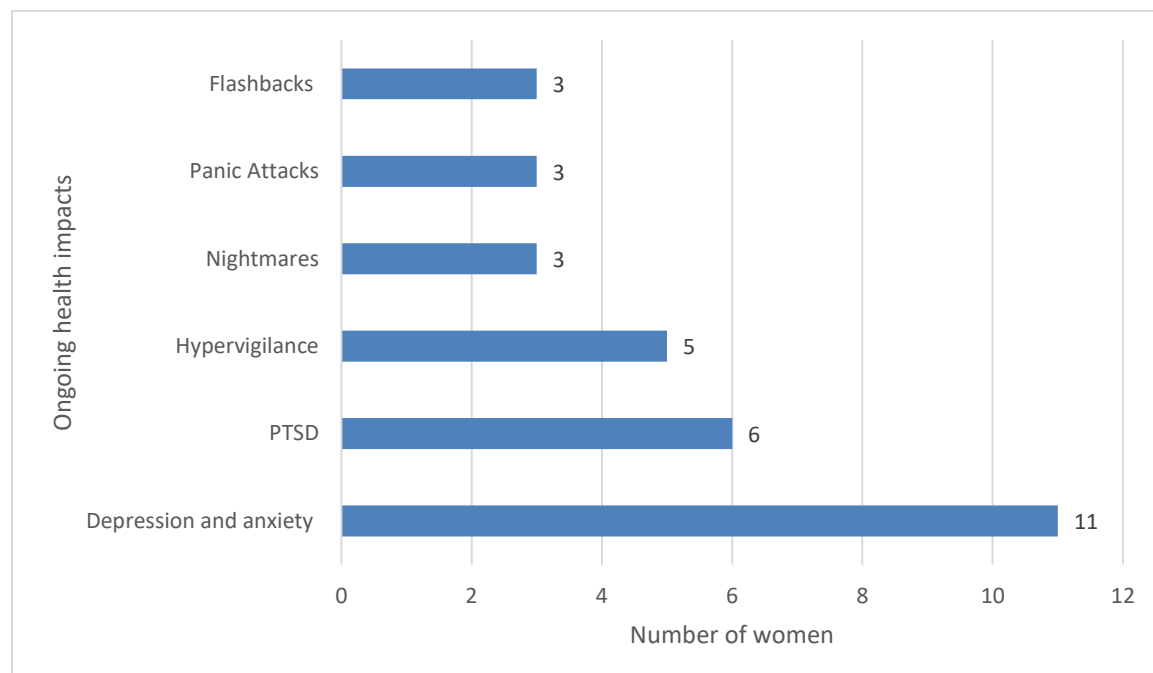
The findings of the VRCFV (2016) described the failure of systems responses as having an impact on the health of victim/survivors post-separation. The women's experiences of the failure of these systems responses have been previously discussed in this chapter and included those outlined in the findings of the VRCFV, being a lack of safe, affordable, and stable housing, lack of financial support, and lack of access to legal assistance and protection. These system failures do not support victim/survivors or hold perpetrators to account. The impacts on the health of the women, because of these failures, included prolonged exposure to the perpetrator, anxiety, exhaustion, and an ongoing sense of hopelessness which they

describe as impacting on their confidence, self-worth and contributing to their overall stress and distress.

The women spoke of the anxiety of having to justify their behaviour and decisions to friends, family, and professionals, who seemed unaware that the abuse continued after separation. This often meant they did not seek support and assistance at times when they needed it. Rachel pointed out that the DFA she had experienced was, '...still having an ongoing effect today, ongoing post-trauma, depression, anxiety, and I still struggle with relationship issues, just with anyone'.

The women also spoke about the 'guilt' they lived with at not being able to 'save' their relationships. Fraser (2003) discusses societal expectations that 'good' women know how to love and know how to bring out the best in their partners, standing by their partners and dealing with the emotional responsibility of 'healing/soothing/settling/fixing' to ensure relationship success (Fraser 2003; Lelaurain, Fonte, Giger, Guignard and LoMonaco 2018; Hill 2019). The women talked of how this guilt continued to plague their decisions and judgements moving forward, impacting on their health through distress and exhaustion. Figure 7 (below) shows ongoing health impacts, post-separation.

Figure 7 Ongoing health impacts, post-separation



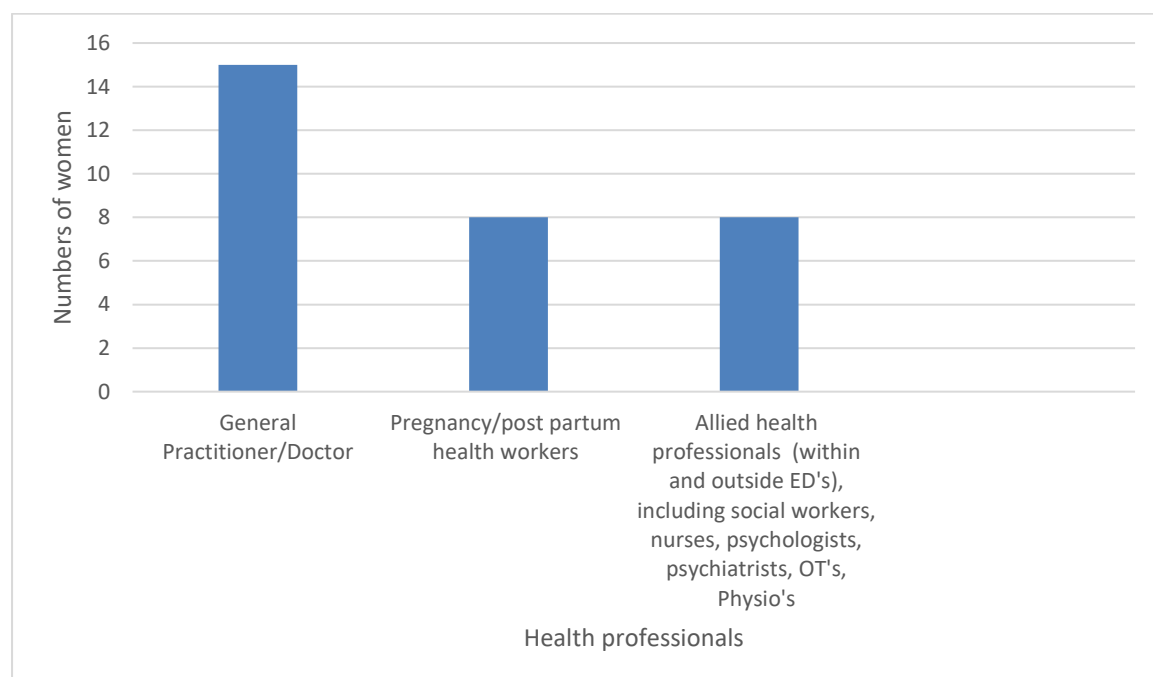
Feminist critical theory argues that dominant social discourses arise from the ways in which traditional gender roles are reinforced, leading to culturally accepted behavioural norms

(Pease 2019). Those norms are a ‘euphemism for patriarchal ideology’ (Pease 2019:70), maintained and reproduced by structures and systems within society as well as by individuals. The examples above reflect those cultural behavioural expectations and the ways in which they impact on the health of women living with or recovering from DFA.

Health professionals and their responses

So far in this chapter I have outlined the types of abuse experienced by the women victim/survivors and discussed the impacts of this abuse on their health. I now explore the range of health professionals accessed by the women and the responses from those health professionals at the time of presentation. All but one of the women (n=24) sought health assistance from more than one health professional while living with the perpetrator. Figure 8 (below) illustrates the range of health professionals accessed by women, and the number of women who presented to these health professionals while living with the perpetrator.

Figure 8 Health professionals accessed while living with the perpetrator



Presentations and responses: pre/post-birth

Eight women specifically discussed their contact with health professionals during pregnancy and/or post-natal care. Pregnancy is known as a time of heightened risk for commencement

or escalation of abuse (Brownridge, Tallieu, Tyler, Tiwari, Chan and Santos 2011; Campo 2015; Baird et al. 2020). Lina, with two children and no extended family in Australia, described her pregnancies as stressful and anxious, balancing the health of her baby alongside managing the 'difficult behaviour' of the perpetrator. Lina recalled accessing several health professionals during this time, including her doctor, midwives, maternal and child health workers, and a counsellor, none of whom identified the reasons behind her anxiety, nor validated her concerns when she spoke of the 'difficulties' in her relationship. She was advised to make more of an effort for her husband and spoke of how this advice kept her and the children in a dangerous situation. She said:

Not only did no health professionals pick up on this when I went for help while I was living with the abuse, the exact opposite was true. When I was pregnant with my daughter, I remember a poster at the hospital that said, 'the only thing kicking you should be your baby – if this is you, ask to see a counsellor', so I did. When I went to see the counsellor, I spoke to her of how things were at home, and she actually suggested that I take the time to get the baby to bed and make him a meal and make him feel like he was special again. The message was loud and clear, perhaps if you weren't so useless at being a wife. She sent me back to a dangerous situation. I actually left my husband when my daughter was 18 months old because he started to hit her – if this had been dealt with while I was pregnant, she would never have known that kind of fear.

Robyn recalled experiences post-birth, which resonated with discussions from all focus groups. During a maternal and child health nurse visit to her home, her husband grabbed her arm harshly and called her a useless cow while she was in the kitchen making the nurse a cup of tea. She entered the room crying and the nurse asked her husband to leave the room so that she (the nurse) could ask the screening questions required as part of the NSW Health family violence screening program for maternal and child health. Robyn reported that he told

the nurse that they had no secrets and the nurse called him a 'romantic husband' and let him stay. During this visit, the perpetrator expressed concern to the nurse that Robyn was 'continuously crying and overwhelmed' and asked the nurse for assistance in how to best support her. He used the term 'post-natal depression' in this session and Robyn stated that this changed the course of the conversation from that moment. The nurse ran through a checklist with Robyn and announced that according to the Edinburgh Post-natal Depression Scale (EPDS), she had post-natal depression. The EPDS is a tool of 10 self-report items that asks respondents to rate feelings and associated severity over the past seven days. The categories include feelings of anxiety or concern, changes in sleeping habits, feeling sad or miserable and feeling overwhelmed (Cox, Holden and Sagovski 1987). Maushart (1997) argues that the introduction of post-natal depression has been a two-edged sword for women. On the one hand it has legitimised a form of acute suffering that can occur following the birth of a child, however, it has also pathologised many of the normal experiences post-birth for a woman, including 'feeling anxious, depressed, isolated and overwhelmed' (Maushart 1997: 161). I argue here that the EPDS also individually pathologises post-birth women when they present with health consequences from, and reactions to, DFA, disconnecting these health impacts from abuse and oppression that post-birth victim/survivors experience. This disconnection is an example of structural oppression created through gender-blind medical responses to women discussed previously and signals a need for feminist critical analysis of this diagnosis (Smit 2002; Mollard 2015). When this is coupled with the pathologisation of many normal post-birth experiences for women, the EPDS can become a dangerous weapon in the hands of the perpetrator and a health professional who displays an acceptance of DFA myths, as was the case in this example (confusing controlling traits as 'romantic'). This disconnection, which also demonstrates the capacity of a perpetrator to charm, manipulate and invite collusion with a health professional through reinforcing social norms and expectations, influences the responses to women living with DFA.

Presentations and responses: stress and anxiety

Eight women discussed their presentations to health professionals for stress related symptoms including anxiety and depression. They spoke of treatment centring only on presenting symptoms, with no discussion of these as a potential response to gendered abuse.

Furthermore, in situations where the perpetrator accompanied the woman, the perpetrator introduced a narrative to the health professional, using emotive language to describe her as irrational, hysterical, unreasonable or mentally ill, and emphasising the ways in which she did not conform to typical and appropriate behaviour expected of a woman and a mother. In addition to this, the perpetrator framed himself as the victim of her 'dysfunction' and appealed to the health professionals to protect him and their children. This occurred in all instances where the woman was accompanied by the perpetrator, or where the perpetrator was involved in help-seeking behaviour. The women recalled that with the attention focused on her stress as a symptom of mental illness, the diagnoses and treatment that followed validated and strengthened the perpetrator's story, enabling them to further control and manipulate the woman, as well as influence relationships with family, friends, and professionals.

Responses and treatment such as those described above placed women and their children at greater risk. Di, a 35-year-old mother of three children, highlights, 'I was thinking I was just a drama queen, the way he told me I was'. Di explained that a doctor prescribed Largactil to deal with her 'propensity for drama', as the perpetrator had told the doctor when he took her for assistance to deal with her 'stress'. Largactil is a neuroleptic major tranquiliser, used to treat psychotic disorders such as schizophrenia (Haddad, Kirk and Green 2016). This medication has major side effects, including dizziness, drowsiness, blurred vision, agitation, breathing difficulties and weight gain (Dorozenko and Martin 2017). Di reported that this medication turned her into 'a zombie' for several months, strengthening the perpetrator's mantra about everything being in her imagination. Di stated that this enabled him to completely control everything as she was too 'zonked out' to do anything about it or to protect herself in any way.

My husband had complete control while I was on Largactil,
you could tell he just loved it. I thought I was crazy, I thought
I was going mad, and I went to this practitioner to help me,
to tell me that I wasn't going mad, but I was petrified. I hated
it; I didn't understand – I didn't know.

Thirty-six-year-old Sandra recalled that her husband was a highly respected general practitioner, with great social standing in the rural town in which they lived. She talked of being unable to seek assistance because no-one would have believed her story. Sandra's husband diagnosed her with depression, placed her on anti-depressants and talked to friends and family about her mental illness and the stress of having to look after her and protect the children. He referred Sandra to one of his colleagues, who was a psychologist. Sandra spoke to this psychologist about her husband's temper and the psychologist breached confidentiality by telling the perpetrator what she had said. Following this, Sandra received a phone call from her husband saying she would never see her children again as punishment for speaking in this way about him to a colleague. Sandra said she had to work extremely hard to get him to understand that the psychologist had made a 'mistake' and that she had not said that at all. As Sandra recalled:

He said I cannot believe what you told the psychologist, you have betrayed my trust and he went on and on about this. I was shocked, I did not give my permission for the psychologist to talk to him about this, surely a psychologist would know that this is the worst thing you could do. He broke my confidentiality and put me in grave danger.

Examined through the lens of feminist critical theory, these examples demonstrate the ability of perpetrators to weaponise cultural, medical and psychological norms, and gender-blind health systems and those who work within them to blame the victim, taking the focus away from the perpetrator and expanding their control.

Presentations and responses from emergency departments

There were nine presentations to emergency departments by six of the women victim/survivors during the time they were living with the perpetrator. All nine presentations resulted in the health professionals focusing on the emotional state of the woman at the time of presentation, regardless of her symptoms or her story. The presentations and treatment demonstrated several themes consistent with the examples outlined above, including the

influence of cultural beliefs and social norms around expected behavioural presentations of trauma and of good women/good mothers (and by default, the behaviour of bad women/bad mothers). Responses based on these expectations are blind to, and therefore make invisible, the lived experiences of women victim/survivors and amplify the ability of a perpetrator to weaponise these themes and manipulate both the health professionals and the health outcomes for victim/survivors.

Melinda, for example, suffered extreme physical abuse including the perpetrator threatening to shoot her while holding a gun to her head and then attempting to suffocate her by pushing her head into the carpet. Melinda recalls thinking she was going to die when she 'blacked out' during this episode. She said she was physically ill and had difficulties breathing upon regaining consciousness. The perpetrator took her to an emergency department, and Melinda explained it was not the first visit to an emergency department following his violence. She also stated that he always took her to different emergency departments. Melinda recalled that once there, he calmly and rationally talked to triage staff of his concerns about her mental health. She remembers being confused and afraid and unable to think clearly but tried to tell them that he had almost killed her. She says she became increasingly agitated because they did not listen to her but believed him. Melinda said she was treated like a 'criminal' in the emergency department on that occasion. A psychiatrist was called in to 'control her' and she was medicated. She said that at no time was she asked any questions asked about her injury or her relationship, and no connections were made between her presentation and potential abuse, even though she was trying to tell them what had happened. She explained that he came across as a calm and concerned partner, while she came across as this increasingly 'crazy, angry' woman.

Melinda's experience not only demonstrates the ways in which a perpetrator can use a gendered health system and those who work within it by playing into narratives of mad women; her experience also reveals a lack of knowledge on behalf of the health professionals in identifying potential trauma and common tactics used by perpetrators in these situations. Herman (1997) states that perpetrators attack the credibility of their victims to control and direct the narrative about the woman and that this tactic finds fertile ground in a gendered medical system where psychological theory is founded on the denial of the reality of women's lives. As previously stated in Chapter 4, women victim/survivors of DFA experience multiple intersecting dimensions of oppression which result in layers of trauma. These layers of

trauma play out in the automatic stress reactions to abuse and the effects of living with coercive control and gendered oppression (Wilkin and Hillock 2014). The reactions of victim/survivors to this complicated trauma can be as wide ranging as extreme passivity through to explosive anger, substance misuse or self-harm (Herman 1997; Wilkin and Hillock 2014). Feminist critical theory recognises many of these reactions, and the relationship with the social conditions of women's lives, as acts of resistance to abuse (Coates and Wade 2007). However, a medical discourse of mental health interprets these as a rejection of the feminine 'norm' (Hillsburg 2017). Anger, for example, becomes a symptom of mental illness, not seen as a potential act of resistance (Hillsburg 2017; Maji 2018). Melinda was not the only woman in the focus groups to have had this experience.

Maria, who was 38 years old, with four children, presented to the emergency department a week after her husband 'slammed her head' into the sink, causing a large split in her head, which he told her to repair with super-glue. At the time, he did not allow her to seek medical assistance, but he changed his mind a week later when the wound became infected. Maria explained that over many years he had taken her to several emergency departments following assaults, and like other perpetrators, choosing a different emergency department for every presentation, as well as timing the visit for the early hours of the morning when there were fewer staff. She said he always told her what they would say to explain any injuries and she was warned to 'stick to the story'. Upon this presentation, he told staff that she had refused to come to hospital for a week because she had mental health issues and hated hospitals, doctors, and medical intervention. He described the impact of this as 'distressing' for him and their children. He stated to staff that this had been worse following the birth of their last child, several months prior to this 'accident', and asked the staff to help him. Maria reported that not only did they listen to his story, but they did not ask to talk to her alone or question his version of events. She was told how 'silly' she had been to let it get to this stage and that she had to stop thinking only about herself. Maria's example again demonstrates treatment based on presenting symptoms, and the ability of the perpetrator to weaponise a health system pre-disposed to interpreting women's distress as a form of mental illness and from that, manipulating and successfully colluding with the health professionals. It also demonstrates the internalisation of cultural norms of men's authority by those health professionals, so readily accepting the perpetrator's account that she had an existing mental illness, now intensified following the birth of a baby. Maria was

diagnosed with post-natal depression during this presentation. There was no consideration in the responses of the health professionals of pregnancy, new birth or delayed medical attention as a potential indicator of DFA. These examples also demonstrate the control of the perpetrator in the timing and place of seeking health assistance.

Post-separation, the women continued to deal with impacts on their health that were a consequence of the abuse. As previously discussed, some of the women experienced stalking and other controlling behaviours. Many of the women stated that the impacts on their health became obvious to them after leaving the relationship, as they had limited emotional or physical capacity to address health issues while they were with the perpetrator.

Joining the dots

The women came to the realisation that they were and had been victim/survivors of DFA, made connections and ‘joined the dots’ between the abuse and their health, in a variety of ways after leaving the relationship. Hill (2019) argues that women first need to realise they are in an abusive relationship, before any connections are made and options followed up. This was the case for the women victim/survivors in this research.

Of the four women who experienced physical abuse, the physical trauma associated with their physical injuries was an easy connection for them to make in terms of having an impact on their health, however, they explained that they were manipulated, or ‘gaslighted’ into believing that they were over-reacting, and that they were to blame. Penny, aged 35 with two children, talked of how she came to believe that there must have been something wrong with her, or that she was in some way deficient if he had to do these things to her. She explained that she had his voice in her head repeating this to her. As Penny said:

I went in there thinking this was my fault, I deserved to be punched in the head after what I said. There must have been something wrong with me if he had to do that do me.

This manipulation, including the perpetrator tactics of minimising and/or denying his actions, and threats for punishment should she disclose the truth about how an injury occurred, had the effect of keeping the women silent in many presentations for physical injuries. The role

of perpetrator manipulation in silencing women and health professionals will be explored further in Chapter 8 of this thesis.

For the women who did not experience physical assaults, there were several issues contributing to their lack of clarity about DFA and the connections of the impacts of this abuse on their health. Thirty-year-old Lina was isolated from her family of origin and the perpetrator actively ensured that she was given very few opportunities to socialise without him. One of the consequences of this was that the perpetrator was her only point of reference and validation for what was happening and whether it was acceptable behaviour. It was only his voice in her head. Lina explained:

He used to say that he wasn't a wife-beater, but that anyone married to me would be doing these things. If he'd married a normal human being, he would have been a nice husband, but it was that he's been lumbered with this woman that was so defective that – what do you do, every time I'd seek help, I'd end up thinking well I must be this hopeless wife that anyone would rage at.

Sharon was very articulate in the group discussion about the abuse in the relationship and the impact on her health, however she stated that she only realised this after leaving the perpetrator. Sharon voiced the experiences of other victim/survivors in the focus groups when she said that she needed to be free of the voice of her perpetrator inside her head, and to trust her own feelings, before she was able to make any of these connections. She reported that:

I didn't understand the impacts on my health. I am fairly intelligent, but part of the abuse is manipulation of your sense of right and wrong and justification for actions and confusion and I think that warped my view.

All the women talked about having the voice of the perpetrator in their heads, feeling that they were responsible for what was happening, not having enough of an understanding as to

what behaviours were considered abusive and not being aware of the need to look further into their health issues. They also spoke of how the responses of the health professionals validated the perpetrator's voice and reinforced the idea that they were to blame for the perpetrator's behaviour.

The women spoke of how health issues for themselves and their children became acute and complex after leaving the relationship. During this time, they accessed various health professionals, some of whom were able to assist the women to understand they had been living with abuse and were able to make connections between abuse and health, while others did not. Many of the women made their own connections and discussed the resistance they received from health professionals when proposing these links.

For example, five of the women did their own research once they had left the relationship. They did so because they felt that the mental illness diagnosis was not an accurate fit for them. Rhiannon described discovering she had been in a DFA relationship as a 'game-changer' for her. Katrina, who was subject to technological abuse, described how she found a new sense of freedom when she was finally able to use a computer without having to worry that the perpetrator was watching what she was doing and checking up on where she had been. This enabled Katrina to investigate the types of behaviours and tactics he had used, and she was able to identify this as DFA. Upon this discovery, she contacted a family violence agency, where this was validated, and the work began on connecting her health issues with her experiences.

Two women discovered through their own research that the behaviours of the perpetrators were legally considered DFA and that a diagnosis of 'Post-Traumatic Stress Disorder' (PTSD) fitted their understanding of their presenting issues and experiences far better than the depression and anxiety labels they had been given following presentation to an emergency department. Rachel took her laptop with her to show her GP what she had found and why she felt it was the right diagnosis for her. She said she was surprised when he argued against this. She asked him if she could go on a mental health plan to assist with the cost of ongoing counselling and reported that, again, she had to argue with her doctor before he would give her this referral. Christie recalled that when she explained the abuse and the impacts on her health to her doctor, he told her it was time to move on, focus on the children and forget about her relationship. Christie remembered thinking that this would have been good advice if she and her husband had 'just separated', but she had post-traumatic

symptoms of terrifying flashbacks and vivid nightmares because of the abuse and needed assistance in managing these. Other women echoed the sense that health professionals did not understand how invasive post-traumatic symptoms are following DFA, and nor did they understand the time needed to recover.

Five of the women found help when they sought assistance for their children following separation from the perpetrator. One woman, Melinda had arranged for her daughter to get assistance for an eating disorder and to be included in a support group for parents. The facilitator of the parent support group took Melinda aside after one session and gently let her know that as she was discussing the behaviours in her previous relationship, she was talking about abusive and controlling behaviours. Another woman described the connection being made for her when she took her two daughters to a Centre Against Sexual Assault clinic for assistance after learning that their father had sexually abused the children. It was in a conversation with the sexual assault social worker that the worker told her that in addition to the sexual abuse of her daughters her husband had been committing DFA against her and the children.

A consistent theme amongst the women was the sense of relief they felt when the connections were made between their health issues and the abuse. Sandra looked for some assistance post-separation for what had been labelled her 'mental health' issues during the time of living with the perpetrator.

After I left him, I went for help and the last lady who was from a family violence agency was able to connect the dots, she helped me out. None of the others took charge of the situation or gave me any ideas about it, it was just me sitting there going blah, blah, blah and them giving me ideas of things for me to try fix myself. No action, no proactive information, he was stalking me and when this lady labelled it as stalking and abuse – then I knew. I was horrified that this was happening to me. If I hadn't have talked to her, I may still not know that this is family violence, I don't know.

Rhiannon, an Aboriginal woman, also expressed the relief she felt to finally have an understanding that fitted with her experiences of abuse and the impact of these on her mental health. Rhiannon felt that she was brushed off and disregarded by those she went to for assistance because of her Aboriginality. She explained that the perpetrator was not Indigenous, and she felt that this contributed to many assumptions on behalf of health professionals in terms of who was 'the problem' in their relationship. Rhiannon's experience demonstrates not only a lack of knowledge around DFA on behalf of the health professionals, but also the consequences for her of the intersecting discrimination of a gender-blind, colonial focused and racist medical health system and those who work within this system. Rhiannon finally found help through a family violence agency,

DV Connect referred me to a psychiatrist that knew about family violence, she told me I had no mental illness or psychosis, but I had PTSD. That was great, because up until then all doctors and psychs told me it was all about something being wrong with me. I had been diagnosed with bipolar, hormonal problems, misdiagnosed several times, not one linked it to family violence.

The women's experiences demonstrate that when the structural conditions of their lives were taken into consideration, they were less likely to be offered diagnoses and treatment options based on a gendered deficit notion of mental ill health, as had happened for them previously. These experiences show the importance of recognising the impacts of the manipulation and gaslighting tactics of the perpetrator, to validate the lived experiences of the women victim/survivors and deconstruct the perpetrator narrative with new knowledge and information. These experiences also demonstrate the difference for the women when presenting to a health professional who was knowledgeable about DFA with a gendered understanding of the consequences of intersecting structural conditions of abuse on the health of victim/survivors.

Conclusion

In this chapter, I have discussed the experiences of the women victim/survivors, exploring the wide range of abusive behaviours they were subject to and the impacts on their health. All but one of the women accessed health professionals for assistance while living with the abuse, and all women accessed health professionals during recovery. Six women presented to emergency departments following a physical assault, some alone and others in the presence of the perpetrator, one woman being brought in by the police. The women's experiences demonstrated that the responses from health professionals and the treatment they received were bereft of a gendered understanding of the impacts of the structural conditions of their lives.

The women and the health professionals exhibited beliefs and an understanding of DFA similar to that held in the general community and which failed to consider the presence, role, and consequences of coercive control, and the ways this may present in the behaviour of a woman seeking health assistance (Webster et al. 2018; Hill 2019). Alongside this, the women's experiences demonstrate that medical systems steeped in traditional expectations of good/bad/sane/mad women and mothers which provides fertile ground for perpetrator manipulation and responses to women that blame, pathologise, individualise and influence treatment. Pease (2019) argues that gender-blind theories emphasise individual deficits and pathologies, therefore the positioning of symptoms needs to be 'framed within a nuanced understanding of patriarchy' (Pease 2019:22). The women's experiences demonstrate this.

The next chapter examines the findings of the online surveys and in-depth interviews with health professionals and managers of family violence agencies. It considers the health professionals' knowledge and understanding of both DFA and the role of screening and compares these findings to the women's experiences of seeking assistance for health issues as presented in this chapter.

Chapter 7. 'We just know': Practitioner experiences

The phrase 'we just know', is a quote from one of the emergency department social workers responding to my interview question about how workers in emergency departments identify the presence of DFA. The worker's response was bereft of an explanation as to how, or what processes and procedures supported identification of DFA. This chapter is an analysis of the emergency department social workers' responses to the survey and interviews. The findings demonstrate that in settings without universal screening, health professionals did not have the confidence, skills, or resources to identify women living with DFA, nor to respond to them, but were not aware of this, or of the consequences of gender-blind responses to DFA. Thus, I found they did not 'just know'.

Feminist critical theory emphasises the need for workers to not only understand the ways in which macro social structures contribute to gendered oppression, but also to challenge and address structural disadvantages (Healy 2014; Morley et al. 2019). Therefore, in my research, it was important to do more than gain an awareness of how health professionals identified, conceptualised, and managed potential presentations of DFA. It was also critical to understand the contribution of the health system to current practice and to advocate for systemic change. The information from the emergency department social workers not only revealed insights into the ways in which DFA was identified in emergency departments and the perceptions and knowledge of the social workers in terms of the impacts of abuse on the health of a victim/survivor, but it also exposed workers' reliance on medical model responses to women's emotional distress, and their understandings of the place of DFA screening programs in emergency departments.

In this chapter, where appropriate, I compare responses from the women victim/survivors and the social workers to highlight the disparity between potential indicators of DFA nominated by the emergency department social workers, and the women's experiences. The reasons for these differences, will be explored in the following chapter. I conclude by examining the responses from interviews with the managers of family violence agencies, discussing their understanding of the role of the health system in responding to DFA, and views on the place of screening within emergency departments.

Emergency Department social workers

To recap, 35 emergency department social workers completed the online survey, and of these, ten participated in a follow-up in-depth interview. This discussion is based on the answers to the survey and the interviews of those 35 participants. The social workers worked in hospitals from all states and territories throughout Australia and represented a cross section of regional, rural, metropolitan (suburban and city) locations. Six of the 35 social workers worked in hospitals where screening programs were in operation at the time of participation. Three of the programs were available to patients presenting to emergency departments. Of the 35 social workers, two had experience working in the VIP program in New Zealand. In this section, first, I discuss the social workers reflections on the rates of identification of DFA in their emergency departments, before exploring how identification is achieved in screening and non-screening environments. I conclude this section with a discussion of the social workers' knowledge of universal screening programs and their attitude towards the implementation of such a program in the emergency department.

Rates of identification

In Australia, it is estimated that 34 percent of women over the age of 15 years will have experienced physical or sexual abuse (ABS 2017). Cleak, Hunt, Hardie, Davies and Bell (2021) argue that at least 54 percent of women who present to an emergency department will have experienced DFA in their lifetime, yet it is estimated that only 5 percent of victim/survivors are identified (Hinsliff-Smith and McGarry 2017). At the time of conducting the research, it was difficult to obtain reliable data on identification of DFA within emergency departments. For workers from hospitals where there was no screening program in place, the information was anecdotal, with the majority of workers expressing concern about the low rates of identification and acknowledging that it depended on staff expertise and confidence. As one social worker from a metropolitan women's hospital in Victoria noted:

The thing is we don't even keep stats on this, so I only know anecdotally what comes into social work from the ED staff. Some staff are great and have it on their radar, some have no idea and don't know what to think.

Two workers from specialist women's hospitals (one each from Victoria and Queensland) were particularly conscious of their low identification rates, given they only saw women who presented to their emergency departments with reproductive health issues. Research demonstrates that pregnancy, new birth and choices around contraception and termination are times of increased risk of DFA for many women (Baird et al. 2020). One worker from a metropolitan women's hospital in Queensland explained:

We know that what we are doing is not working, because we are a specialised women's hospital, and our rates of identification are not the same as what you would expect.

Fifteen of the respondents worked in emergency departments that were the only accessible after-hours medical service for women in their region and these participants said they expected higher rates of identification, especially after hours and over weekends, however, this was not the case. In larger metropolitan hospitals, the social workers stated that they 'should' be picking up on more cases of DFA, as one worker from a metropolitan hospital in SA said:

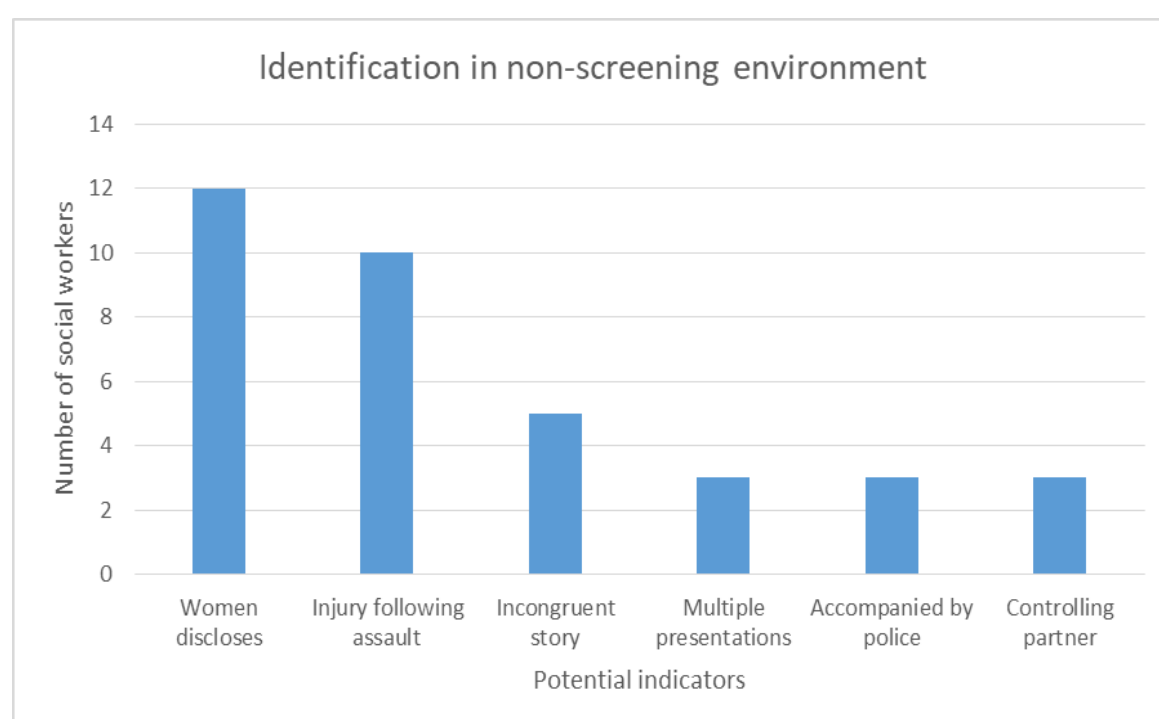
We haven't been doing it well. We had been involved with one family for six years and didn't know. Now, in hindsight, I can see it. He was always here, she had no communication with her family. We have to do something. Statistically we are not picking up on what we should. We know that sometimes our ED is the only place people can come after hours and on weekends.

All emergency department social workers were concerned about the low rates of identification. Their information, alongside previous research, demonstrates that women dealing with DFA are not being identified at the rates at which they are presenting (Cleak et al. 2021).

Identification of DFA in non-screening environments

Twenty-nine of the 35 emergency department social workers worked in hospitals where there was no screening program in place within their emergency department. These workers were asked how they identified DFA in female patients who present for health assistance and gave examples of a range of practices. These are summarised in Figure 9 Identification in a non-screening environment, below. (Note respondents could choose multiple items, therefore responses total more than the sample size).

Figure 9 Identification in a non-screening environment



As can be seen from Figure 9, potential indicators of DFA used by social workers in non-screening emergency departments include self-disclosure by the woman, the presence of an injury from an assault, an explanation of an injury or presentation that did not match the physical evidence, multiple presentations to the emergency department, and the presence of police or a controlling partner. The social worker from a metropolitan women's hospital in Queensland summed this up:

Women who present to the ED are not routinely screened and are identified mainly through self-disclosure. There will be occasional disclosure through direct questioning with suspicious or serious injuries.

I now discuss these factors and compare them, where appropriate, to the experiences of the women participants outlined in the previous chapter.

Self-disclosure

Twelve of the 35 emergency department social workers stated that they would rely on self-disclosure from a woman victim/survivor to identify the presence of DFA. The workers stated that staff may have a suspicion of something being 'not right', but it would depend on the confidence of that staff member as to whether they acted on their suspicion. This social worker from a rural hospital in Queensland explained, 'we identify when women disclose it. Some staff members are confident to ask if they have a suspicion, but that is not always the case'.

For women victim/survivors to disclose the presence of DFA to health professionals, they need to first be aware that they are experiencing DFA (Hill 2019). The experiences of the women outlined in the previous chapter demonstrated that the majority were not aware they were in an abusive relationship, and therefore did not self-disclose. Relying on this as a main method to assist in the identification of DFA is problematic as victim/survivors are not going to self-disclose if they are confused or unaware, they are dealing with DFA and not having a conversation denies them the opportunity to begin to understand this. As Robyn explained,

I think it would definitely be very helpful to be asked about it in an emergency department – not just asked, but to have it explained that this is domestic violence, because, as I said, I didn't know that's what it was. I didn't even realise.

Injury following an assault

Ten social workers stated that they would suspect the presence of DFA if a woman presented with a physical injury, especially if that injury was serious, 'suspicious' or was consistent with an assault. The workers explained that depending upon the confidence of the worker, they may ask the woman about the injury, or their colleagues may call in a social worker to have this conversation with the woman. The emergency department social worker from a metropolitan hospital in the NT stated, 'there would be direct questioning with suspicious or serious injuries, however, this is dependent on the curiosity and confidence of treating staff'. This quote, and the overall reliance on physical injury to identify DFA, presents several concerns. The quote demonstrates that women victim/survivors presenting with an injury may or may not be identified, depending on whether the injury is considered 'suspicious' or consistent with assault. The response from the health professional would be contingent on their confidence. Alongside this, physical abuse, although the most understood form of abuse within the community (Webster et al. 2018), was the form of abuse least experienced by the women victim/survivors in this study, and yet, those who did present to an emergency department with a physical injury were not identified due to the women presenting with unacceptable female trauma responses, and/or an acceptance of the perpetrator narrative. Hill (2019) argues that the focus on 'incidents', including physical abuse, blinds the professional to the presence of coercive control. Coercive and controlling behaviour is estimated to be present in over 80 percent of DFA and is linked to DFA fatalities (NSW Domestic Violence Death Review Team, 2020), highlighting the importance of identifying patterns of controlling behaviours, rather than an over-reliance on physical injuries.

Incongruent story

Five of the emergency department social workers stated that if an injury or story behind a presentation did not fit with the physical evidence, this could be an indication of DFA. The social workers said that this may be picked up at triage or by the attending medical officer. The social worker from a metropolitan hospital in WA explained, 'staff may question a patient if the explanation for the injury seems dubious. It depends a lot on the staff member and if they feel comfortable'.

Again, the confidence, knowledge and skills of the health professional were highlighted as was relying on the presence of a physical injury to assist with identification. For the women victim/survivors who presented with what they felt was a 'dubious' story accompanying their injuries, none were questioned, as shown in Marias's experience:

He (husband) came with me into the room and said that I
had fallen over and got a bruise and twisted my finger
somehow, and he (doctor) believed my husband.

Maria was not the only victim/survivor who felt that the story presented was taken as the truth, even in circumstances where the story was incongruous or suspicious.

Accompanied by police

Three of the non-screening emergency department social workers stated that police accompanying a woman would be a 'red flag' for DFA. The social workers explained that police are often called to attend a scene where violence has occurred, and in these situations, the police would identify the presence of DFA for the health professional prior to arriving at the emergency department. The emergency department social worker from a regional hospital in NSW explained, 'when police accompany a patient, it can inform ED staff of an FV alert'.

This form of identification relies on the ability of the police not to be manipulated by the perpetrator and for them to correctly identify the aggressor in a DFA situation. Research demonstrates that women victim/survivors are misidentified as the aggressor by police in one in ten applications for protective orders (Ulbrick and Jago 2018). This is particularly concerning because research in Queensland has shown that almost half the women killed had previously been identified by police as the perpetrator, and nearly all Aboriginal women killed have been recorded as both perpetrator and victim (Ulbrick and Jago 2018; Gleeson 2020). The overwhelming reason for this is the ability of the perpetrator to further their control by taking a 'victim stance' in the presence of police, alongside women presenting in ways that do not fit police expectations of victims and a failure by police to understand the difference between a single incident of defence-based violence and aggression-based violence based on patterns of power and control (Davis and Link-Gordon 2021). Over one third of perpetrators, when directed to call the Men's Referral Service (MRS), will identify as the victim, and present

a detailed story, inviting the professional to collude with them and attempting to control the narrative to disguise their abuse (No to Violence 2011). The perpetrator may also communicate calmly and rationally with the police, in comparison to a woman victim/survivor, who may be in a traumatised state with heightened emotions (Ulbrick and Jago 2018; Gleeson 2020; Davis and Link-Gordon 2021). This, combined with any intersecting vulnerabilities of a victim/survivor that can enable the practical exercising of structural discrimination, such as Aboriginality, disability, or substance misuse issues, can contribute to victim/survivors being misidentified as aggressors by police (Ulbrick and Jago 2018).

Two women participants, Katrina and Melinda, explained that DFA was not identified upon presentation to the emergency department even though they presented in the presence of police. They both spoke of being treated as the ‘aggressors’ and had the experience of the police believing the perpetrator’s version of events and then relaying this to the emergency department staff. As Katrina explained,

Their comments carried so much weight. The coppers, I said to them, are you serious? When we got to the hospital, they did not assess or ask me any questions. Even the fact that the police took me to hospital didn’t get them thinking that something was on.

The women spoke of the secondary traumatisation they experienced in these situations, describing a sense of great relief when the police first responded, only to have that turn into distress and disbelief when the police colluded with the perpetrator. These experiences, alongside the research discussed above, demonstrate that relying on police to inform emergency department staff of the presence of DFA can be problematic.

Accompanied by a controlling partner

Three of the emergency department social workers stated that they would suspect the presence of DFA if a woman was accompanied by a controlling partner. They explained that if the woman deferred to the partner when answering questions, or if he was impatient for her to be discharged, this could be an indication of the presence of DFA. The social worker from a metropolitan hospital in SA stated:

If a patient is accompanied by a male who presents as controlling, answers questions for the patient, does not want the patient to remain in hospital or if the patient becomes withdrawn in his presence, then the staff might suspect family violence.

Reliance on a health professional identifying a perpetrator through obvious controlling behaviour is problematic. No to Violence (NTV) (2011) argues that a controlling partner often attempts to gain the confidence of a professional and will work to control the conversation and collude with a practitioner. A perpetrator using these tactics will not come across as domineering and will more likely appear calm and reasonable. No to Violence research demonstrates that professionals need training to identify collusive tactics of control by perpetrators. DFA was not identified for the women in this study who presented with the perpetrator and where there were indications of control, such as talking over her, asking and answering the questions, telling the 'story' of how the injury occurred and pushing for early discharge.

Multiple presentations

Multiple presentations to the emergency department by a patient were identified as a potential indicator of DFA by three social workers. One worker explained that if a person was presenting regularly, this could be a 'good indication' that something was not right, while another stated that it may prompt a review of previous presentations to see if there was a pattern emerging in terms of type of injury or illness in the presentations. A social worker from regional Queensland explained, 'we would only pick up on it if we suspected it when someone presented on a regular basis with anxiety, depression, etc'.

The women victim/survivors discussed multiple presentations to emergency departments, however, in these instances, the perpetrator took the woman to different hospitals for each presentation. The issues arising through the lack of a shared patient health information database and hospital record system in some states within Australia have been discussed previously. All but one of the women victim/survivors lived in a state with no shared record system, therefore their multiple presentations to different emergency departments

went unnoticed. Penny was the exception to this, however she explained that the health professional who attended her on the second presentation in three months to the same emergency department did see a pattern, and asked her why she was so clumsy, 'It didn't seem to matter that I had presented at the hospital several times, they were thinking that all of a sudden, I had become really clumsy'.

This quote above again demonstrates that the response a woman victim/survivor receives depends on the specific health professional and their level of knowledge, skills and/or confidence.

Staff would just know

Alongside the potential indicators used by the social workers in non-screening environments discussed above, 14 participants reported that they would be aware of the possibility of the presence of DFA in women presenting to the emergency department but gave no information as to how they would arrive at this conclusion. These workers responded openly that they provided a 'limited' service, in that they were not physically located in the emergency department unless paged, and/or identification of DFA was an 'ad-hoc' process with no clear system in place, whereby some clinicians clearly had this on their radar and knew what to look for, while others did not.

When comparing the information from emergency department social workers in non-screening environments to the experiences of the women victim/survivors, the presence of these potential indicators nominated by the social workers did not always translate into identifying the presence of DFA or to women victim/survivors being asked about their situation. The responses of the social workers demonstrated that many were aware of potential indicators, but if staff lacked confidence, skills, or the knowledge to know when to act, DFA was not identified, and women victim/survivors received no support. Further to this, the potential indicators nominated by the social workers give rise to other issues of concern when compared to the experiences of the women victim/survivors, such as a reliance on self-disclosure, or workers focusing on the presence of physical injuries. Other well-known risk indicators for DFA were not raised by the social workers in non-screening environments, including pregnancy, new birth, recent separation, or other known intersecting vulnerabilities as described previously by the women participants and in contemporary literature (State of Victoria 2016c).

Screening environments

Six of the 35 emergency department social workers reported that their hospital offered some form of DFA screening programs. Two of these were within the NSW case-finding model, one in the SHRFV program in Victoria and two situated in emergency departments, in Tasmania and Queensland, respectively.

As mentioned in Chapter 3, both the case-finding and sensitive enquiry models (in NSW and Victoria respectively), are considered 'selective screening models' with screening initiated only in specific circumstances. The remaining two screening programs identified by the emergency department social workers met the criteria of a selective screening model. The program in Tasmania screened women within a certain age range and was not available after business hours, and the program in Queensland, although a 24-hour program, initiated screening only when indicators were present. These screening programs were not universal, in that not all women were screened at presentation (O'Doherty et al. 2014).

The emergency department social workers from screening environments demonstrated a deeper understanding of potential indicators of DFA than those from non-screening environments. For example, those from screening environments discussed 'at risk' populations of women, including those seeking assistance for prenatal and post-natal care, mental health presentations, women recently separated and those from diverse and highly vulnerable social locations, including Aboriginal women, women from non-English speaking backgrounds and women with a disability. A social worker from a regional hospital in NSW explained, 'We look for women with increased statistical risk such as Aboriginal women and those booking in for maternity care'.

The workers from screening environments were also concerned about the number of women victim/survivors that were not being identified within their programs. They expressed frustration at the limitations of their programs, including limited hours of operation, strict eligibility criteria which often excluded vulnerable cohorts (i.e., age, relationship status, presenting health issue), restrictive question formats which did not allow for discussion of individual circumstances, limited training resulting in differences in staff knowledge and confidence, a lack of monitoring or supervision to embed new understandings, alongside a lack of built-in processes for evaluation. As the social worker from a metropolitan hospital in Tasmania said, 'We are only screening women between the ages of 18 and 65. This makes no sense. We know there are older women dealing with this'.

The social worker from a regional hospital in NSW was concerned that many health professionals she was working with would not be able to identify a woman living with or recovering from DFA, despite working within the case-finding model. She explained that screening in this model was based on a set of pre-programmed questions with pre-set follow-on domains dependent upon the answers given to the preceding question. For example, women were asked 'do you have a partner', to which if they answered no, the line of questioning ceased. The worker was particularly concerned about this as she was aware of the research around increased risk to women post-separation. She explained that the prescribed questions did not allow workers to 'follow up on a hunch', and many of her colleagues administering the questionnaire did not have a good enough understanding of the potential indicators to have that 'hunch' which signifies the need for greater investigation. She explained:

I don't think they do, especially the more subtle kinds. They rely on these forms to tell them what DV is and are not picking up on the half of it because the questions aren't deep enough. At least 50 percent of my caseload would be DV, but very few of these cases are captured in our data.

The workers from screening environments explained that their programs included training for staff to increase their knowledge and confidence to understand some of the indicators and ask the questions, however, this training was often not mandated, varied in length or hours of training, involved different information and had little or no post-training consolidation and/or review. The social worker from a metropolitan women's hospital in Victoria explained:

In NZ, we did all face-to-face training, full days of it, and then this was consolidated through a file review with a mentor/champion, and we had an annual update. Even then, you knew you were only understanding the basics. Here it is becoming more an hour or two here and there and online modules like the OH & S modules we do online.

It is clear from the emergency department social workers working within screening environments that there were limits with selective screening programs as they did not ask questions of all women and screening was not available in all emergency departments. In these programs, it was at the discretion of health professionals to recognise potential indicators and initiate a conversation with a woman or call in a social worker. As can be seen from the experiences of the women victim/survivors and the emergency department social workers, this can result in a lack of intervention and support, and responses that do not recognise or respond to the consequences of DFA.

As previously stated, emergency department social workers in both screening and non-screening environments were concerned with the low rates of identification and indicated that there was a need to address this. When asked about universal screening as a way forward, there was a clear difference in the responses from social workers who had experience working in the NZ model and those who did not. I now discuss these responses.

Knowledge and attitudes towards screening programs

All emergency department social workers were aware of universal screening practices and programs in use within their emergency departments for the detection of other factors known to have impacts on health and mortality, such as smoking, diabetes, and heart disease. Social workers whose experiences were based solely within Australian hospitals had multiple concerns relating to both the effectiveness and the practicalities of implementing a universal screening program for DFA within emergency departments. Concerns included the effectiveness of such programs, the potential of a program to damage the trust women have with health professionals, the perceived lack of referral options in the community, and the practicalities of these approaches in busy emergency department environments. The social workers with experience of universal screening programs had concerns about the unpreparedness of Australian hospitals and health professionals to implement universal screening.

Effectiveness

The emergency department social workers were aware that 'something had to be done differently' and that screening could lead to an increase in identification. When asked about universal screening in emergency departments as a potential way forward to address this,

five social workers from non-screening environments stated that this may not be effective, in that it although it may lead to an increase in identification, it may not translate to women leaving an abusive situation. This is not an aim of any of the screening programs previously discussed in this research, however, it was an example of the lack of knowledge on screening programs within the sample in this research. As one social worker from a regional hospital in Queensland said, 'We can identify them, but that doesn't mean they leave'.

Three social workers cited WHO recommendations (discussed in Chapter 3), arguing that although health professionals have a critical role to play in identifying DFA, there are risks and costs involved in universally screening (WHO 2013a). This view is aligned with researchers who argue that universal screening does not necessarily improve health outcomes for women or lead to them leaving the perpetrator (Hegarty 2015; VEGA 2018).

In contrast, the workers with experience in the VIP model explained that the effectiveness of a universal screening program is not measured by the number of women who leave an abusive partner following identification of DFA, and that it is difficult to measure improved health outcomes in the short term, or even over the course of one generation. One social worker from a metropolitan women's hospital in Victoria explained, 'What we know is that women don't just leave after being asked, any measurement on women leaving after being asked is not understanding what victims' help-seeking is'.

These workers understood that screening provides an opportunity for every woman to have a conversation about the impacts of abuse on her health and for her to be given information on available support. They explained that this sends the message that the hospital cares about them and takes a firm position against DFA. These workers stated that the expectation for a woman to leave a relationship once abuse is identified was unrealistic and often unsafe, and that this should not be the expected outcome of screening. The VIP experienced workers conveyed a more comprehensive understanding of potential 'trigger points' in a woman's journey out of DFA, than that of the other emergency department social workers. As one said:

For those women, they are not at any stage of readiness to leave, but they may have identified for the first time that what you are presenting with here is linked to family violence. It becomes the beginning of their journey. We can identify them, but that doesn't mean they leave.

The VIP experienced social workers made a clear distinction between WHO guidelines necessary for work in some jurisdictions where women, health workers and community support may be at risk, and other jurisdictions such as Australia and NZ, where conversations can be held safely and where there is community support. The concerns from these workers were around the lack of preparedness of hospitals and health professionals in Australia to be having these conversations. As the social worker from a metropolitan women's hospital in Victoria explained:

The hospitals and hospital staff have a long way to go. I was part of setting up the program in New Zealand and over there all the hospital data systems are linked. We mandate quality and safety, we have things in place, training, support, referral pathways. Over here, you would need to really skill up and educate workers. There needs to be huge shifts in the knowledge that staff currently have or else they will just be reproducing myths and not responding appropriately to women.

These workers expressed confidence in asking all women once processes were in place and education was mandated for all workers. They demonstrated a realistic understanding of the role of such a program in terms of its effectiveness and knowledge of risk and spoke of the potential for a screening program to create opportunities to address and contribute to changing the culture of a hospital, the health system and its staff. The workers with VIP experience also understood that it is not appropriate to measure the effectiveness of such a program against other universal health screening already undertaken in an emergency department. As previously mentioned, Pease (2019) picks up on this issue when discussing

screening as a potential way forward to address DFA. He argues that screening for an illness or disease is empirical and, as such, quantifies risk factors. DFA, however, is a social phenomenon and requires a more nuanced approach. Addressing this to ensure good practice in screening for DFA will be further explored in Chapter 9 of this thesis.

Potential to damage trust

Five emergency department social workers stated that universal screening had the potential to damage the trust women have in their hospitals and in their relationships with hospital staff. These workers spoke of their own reluctance and that of their colleagues, in introducing questions that could be seen as intrusive, especially in situations where there was no physical evidence of an injury or in circumstances where the woman had not said anything to indicate that this was an issue. These social workers also made the connection between an increase in identification rates and an increase in notifications to child welfare, stating that this would affect the trust and safety of the relationship between women and their health professionals. One social worker from a regional hospital in Queensland explained that once women were aware that by disclosing, they would have to leave the perpetrator or risk losing their children, they would decide not to talk. She said:

Many women in FV relationships come from traumatic family backgrounds anyway, and many of them have had child services input in their lives. They see the hospital as a safe place and may be too afraid to talk about it because they may think that child services will be called on them.

This quote demonstrates two issues; the first is that identification of the presence of DFA automatically results in a report to child welfare authorities, and the second is that there is a 'type' of woman likely to be dealing with DFA. First, the workers with experience of universal screening discussed the need to report to child welfare only in circumstances where a 'threshold' of risk had been reached and stated that there were ways to have a supportive and transparent conversation with a woman victim/survivor if this was necessary. (Mandatory reporting and balancing child safety concerns with the threshold of reporting are explored in

further detail in Chapter 9.) The social worker from a metropolitan hospital in Tasmania explained:

It's challenging to have a conversation with a woman around child safety, but if you frame it around safety, there are ways to have the conversation. Still women who are ready to talk will talk, it doesn't stop them – they thank you. We have had a lot of comments from the women being asked, 'thank you for asking', 'it's great that you are doing this', so it's all been very, very positive.

Second, that women dealing with DFA are likely to have come from a 'traumatic family background' and therefore have had previous experiences with child welfare services, reveals the belief that there is a 'type' of woman who is likely to become a victim/survivor of DFA. This understanding subtly transfers some responsibility for the abuse onto the victim/survivor, positioning a woman with trauma experience as one who is likely to have a potential deficit in her emotional wellbeing and therefore likely to be in an abusive relationship. Research based on feminist critical theory requires that beliefs such as this, which are inherently blind to gendered oppression, be made visible and challenged to advocate for change.

Community sector capacity

Seven of the emergency department social workers raised concerns about the lack of capacity within DFA support services in their communities. They said these agencies did not have capacity to respond to an increase in referrals, which would likely happen if hospitals identified more women and referred them to these agencies. The workers described the lack of existing referral pathways, partnerships, and networking opportunities between their emergency departments and DFA community agencies and said that it would be irresponsible as they cannot 'give women choices' if they are not available. One worker from a metropolitan hospital in Queensland summed up:

It raises more questions for me. We get very little help from the DV services in the community. Our DV service has nowhere to send them, we have difficulty getting our DV service to do anything if it's later in the afternoon and we lack partnerships with other community agencies.

This demonstrates that some workers have few relationships with family violence agencies contributing to a limited understanding of the capacity and potential role of these agencies in supporting women victim/survivors. These workers used this lack of knowledge as a justification to not endorse universal screening.

The social workers with experience working in the VIP model were aware that addressing capacity for increased referral and support was a necessary component of a universal screening program but viewed this as a challenge that could be overcome with appropriate attention to networking, communication and partnership establishment. They did not see this as a reason to avoid increasing identification rates and supporting at risk women victim/survivors.

Practicalities

Alongside the concerns discussed above, seven of the social workers raised issues in relation to the practical suitability of a universal screening program within an emergency department setting. These issues included a lack of physical space to hold a private conversation, and the time constraints of working within a busy, and often crisis driven, emergency department. The workers pointed to the current procedures common in many emergency departments, where triage questions are asked in a public space, and argued that emergency departments would have to be completely physically re-designed to conduct DFA screening. They also stated that they would find it uncomfortable to ask a partner to step outside and that this may lead to a patient filing a complaint against them. The social worker from a metropolitan hospital in NSW explained:

There is also no space to have these conversations here to talk to every patient on their own. Structurally and systemically, the designing of EDs do not take DV into account. Many of the barriers here point to privacy and time.

The workers with experience of the VIP model were also concerned about the practicalities and time constraints and explained that it takes time and planning to address these issues. They spoke of the need to create a culture that embraced these necessary changes. The social worker from a metropolitan women's hospital in Victoria said:

This is a long and protracted piece of work to change the culture of a hospital but providing an opportunity to talk about it and provide intervention at that time is very important. We know this is a process.

Another practical concern raised by one social worker was the issue of staff turnover and the implications for consistency in training. This worker was from a metropolitan hospital in the NT, where she explained it was difficult to recruit and retain staff for any length of time. She had only been in her position for several months and was unaware that there had previously been a pilot screening program in the emergency department of the hospital, previously discussed in this thesis (Young and Hayhurst 2003). The emergency department social workers who had worked in the VIP model again saw this as a challenge which could be overcome, and not an argument against universal screening. These workers emphasised the need for consistent and mandated training to ensure that it was undertaken and maintained by all staff. As previously discussed, risks of prevalence and hospitalisation rates for DFA are compounded by multiple layers of discrimination, and amongst Aboriginal women in the NT, this culminates in a hospital presentation rate that is 86 times higher than for non-Aboriginal women (COAG 2014; Our Watch 2020). Given the risk to this population group, it is important to overcome any challenges to address this issue.

The information from the emergency department social workers clearly demonstrated that identification of DFA was not occurring to the extent that they thought it should be

happening. Current practices are ad-hoc, fail to identify, intervene, or support women victim/survivors of DFA, and depend on the confidence or curiosity of the health professional. The majority (n=25) of the emergency department social workers in non-screening environments responded in ways that would not challenge the situation or lead to change.

Those working in screening environments, including those with experience working in the VIP model, understood the concerns raised by their colleagues as they had faced them prior to participating in their screening programs. These workers were aware that the 'concerns' raised reinforced the 'reluctance' they observed within Australian hospitals to embrace universal screening in emergency departments. They were firm in their opinion that it was what had to happen to address this issue. The social worker from a metropolitan women's hospital in Victoria stated:

It's not easy and it takes time and work, but you can't have some women offered assistance and others not, depending on whatever health professional they get at the time.

I now turn to the responses from the managers of the family violence agencies, to explore their understanding of the role of the health system and universal screening as a potential way forward to address this issue.

Managers of family violence agencies

As previously stated, this research included one-to-one interviews with managers from five specialist family violence agencies (see Appendix 11: Interview questions for managers of family violence agencies). These managers worked in agencies located in Tasmania (1), NSW (1), NT (1) and Victoria (2). The focus of these interviews was to gain insight from those with extensive experience in the DFA sector, specifically focussing on the role of universal screening in emergency departments to identify and support women victim/survivors. The responses from the managers confirmed and validated the experiences of the women and the gaps in knowledge and associated practice of the emergency department social workers. In this section, first, I discuss the managers' knowledge of screening programs, then their understanding of the unique position of emergency departments to support victim/survivors

and finally their opinions on the aims of a universal screening program for use in an emergency department setting.

Screening programs

All managers had worked in the DFA sector for more than a decade, including three for over twenty years, and were aware of various DFA screening programs within the health system including in maternal and child health settings and some general practice clinics. They were also aware of DFA screening practices used in the community sector. Two of the Victorian managers were familiar with the Common Risk Assessment Framework (CRAF – a precursor to the Multi-Agency Risk Assessment Management tool in operation in Victoria) and a manager from Tasmania explained that a similar risk assessment framework operated in their jurisdiction. These managers stated that the CRAF was an example of a screening tool which enabled workers from different disciplines and professions to work from a shared understanding of the drivers and gendered nature of DFA, alongside shared definitions, risk factors, myths, impacts on victim/survivors, perpetrators, and available resources and support. The managers spoke of the benefits gained when workers and agencies deliver a consistent approach. As one manager from an agency in Victoria explained, ‘Women need a consistent approach. We don’t want some women getting a good response, some getting a terrible response and some women getting no response at all’.

The managers had some knowledge of screening for DFA in emergency departments and responded positively to this as an effective component of practice when working with victim/survivors in a hospital setting. This positivity was tempered with a discussion on the need for screening to be part of a larger program working towards changing the culture of hospitals and health system responses to women dealing with DFA. The managers reiterated the need for planning and strong partnerships with family violence agencies in the community. The manager from an agency in Tasmania had been involved in the establishment of the program in an emergency department of a metropolitan hospital and knew the work that was required to establish such a program:

Of course, we should be screening everywhere, but there is a lot of work involved, the level of education needs to increase significantly amongst all workers, and you need to make sure there are adequate referral pathways.

The managers expressed frustration with the lack of identification and response to women who presented to hospitals, often in need of assistance after hours. Managers spoke of occasions when women victim/survivors relayed to them that hospital workers did not know the existence or whereabouts of the family violence agency closest to that hospital when the women asked for support.

Screening in emergency departments

The managers were knowledgeable about peak times for the perpetration of abuse, as their agencies catered for an increase in demand for services during these times. A manager from Victoria explained the increase in need throughout the Christmas period, she stated:

The stats reflect what family violence services see every holiday season. We always see a stark increase ... for police, emergency services and family violence services, the number of women who contact them for support will only increase. It is a time when family violence services are busiest.

She went on to explain that during these periods there was a rise in intervention order breaches, harassment and stalking of victim/survivors, and property damage. The managers of the family violence agencies use this knowledge to prepare their services for an increase in calls for assistance and support after hours, on weekends, and on public holidays. For these reasons, the managers considered that emergency departments were critical sites of intervention for victim/survivors as they were often the only accessible services during these peak times, especially for women living in rural and remote areas.

The managers were aware that women living with DFA were more likely to present to emergency departments and knew that those women were not being systematically identified in emergency departments. For example, the manager of the family violence agency in Tasmania spoke of women coming through her agency who had presented to an emergency department for treatment for injuries or anxiety that were a result of DFA, and who were not asked any questions relating to their relationship or the presence of DFA. The managers explained that the lack of screening at these times meant missed opportunities, as noted by a manager from NSW:

We know that many women come through our service who have been hospitalised 12 times and never been asked the question and each of those times it has been a lost opportunity to intervene and prevent DV from occurring. It's not that simple, but we need to be doing something.

This knowledge is validated by the experiences of the women victim/survivors who had attended emergency departments while they were living with the abuse. Some of the women presented several times and to different emergency departments over several years and were not asked any questions about DFA. One of the managers from Victoria was critical of the presence on clinical indicators as a precursor to screening, as this was reliant on staff knowledge and open to perpetrator manipulation. This manager stated that asking all women at all presentations was the only way to begin to address this.

Aims of screening

When asked, the managers demonstrated a nuanced understanding of the aims of a universal screening program within an emergency department. They were critical of any expectation that unless risk determined otherwise, a woman would be expected to make some immediate change to her living situation or circumstances if she was to disclose DFA or if it was identified. As the manager from a Tasmanian family violence agency explained:

It's a very base statement or understanding if we say screening will lead to women leaving violent relationships – that is not the case. It assists in their help-seeking behaviour, by asking about it. They may deny this, but you are sowing the seed that this is an okay place to ask, this is serious enough that people are asking. It starts the whole process of thinking and decision making.

The managers explained that a universal screening program would aim to identify DFA to assist a woman to understand what was happening and help her to make the connections between her situation and the impacts on her health. They discussed that the important factors would be to have the conversation, ensure that a woman understands that certain tactics and controlling behaviours are DFA, and that she is believed and validated. The managers stated that it was important in any intervention that responsibility for the behaviour be placed with the perpetrator. They also reiterated the importance of assessing the safety of the victim/survivor or making a referral for risk assessment and safety planning to be completed. The managers said it was a vital opportunity to give a victim/survivor information about support and assistance for future reference and argued that screening is not about expecting a woman to leave the relationship, or make immediate changes to her life, but to offer avenues for support. The manager from a NSW family violence agency summed it up:

It's about understanding what the turning points are. It is talking to them about escalation, it not being their fault, the effects on their children and themselves. Those are the things that are the turning points. There is a whole lot of help-seeking before this, before their turning point. It's the building blocks in terms of that help-seeking behaviour.

These responses from the managers demonstrated an understanding similar to those expressed by the emergency department social workers with experience of the VIP model as

well as the women victim/survivors. They were aware of the potential impacts on the health of a victim/survivor, the unique position of an emergency department as a point of access for assistance, and the lost opportunities when victim/survivors present to an emergency department and are not screened.

The responses from the managers, when asked about potential impediments or barriers to the implementation of such a program, were again similar to the responses from the workers with experience working in the VIP model. The managers explained that working to change the culture of the hospital and the skill set of those working within the hospital system, alongside partnerships with community agencies, were all areas that would need to be addressed prior to the commencement of a universal screening program within an emergency department. The managers believed these were challenges that could be overcome with careful planning and commitment. As a manager from the NT said, 'The situation up here is out of control. We need to be addressing this, not saying it's all too hard'.

Conclusion

This chapter has explored the ways in which emergency department social workers identify the potential presence of DFA in women, by examining practices in non-screening settings and where appropriate, comparing the indicators described by social workers in these settings to the experiences of the women victim/survivors outlined in the previous chapter. This comparison exposed a disconnect between nominated practices of emergency department social workers and their colleagues, and the reality for women presenting to these non-screening environments. In contrast to a belief that 'we just know', this evidence suggests they do not actually know whether a woman is experiencing DFA. Factors contributing to this disconnect included a lack of confidence on behalf of the workers to have conversations about DFA, and a lack of knowledge around potential indicators to flag the need to have the conversations. Also evident in the information from these workers was the ways in which they continue to work through the lens of broader community values and beliefs around DFA, including myths that identify who is likely to be a victim and how a victim should present, as well as likely behavioural presentations of perpetrators.

This chapter also explored the experiences of emergency department social workers from screening environments, demonstrating that although many of these workers had a

more in-depth understanding of the potential indicators of DFA (especially those who had worked within the VIP model), limitations of the screening programs in Australia continue to produce low rates of identification. Workers within these programs, alongside the managers of the family violence agencies, expressed frustration at the lost opportunities for women victim/survivors.

Managers from the family violence agencies were aware of the many missed opportunities occurring for women who present to emergency departments. The contribution from the managers validated the responses from the women victim/survivors, as Christie explained:

I think it's better to try to ask rather than not ask and at least give the woman the opportunity even through for the first 10 times she might say, 'no, I'm fine', or she may just think it's normal because of the way she's been brought up or the way we do things in this country.

The following chapter explores the role played by the perpetrator, and the ways in which perpetrator tactics contribute to non-disclosure for the women victim/survivors and non-enquiry on behalf of the emergency department social workers. The discussion privileges the lived experiences of the women victim/survivors, to make visible and challenge the practices that contribute to gendered oppression, essential for research based on feminist critical practice.

Chapter 8. 'It has to be named': Barriers and consequences

In Chapter 6, this thesis explored the impacts on the health of women victim/survivors who had been living with or dealing with DFA. The discussion briefly recounted the reasons given by the women as to why they did not disclose the abuse when presenting to an emergency department. These reasons included women not understanding that the perpetrator's behaviour was abuse and therefore being unaware of the connections with health issues or being manipulated into thinking their personal deficiencies were to blame for the perpetrator behaviour and fearing that the health professionals would also blame them. The women also spoke of other reasons not to prolong a conversation with health professionals, including fear of reprisal from the perpetrator and needing to return home to protect their children from the perpetrator. For many of the women, previous attempts at discussing their concerns with health professionals had placed them at further risk, therefore they worked to mitigate this risk by remaining hypervigilant and not disclosing anything in subsequent presentations.

The previous chapter explored the ways in which emergency department social workers identified the potential presence of DFA in women who presented for assistance. This information demonstrated that there were no emergency departments among this sample group (either screening or non-screening environments) in Australia, where DFA was identified at the known prevalence rates within the community. This is significant given the unique and universal accessibility of emergency departments previously discussed and that women experiencing DFA present at greater rates than other women in the community (Kothari et al. 2015; Cleak et al. 2021). The emergency department social workers nominated circumstances under which they would identify the presence of abuse, which were at odds with the experiences of the women victim/survivors who, when presenting in those specific circumstances, remained unidentified.

The title for this chapter, 'It has to be named' comes from one of the women victim/survivor focus group participants, who explained that for her to understand that her partner was committing DFA, a health professional would have had to have named it as that. This is important for several reasons because first, the health professional must have the requisite knowledge about DFA, and skills to conduct the conversation safely. As Sharon explained:

It has to be named, I would always excuse the behaviour because you have his words and his voice and his excuses in your head. So used to twisting and not identifying what is going on. Women in these situations need somebody to validate your feelings because in the relationship your feelings are always invalidated. Until my friend gave it the label and validated my feelings, that's when I knew.

In this chapter, I use an analytic lens of perpetrator tactics to examine the barriers to disclosure for the women victim/survivors and obstacles to enquiry by workers. Looking at these barriers and obstacles through this lens adds a new perspective to the previous discussion. This analysis is important as it ensures that the focus remains on perpetrator behaviour. As well, I discuss a number of other factors that contribute to the adequacy of health professional responses. I follow this by examining the consequences of these responses in terms of secondary traumatisation, misdiagnosis, and the contribution to increased risk for victim/survivors.

Perpetrator tactics

There has been a great deal written on barriers to self-disclosure of DFA within health settings (Hegarty and Taft 2001; State of Victoria 2016b; Spangaro 2017). Hegarty and Taft (2001) argue that there are internal and external factors contributing to these barriers, with internal factors related to the victim/survivor's belief system, including shame and embarrassment, fear of not being believed, and a sense of hopelessness, alongside external factors such as social isolation, concerns around confidentiality and a lack of available and appropriate support (Hegarty and Taft 2001). Spangaro (2017) reviewed health system responses to DFA and concluded that there are three key issues that victim/survivors consider when deciding to disclose abuse: safety from the abuser, safety from shame and safety from losing control. The barriers to disclosure signalled by the women victim/survivors in my research included these internal and external factors and concerns for safety.

This research, informed by feminist critical theory, prioritises the framing of the discussion around barriers to disclosure in ways that do not contribute to victim blaming or to the pathologisation of women victim/survivors (i.e., their own sense of hopelessness or

deficit-based thinking). Moreover, the research privileges women as experts of their own lives, prioritising their subjective experiences and the significance they give to these experiences. Subsequently, the findings challenge dominant discourses, including medical discourses, that elevate deficit victim/survivor presentations and identity, and instead frame these discourses as responsible for the consequences of perpetrator behaviour. This research names the tactics of the perpetrator, and clearly articulates the connection between those tactics, the ways in which the medical model and current practices within emergency departments enable them, and the consequences for the women victim/survivors. Therefore, the discussion below will frame barriers to disclosure and responses from health professionals, in direct relation to perpetrator tactics and behaviours.

Perpetrator behaviour and responses from health professionals

Despite a growing emphasis on understanding perpetrator behaviour, the tactics used to control victim/survivors, and the damage done to victim/survivors upon receiving a negative social response (Coates and Wade 2007; State of Victoria 2016a; Hill 2019; Pease 2019), discussion around barriers to disclosure continues to focus on the behaviour and motivation of victim/survivors (Hegarty and Taft 2001; Spangaro 2017). For the women victim/survivors, the behaviours and tactics of the perpetrator affected their safety and self-assessment of risk and added to their confusion as to whether they were the cause of this behaviour and/or whether they understood the behaviour as abusive. Perpetrator tactics affected their understanding of how others perceived them as women, as mothers or as 'mad', and their concerns around the outcome of any attempts to address their situation.

For the emergency department social workers, perpetrator tactics affected their ability to identify and support victim/survivors, resulting in their focus being directed away from the possibility of abuse, blaming the women for their emotional distress and framing this as a mental health issue. This practice places the attention on what is wrong with the woman as opposed to what has happened or is happening to her and what the perpetrator is doing. Wilkin and Hillock (2014) argue that trauma informed practice asks professionals to focus on what has happened to an individual, rather than what is wrong with that individual, avoiding a focus on individual pathologies, which requires a change in thinking, away from the historical gendered medical model informed practice. I argue that when working to

address presentations of potential DFA, this also requires an analysis of the consequences of perpetrator tactics in the thinking and practice of health professionals working within gender-blind environments that privilege gendered social norms and male narratives.

Coates and Wade (2007) describe social responses as the reactions from others to those dealing with violence and/or adversity. These responses can be from social networks including friends, family, and colleagues, or from professionals who work in organisations and systems tasked with assisting women victim/survivors, and in fact, from the systems themselves. The type of response is significant in terms of a victim/survivor's ability to trust, disclose and recover (Coates and Wade 2007). Coates and Wade (2007) discuss the consequences of negative social responses as leading to secondary traumatisation. Herman (1997) also refers to any punitive and disempowering response from professional intervention as responsible for secondary traumatisation in women and children who have been abused. Sweeney et al. (2018) name this as 're-traumatisation' and give examples of professional interventions that demonstrate this, including not believing the victim/survivor and pressuring women to take medication for their issues.

It is important to note that victim/survivors of DFA who receive negative social responses from a health professional are more likely to receive a diagnosis of a mental health disorder and are less likely to disclose in any future help-seeking events (NSW Government 2017). Therefore, a negative social response from a health professional can have profound negative consequences in terms of future disclosure and treatment that leads to re-traumatisation for a victim/survivor of DFA.

Denial, minimisation, and blame

Common tactics used by perpetrators to confuse victims and health professionals enable the perpetrator to maintain control. These tactics include denial and minimisation of abusive behaviours, recasting those behaviours as non-violent or acceptable, and blaming the victim (Department for Child Protection and Family Support 2015). These tactics were present in the experiences of all the women victim/survivors, with the perpetrator purposefully confusing them and maintaining that confusion to ensure that the women did not have the information or confidence required to challenge this understanding. Christie spoke about how the perpetrator's manipulation worked to make her believe she was to blame:

He would say that he's not doing anything wrong and that you're the one asking him to do this – you get into that mind set and you can't get out of it.

The women spoke of the ways in which the perpetrator confused and blamed them not only for the abuse, but also for any consequences of the abuse. This was apparent in presentations to the emergency department, when the women were too ashamed to talk about the true origins of their injuries, lest the health professional also place the responsibility onto them. As previously discussed, women gave many examples of the perpetrator recasting themselves as the victim, and the victim/survivors as aggressive or 'hysterical' women with mental health issues (often connecting this with their ability to mother). This blaming of the victim, and the ways in which health professionals readily accepted this, influenced the diagnosis and treatment received by the women victim/survivors. These perpetrator tactics were effective as a barrier to disclosure for the women and influenced the motivation and/or ability of the health professionals to enquire about the potential presence of DFA. In systems where workers are not well-informed and therefore not alert to potential tactics such as these, false allegations against victim/survivors gain power (Mandel et al. 2021). For the women victim/survivors who experienced this, the behaviour from the perpetrator and subsequent negative social responses from the health professionals as a result of the manipulation, had future consequences. These experiences influenced subsequent help-seeking episodes.

Gaslighting: Undermining confidence and using isolation

The experiences of the women victim/survivors and the information from the emergency department social workers demonstrated that the perpetrator behaviour often included gaslighting of both the victim/survivor and the worker. The term 'gaslighting' was defined in Chapter 2 and refers to behaviour by a perpetrator to deliberately deny, manipulate or concoct events to make the victim doubt their own recollection of a situation (Hill 2019). The women victim/survivors spoke of gaslighting and the ways in which the resulting confusion, anxiety, loss of confidence and exhaustion contributed to them remaining silent during presentations to the emergency department. They were afraid they would not be believed should they talk to a health professional and had been led to believe by the perpetrator that

the health professional would blame them for the consequences of the perpetrator's behaviour.

The women's experiences of gaslighting also often revolved around the perpetrator questioning their mental health, saying they were crazy and continuing this narrative with the health professionals upon presentation to an emergency department. Maria recalled:

He was trying to make me go crazy or get locked up or push me to do something really bad and he wanted me to go on depression tablets. I didn't want to go on depression tablets because I know I am not crazy, but I went on depression tablets because like you can't help it, because it's not just you – all these doctors now thinking that you're the bad one and you go crazy even if you know you're not crazy.

This quote demonstrates treatment described previously, known to re-traumatise a victim/survivor. The gaslighting behaviour of the perpetrator influenced the response, treatment and support offered to the women by the health professionals. These professionals work within a system that increases their susceptibility to gaslighting by a perpetrator, because of the historical and contemporary practice of labelling responses to gendered abuse as mental illness (Herman 1997; Moulding 2016; Cleghorn 2021). In Chapter 6 I examined the ways in which a perpetrator can weaponise health system responses already pre-disposed to interpreting women's behaviour as a form of pathology. This was explored in the context of pregnancy and new birth, an area recognised as a time of increased risk for DFA. Influencing health professionals to frame women's responses to the structural conditions of their lives during this period as illness, is a form of gaslighting and demonstrates an invitation to collude by the perpetrator, not always recognised as such by the health professional. This invitation finds fertile ground in a health system already pre-disposed to interpreting a women's reproductive journey as an illness and often as a mental health issue. Other examples of gaslighting discussed by women victim/survivors included the perpetrator successfully manipulating the health worker into interpreting the perpetrator's constant presence as caring and/or romantic, or the perpetrator positioning himself as the protector of the children and indeed, needing protection himself against his aggressive partner. Robyn, for example,

described this manipulation, which enabled the perpetrator to establish 'a partnership' with the health professional. This collusion is an example of a perpetrator tactic leading to a negative social response from the health professional that acts as a barrier to disclosure for the women and inhibits enquiry by the health professional. Collusion had a profound influence on diagnosis, treatment, and support and opportunities for women to discuss and explore their concerns.

Intimidation and threats

The women victim/survivors spoke of intimidating and threatening behaviours from the perpetrator and the ways in which this influenced their likelihood or capacity to talk about their concerns when they met with health professionals. Intimidating and threatening behaviour is a tactic adopted to hurt, frighten, isolate, coerce, and control victim/survivors (Department for Child Protection and Family Support 2015; Hill 2019). As previously discussed, the perpetrator often had power over the time of presentation, the emergency department to which they presented, and the story accompanying the presentation. The women spoke of being unable to deviate from the narrative imposed upon them, and of being very afraid that the perpetrator would know if they had. The women talked of instances where they were asked about suspicious injuries in front of the perpetrator or were asked while the perpetrator stood on the other side of a curtain, and the 'grilling' they received from the perpetrator if the perpetrator was unable to listen to the conversation between the woman and the health professional. They framed the threats as being 'made to pay' if anything was disclosed. Maria, for example said that she would have been punished when she got home:

I was scared, that's why I didn't tell the truth. I lied at the hospital because I was scared, and he would have really killed me. He had guns at home.

It is important to remember these obvious examples of intimidation and threat at the time of help-seeking behaviour exist within the context of a history of intimidation and threat for the women prior to this presentation. The women revealed that this affected their ability to

discuss their situation, at the time and in the future, including post-separation, as Robyn explained:

I didn't go to hospital until I'd left. After I left him there was a lot of fear of him finding out what I would say, because he knew where I was so I didn't say anything.

The emergency department social workers spoke of a lack of confidence in themselves and their colleagues, which contributed to reluctance to ask questions or ask a partner to leave the room. Presentations where a perpetrator was intimidating affected the ability of a woman victim/survivor to disclose and workers' confidence to enquire. It is important to note that this intimidation continued to influence a woman's ability to disclose well after separation.

Using the children

Tactics used by a perpetrator to hurt, coerce, and control victim/survivors often include attacking, undermining, and interrupting the mother/child relationship (Mullender, Thiara, Skamballis and Humphreys 2006; Thiara and Humphreys 2015; Humphreys, Healy and Mandel 2018a). Behaviours such as criticising her mothering, abusing her (often in the presence of the children and encouraging the children to do the same), threatening to take the children away, threatening to call child welfare services, and telling her that if she discloses, everyone will judge her as an unfit mother, were examples of tactics used against the women victim/survivors in this research, often continuing post-separation (Mullender et al. 2006; Department for Child Protection and Family Support 2015). These tactics had a significant impact on the ability of the women to disclose or discuss their concerns with a health professional. For example, Christie was warned by the perpetrator that if she told 'anyone', 'welfare' would get involved and she would lose the children because she was such a bad mother. She had also been told by her husband that she would end up 'living on the streets' with her children, and the courts would then give the children to him. Christie absolutely believed these threats, as did other mothers in this study. The threat of welfare involvement as a silencing tactic was particularly significant for the two Aboriginal women victim/survivors, who were very aware of the history and ramifications of child removal policies of the Stolen Generations and the continuing over-representation of Aboriginal children in out of home

care. As Kylie explained, 'For me, he was blackmailing me. Saying welfare would be interested in my kids'.

One of the important factors to come from the discussions with the women around potential child welfare involvement was the revelation of the many ways in which the women protected their children despite perpetrator tactics. An exploration of protective behaviours is discussed in greater detail in the following chapter, however, those that are of direct relevance to these findings are examined here.

The women, when presenting to emergency departments, were acutely aware that their children were vulnerable if they were left alone with the perpetrator for any length of time. The women were also aware that the children would be anxious, not knowing what was happening to their mother. To protect their children, and return to them as soon as possible, the women did not prolong their time at the hospital or discuss their concerns, and often discharged themselves early against medical advice. These protective behaviours were a barrier to disclosure and an impediment to treatment for these women. This demonstrates the ways in which a perpetrator uses a woman's love and concern for her children, undermining her ability to discuss her concerns and her access to essential health services. As Kate stated:

I had to go for stitches, they asked how, but I told them I did it with a glass. I couldn't tell them. My children were at home, I had to get back.

The tactic of using the children was not only a barrier for the women in discussing their concerns or staying long enough to receive the medical treatment they required, but these protective choices were judged by the health professionals. This 'judgement' affected the way in which the health professionals perceived the women; rather than act as an indicator that there could be underlying reasons for early discharge, it acted as a barrier to enquiry.

Exploiting diversity

Diversity and difference, and the 'othering' that occurs because of this, increases vulnerability and creates additional barriers for women seeking assistance when experiencing DFA (Department for Child Protection and Family Support 2015; State of Victoria 2016b). The

women victim/survivors talked of the ways in which the perpetrator weaponised diversity and difference to perpetrate abuse and to control any help-seeking behaviour. Women who were pregnant, living rurally, from a CALD background, Aboriginal and those living in a same sex relationship, all had behaviours directed towards them that weaponised their diversity. I have previously discussed some of these examples, however Judy, who was in a same sex relationship, recalled her partner taking her to hospital on two occasions, and on both occasions, the perpetrator was not asked to 'step outside' during the triaging or the examination. Judy attributes this to her partner being a woman and DFA not being on the radar of health professionals when it came to considering abuse as a possibility within a same sex relationship. This was also Judy's experience with other professionals when she eventually sought assistance to escape her partner. She talked of the perpetrator being able to use this lack of intersectional awareness to her advantage on several occasions.

I had no supports. She had already outed me to my family and friends. I had no job. She destroyed my personal property and threatened to kill herself if I ever left. When I did leave, I had to get an IVO on her, which was difficult because the police and magistrate, they were treating it like it was just a girlfriend's tiff – that really brought me undone. The demeanour, the approach of these people – this was not taken seriously.

As can be seen from this example, perpetrators using diversity as a manipulative tactic were enabled by the influence of entrenched social norms, leading to negative social responses. This is an effective tool if a health professional is not able to frame their understanding of abuse, or their responses, through an intersectional lens. This was also demonstrated in an interview with an emergency department social worker from the NT, where there were clear indications in the interview that presentations of DFA were not taken seriously due to a lack of intersectional analysis by the worker and in the health system responses. The worker stated that Aboriginal women were just as likely to perpetrate DFA as were the men. She spoke of a common saying in the NT that, 'the women give as good as they get', yet when asked about a gendered breakdown in these presentations of injuries and lethality, she admitted that the

truth in this 'saying' was not reflected in the data. This social worker went on to say that a gendered analysis of presentation to the emergency department demonstrates that Aboriginal women presented with serious injuries more often than the men and were more likely to die as a result of these. Upon reflection, the social worker noted that of late there had been a spate of injuries in young women by their partners as 'punishment' for using contraception.

Other examples of reproductive abuse, financial abuse and victim blaming were evident in this interview, with several types of DFA explained as 'cultural practices'. For instance, the worker explained scenarios where older women presented with injuries after being made to leave their homes following a situation where a male relative had moved into her accommodation and evicted her. The social worker described this as an accepted cultural practice known as 'humbugging', where there is an expectation for resources to be shared with family or kin when requested or necessary. Research demonstrates that instances of humbugging involving younger men taking advantage of obligation to kin with an older woman, resulting in financial, property and/or physical abuse, is becoming more frequent (KPMG 2012; Zaunmayr 2018). The emergency department social worker was surprised when I connected these examples of 'humbugging' to a definition of financial and property abuse. The social worker also raised the practice of discharging Aboriginal women victim/survivors of DFA from the emergency department, when it was known that it was not safe for them to return home, or they were unable to travel back to community following discharge. The social worker explained that these were Aboriginal women who preferred 'long-grassing', that is, staying overnight in the fields on the outskirts of town and waiting until they could safely make their way back to their community at some later stage. I asked this social worker what would happen in the case of a white woman who was not safe to return home, or for whom home was too far away, and was told that non-Indigenous women do not engage in or prefer 'long-grassing', therefore the different practices here were for cultural reasons. This lack of an intersectional perspective leads to negative social responses for victim/survivors and contributes to non-disclosure by women and partial or no enquiry by health professionals.

Using male privilege

The final perpetrator tactic that worked to silence and act as a barrier to disclosure and enquiry was the use of male privilege. Webster et al. (2018) argue that there has been a

decline in community understanding that DFA is a gendered crime, meaning that men are more likely to perpetrate DFA and women are more likely to be victims. This report also argued that there is community mistrust of women's reports of victimisation (Webster et al 2018). Valenti and Friedman (2020) examine this systemic disbelief of women and argue that female credibility is dangerous to patriarchy because patriarchy is built on female subjugation, therefore, when this is challenged, patriarchy is challenged. Pease (2019) states that male privilege is normative in a patriarchal society, with Herman (1997) reinforcing that the more powerful a perpetrator is, the more he will be the one with the ability to name and define reality. Male privilege, as the social norm, enables this tactic and frames and shapes ideas around relationships suggesting appropriate behaviour that signify romantic and caring men, as well as the ways in which 'good women' and 'good mothers' behave (Lelaurain et al. 2018). For the women victim/survivors, perpetrators who presented as calm, rational, caring, and concerned were believed and seen and treated as good men who were doing the right thing. The traumatised women presented or were represented as angry, irresponsible, aggressive, out of control, and as not fulfilling their role as caring mothers or partners. Their mental health was questioned, and they were judged and not believed. When the women victim/survivors did not conform to societal expectations of victim/survivors, the perpetrator narrative highlighting and/or questioning her mental health was more likely to be believed. Pease (2019) uses the phrase 'benevolent sexism', a subtle form of prejudice that influences the thoughts and actions of individuals when confronted by an individual who does not conform to these gendered expectations. This was experienced by the women participants in this research. This benevolent sexism, practised within a gender-blind health system, enabled perpetrators' tactics to manipulate the workers and the system, and create an atmosphere of disbelief of the women.

Herman (1997) states that perpetrators work on secrecy, and failing that, work to discredit the victim to ensure no-one listens to the victim. The experiences of the women victim/survivors demonstrate that perpetrators were aware of the privileging of their narratives and used this to their advantage in health and hospital settings. The beliefs and attitudes outlined in the NCAS (Webster et al. 2018) survey results, combined with the privileging of male narratives and the historical gender-blindness of the medical system, set the scene for a perpetrator to exploit these factors, weaponise health responses and invite collusion with health professionals (Moulding 2016; Webster et al. 2018; Valenti and

Friedman 2020). In this research, it was clear that the perpetrators were able to do this, and therefore were able to contribute towards a negative social response from the health professional, which then influenced treatment. As Robyn explained:

I broke down because I couldn't believe they would listen to him and the doctor told me I needed to calm down and that I couldn't be blaming him for everything. He [husband] said I was the one with the mental health issues and that I needed to be assessed by a psychiatrist. I had to go and see a psychiatrist.

The perpetrator tactics discussed above contributed to many of the internal and external barriers and safety concerns previously described (Hegarty and Taft 2001; Spangaro 2017). These tactics, which include the use of male privilege, denial, minimising, gaslighting, intimidation and threats, using children, alongside exploiting responses to diversity or vulnerability, were effective in silencing the women victim/survivors, eliciting negative social responses from health professionals, and contributing to the inability and/or unwillingness of workers to enquire.

Additional factors

The literature, the experiences of the women victim/survivors and the information from the emergency department social workers, highlighted additional factors that also contributed to negative social responses connected to, but in some instances separate from, the perpetrator tactics outlined above. These responses were experienced by the women victim/survivors and reinforced by the systems in which the social workers worked. I now discuss these factors.

Workers' own experiences of domestic and family abuse

A recent study investigating the prevalence of DFA amongst female health professionals in Australia found that 45 percent had experienced DFA during their lifetime and that one in nine had experienced abuse in the 12 months leading up to their participation in the study (McLindon, Humphreys and Hegarty 2018). The report stated that this could affect these

health professionals in the way they respond to and support victim/survivors. For some health professionals this could lead to an increased ability to understand and offer a supportive service, whereas for others who had not reflected on their experiences, their ability to identify could be influenced by their own experiences of manipulation and gaslighting or they may be triggered through hearing the stories of victim/survivors (McLindon et al. 2018).

Herman (1997) argues that to hear a victim, a bystander must act, and acting requires engagement and remembering. For some health professionals with their own experiences, this may not be possible. The perpetrator tactics discussed above had a profound effect on the victim/survivors and their ability to understand what was happening to them, which could lead to the same effects for health professionals with their own experiences of DFA. Workers with experience in screening environments discussed worker support as a vital component of a screening program to address this issue.

Gaps in knowledge

As previously discussed, health professionals have limited education around DFA in their qualifying degrees, or any post-graduate training (State of Victoria 2016a; Cleak et al. 2021). The information from emergency department social workers in the previous chapter illustrates that those workers who had not worked within the VIP model had gaps in their knowledge which led to negative social responses. These gaps existed on a number of levels, including a lack of understanding of many potential indicators of DFA, a strong reliance on the presence of physical injury obscuring the need to look for signs of coercive control and related health impacts, a lack of awareness of perpetrator manipulation and how this related to potential trauma presentation of victim/survivors, and a limited understanding of the gendered nature of diagnoses and treatment within contemporary practice that relied on acceptance of gendered social norms, allowing perpetrators to weaponise the health system.

Attitude, language, and approach

The gaps in health professionals' knowledge described above influenced their approach and attitude when working with women victim/survivors. Three of the women victim/survivors experienced this when asked questions during pregnancy and/or post-birth in line with the policy of the case-finding model in NSW. One woman talked of how the health professional apologised to her for having to ask the questions, explaining that they 'had to be asked'. Lena

stated the questions were 'framed in embarrassment', leading her to feel that it would be wrong to answer truthfully. She explained that although she wanted to talk about what was going on at home, she did not feel comfortable having a conversation that was introduced in this way. This damaged her confidence to talk about her situation at that time and into the future:

She said she was embarrassed that she had to ask me these questions. So I went to ground for a while. The way she asked, she sent me back to a dangerous situation.

Christie stated that the routine and clinical way the questions were asked was a barrier to her discussing her concerns. She felt she may have answered differently if asked differently. She stated that it would have been good if the midwife had been skilled enough to have a gentle conversation and talk about the fact that it is not okay to be treated in certain ways, and discussed community supports. Christie says this approach may have validated that her partner's behaviour was unacceptable, she did not deserve to be treated that way; even if she was not ready to make any decisions. She stated that it would have also informed her of help available when she felt capable and safe enough to look for this. As Christie said:

I was screened in NSW during all three pregnancies. They just said it was legislation and they had to ask all women. One nurse gave me the questions to read and said I could just tick them without having to talk. She was uncomfortable asking and I was uncomfortable talking. I just gave her the paper back.

Other women spoke of the attitude of the health professional, and how important it was to feel that the worker cared enough, not only in terms of the importance of the conversation, but also in terms of being ready to believe her. Feeling believed was vital for the women in order to trust the health professional. Di explained how she felt that a conversation would have to happen, including an informed and non-judgemental attitude from the health professional. Sonia summed it up:

You need to be someone who can sit beside me, someone who is trained, not someone who has preconceived ideas. Women are switched into that, they know by the ways someone asks, their body language, the way they look at them, the way they ask questions, the way they frame questions, their tone of voice. If they are condescending, a woman will not talk to them. And if they are busy, they won't talk to them, they'll just stay numb because it's much safer, and if their partner at any time could walk in, there is no way in the world they would say anything, they've got to be at that tipping point.

The framing of the questions in this way constituted a negative social response for the women victim/survivors and created a barrier to disclosure for the women. The women's experiences also validate the social workers reflections on the health professionals lack of confidence. This is a barrier to enquiry from the health professionals.

The gaps in knowledge evident in the responses of the emergency department social workers, alongside mistrust of women's reports of victimisation, contributed to the approaches and responses of these health professionals. These attitudes and the language that accompanied them led to responses which left the women feeling disbelieved, judged, unsupported, silenced and further isolated.

Systems and negative responses

Alongside the knowledge, attitudes and approaches of the health professionals, the systems in which they worked also led to negative social responses for the women victim/survivors, acting as a barrier to disclosure and an obstacle to enquiry by workers. Health systems responses for women experiencing abuse are problematic on several levels, beginning with a history of gender-blind processes, understandings and practices that have been previously discussed in this thesis, alongside the ability of the perpetrator to weaponise these (Moulding 2016; Mandel et al. 2021). Mandel et al. (2021) argue that system manipulation by perpetrators occurs because of the unaddressed bias of gender and racial structural inequality

within the systems. This unaddressed bias adds a further layer of entrenched structural oppression for women seeking assistance. Drawing out and exposing these systemic failures, and understanding the underlying causes, is necessary in order to advocate for systemic and structural change and address the negative social responses experienced by women victim/survivors upon presentation to an emergency department.

Consequences

Many of the consequences for women victim/survivors when accessing health care while living or dealing with DFA have been discussed throughout this thesis. Experiences for the women included non-identification of abuse, the ability of perpetrators to weaponise the system and collude with the workers, and a propensity for workers and health systems to pathologise individual women. These failures have the effect of strengthening the control of the perpetrator and weakening women's power and agency.

The women victim/survivors spoke of ongoing consequences resulting from these responses, which included sending them back into dangerous situations where they stayed for longer than they may have if they had been helped. Christie, for example, stated that the action by the health professionals reinforced what her husband had said to her about everything being in her mind and that her dealings in the emergency department sent her 'underground' and discouraged her from seeking assistance for some time. When she was believed years later, she said the relief was palpable. Lena spoke of the missed opportunities for identification during both of her pregnancies, including the birth of her second child and throughout her post-natal treatment. She states:

My children and I stayed in that situation, and it didn't need to happen if this had been picked up earlier. I didn't understand how bad it was, but that every time they validated him, I felt useless. He used to say that he wasn't a wife beater, but that anyone married to me would be doing these things, if he'd married a normal human being he would have been a nice husband, but it was that he was lumbered with this woman that as so defective that – what do you do, and every time I'd seek help, I'd end up thinking well I must be this hopeless wife that anyone would rage at. I mean, you are already broken mentally so it only takes one person to say stop making such a fuss and be nicer. So yeah, I haven't had a good experience.

During the focus group discussions, the women were asked if it would have been helpful for a health professional to enquire about the possibility of DFA. They were all supportive of this suggestion. The women felt that it 'had to be named' and assistance and support offered. As Kylie commented:

It would have been extremely helpful to have a health professional ask me if something was wrong. I think it would definitely be very helpful to be asked about it in an emergency department – not just asked, but to have it explained that this is domestic violence, because as I said, I didn't know that's what it was for me. I didn't even realise.

The women had clear ideas on what should happen within a screening program and this is discussed in the following chapter.

Conclusion

The lived experiences of the women victim/survivors are critical to understanding the ways in which perpetrator tactics and negative social responses created barriers for the women to

discuss their situation and created obstacles to worker enquiry. Moreover, the voices of the women are vital to understanding the consequences of these responses at the time of presentation and into their future.

This chapter has deliberately focused on perpetrator tactics and responses from health professionals to frame the discussion in ways that do not contribute to furthering the pathologisation of women victim/survivors. Perpetrator tactics included denial, minimisation, blame, using diversity, intimidation, and threats, alongside gaslighting, isolating and exploiting children. These tactics created barriers to disclosure for the women and barriers to enquiry for the health professionals. This framing is important to identify the ways in which the health system, and those who work within it, contribute to continuation of the perpetrators' patterns of control. This chapter also explored additional factors that contributed to negative social responses for the women victim/survivors from the health, including gaps in worker knowledge, attitude, language and approach of health professionals and the influence of macro health system responses to gendered violence.

The following chapter explores good practice in screening for DFA, drawn from the themes discussed in this thesis, including the information from the women victim/survivors, the emergency department social workers, the managers of family violence agencies and the literature, to inform that practice. Good practice in screening needs to ensure that the systems and the workers who work within those systems understand, identify, and challenge this manipulation, alongside the problematic gendered lens through which medical responses to DFA sit.

Chapter 9. 'Know what you are doing and have the conversation'

The previous three chapters examined the experiences of the women victim/survivors, alongside the perspectives of the emergency department social workers and the managers of family violence agencies. This information revealed that the women experienced all forms of DFA, and that this abuse had substantial impacts on their health, not identified during their help-seeking activities. It also revealed that perpetrator tactics played a significant role for the women in understanding the behaviours as abusive, alongside reinforcing and exacerbating the gaps in worker knowledge around DFA, and the gender-blind assumptions and responses of the medical model. These experiences culminated in negative and re-traumatising responses for the women with serious and long-term consequences for them and their children. All the women victim/survivors had been diagnosed with various mental illnesses when presenting for health assistance.

The information from the emergency department social workers also demonstrated that there are limited screening programs for DFA in hospitals in Australia, and less so in emergency departments at the time of writing (June 2022). Of the existing programs, all utilised a form of 'selective screening', none being 'universal' whereby all women who presented to an emergency department, at all times of the day, were screened. The preference for selective screening across Australia continues within the discussion in the draft National Plan to End Violence Against Women and Children 2022–2032 (COAG 2022) supporting screening for DFA in known high-risk health areas. This draft discussion paper does not address the unique position and accessibility of emergency departments for women victim/survivors.

In this research, workers whose only experience was within the Australian health system demonstrated an internalisation of myths (like those held within the community) in their practice, whereby they were more likely to conceptualise DFA as 'incident based' and had gender normative expectations of victim and perpetrator presentations. There was also limited or no evidence of an intersectional analysis by emergency department social workers when considering the potential presence of DFA, and minimal understanding of the potential role of a universal screening program to address many of these issues.

This chapter builds on these findings to articulate the components of 'good practice' for universal screening in emergency departments within Australian public hospitals. I use the

term 'good practice' and not 'best practice' for a number of reasons. Coffield and Edward (2009) argue that the term 'best practice' implies that there is only one approach, one true model that will solve an issue or a problem. Identification of and subsequent treatment and support for women living with DFA who present to an emergency department involves reflective practice alongside cultural and organisational change not only for the health professionals, but for the health system itself. Working to identify and support victim/survivors of DFA is complex and will not come about through one optimum solution of 'best practice'. The term 'good practice' lends itself to improvement and regular reflection and evaluation to identify and address any shortcomings or developments that may arise (Coffield and Edward 2009).

Based on the principles of feminist research, the components of good practice outlined here privilege women's experiences and challenge the practices and systems that allow and enable the continuing control and systemic oppression of women living with or dealing with abuse. The title of this chapter, 'Know what you are doing and have the conversation' comes from one of the women victim/survivors and echoes the comments of others, when asked what health professionals could be doing to assist women when they present for assistance to an emergency department.

The literature review in this thesis explored various screening programs within Australia and internationally, including discussion on the SHRFV program in Victoria, the case-finding model in NSW and the VIP model in NZ (Scott and Kerr 2017; NSW Ministry of Health 2019; Royal Women's Hospital 2020). Although the Australian programs are examples of selective screening, and the NZ universal screening model, all emphasise two distinct but related structural components of good practice to guide the implementation and operationalisation of a screening program. The first component is directed at the macro level and seeks to change the operating culture within the hospital itself. This component includes developing and embedding principles, policies, procedures and practices, appointing specialist staff, community networking and partnerships, and a commitment from leadership to sustainably resource such programs (Scott and Kerr 2017; McCaw 2018; NSW Ministry of Health 2019; Royal Women's Hospital 2020). The second component of good practice is to address health professionals' ability to conduct this work, building their capacity in terms of knowledge of DFA and confidence to act on this knowledge. Good practice in this component involves working to increase the skills necessary to conduct a respectful and supportive

conversation as well as the ability to navigate the procedures and protocols of the screening program and knowledge of relevant supports both within the hospital and community.

The VRCFV final report states that there are four conditions required to support hospitals and their staff to identify and respond to DFA (State of Victoria 2016c). These conditions include support from the institution to adopt such a program, the development of effective screening policies and procedures, and training for staff (initial and ongoing), as well as prompt access to support services, both within and outside the hospital (State of Victoria 2016c). These four conditions align within the two components outlined above. I begin the discussion around 'good practice' by exploring the first component, which outlines necessary macro-level commitment.

First component

Information from the literature and those emergency department social workers with experience in screening programs confirms that the first necessary component of good practice involves strong and sustained commitment for organisational and cultural change. This includes not only commitment from leadership and governance within the hospitals, but also from those who drive health policy and fund health services.

Commitment to cultural change

The VIP model is built on the principle that changing the organisational culture of a hospital involves a systems approach, which is necessary to develop a lasting influence on the ways in which the health system understands its responsibility to respond to DFA and to structure and support the work of health professionals in this area. As discussed in the literature review, the VIP model was implemented as part of a much larger national response from the New Zealand government to deal with the prevalence of DFA (Koziol-McLain and Gear 2012; Fanslow and Kelly 2016). National approaches are one way to ensure consistency across all jurisdictions. This means consistency in the underlying philosophy and aims of the program, alongside uniformity in defining DFA, recording methods, and the collection and sharing of data. Having these shared understandings and processes built into the structure of a program produces accurate and comparable data and reliability in evaluation, as well as ensuring that staff receive the same information regardless of turnover or mobility (Fanslow and Kelly

2016). In NZ this whole of country model has led to macro system changes in legislation, national curriculum development for health professionals, and country-wide risk, safety, and intervention guidelines (Fanslow and Kelly 2016). It has also produced shared policy and processes, memorandums of understanding between hospitals and community agencies and standardised screening tools. These developments promote a nationwide consistent message, with room to localise information for specific communities and specific geographical areas where necessary (Fanslow and Kelly 2016). A whole of country approach such as this, allowing for conversations that influence national curriculum development for health professionals, is an important step towards addressing gender-blind shortcomings in current medical model approaches.

In Australia, there have been calls to establish national standards for health service responses to DFA and for the inclusion of DFA standards in the National Safety and Quality Health Services Standards (McKay et al. 2021). There have also been recommendations for standardisation within state and territory jurisdictions and for ongoing commitment to continuous, sustainable funding to build on previous work in screening programs (Power et al. 2011; KMPG 2012; State of Victoria 2016a; McKay et al. 2021). At the time of writing, these recommendations have not been realised.

Alongside the absence of a commitment to introduce national health standards, other difficulties exist within the Australian context because of differences in legislation, funding and policy between states and territories. The women victim/survivors, emergency department social workers, and manager participants, spoke of the consequences for both seeking assistance and working within this fragmented system. The women who presented to hospitals in border towns such as Albury/Wodonga and Tweed Heads/Coolangatta discussed the confusion when navigating different health policies and procedures and varying family violence legislation, including different risk assessment guidelines, depending on which side of the border they gave as their address, or where the perpetrator was residing. The women who relocated due to DFA also talked of different levels of support from health professionals depending on which state they had come from or moved to. The managers of the family violence agencies noted issues arising from the confusion and difficulties when working across different states and territories with women victim/survivors. The managers spoke of the complications for their own workers when navigating different state legislation

to advocate for service users and address their safety issues. One manager from a family violence agency in Victoria, stated:

It depends where women live. Some women are screened because it's state policy, and some aren't. Some health workers we deal with don't know the legislation across state lines for example and this makes delivering consistency to women in this situation very difficult.

Many issues impacting on the health of citizens across Australia are nationally coordinated and funded. These include the national immunisation program and the 'better access initiative', providing access to mental health specialists across Australia (Department of Health 2022). Good practice for DFA screening would begin with a nationally coordinated program that could lead to consistent service, policies, training, protocols, practice and evaluation.

Hospital leadership commitment

The programs discussed in this thesis stress the importance of having hospital and health system leadership commitment to support program development, sustain implementation of policies, procedures, and prioritise time for staff participation in training, operationalisation, practice reflection, evaluation and consultation. The VIP, SHRFV and NSW case-finding programs are based on a firm commitment from leadership within the hospital and involvement in oversight of the program, tasked with setting objectives and measurable outcomes within the individual hospitals (Fanslow and Kelly 2016; NSW Ministry of Health 2019; Royal Women's Hospital 2020).

Commitment from leadership within a hospital also assists in the expectation that all staff, at all levels, are required to participate in the program. Although staff training and capacity building sits within the second component of good practice, the VIP model stresses the need for management commitment to ensure that the time needed for training, supervision and practice reflection is given the weighting and status necessary to sustain this practice and bring about long-standing change (Fanslow and Kelly 2016). Knowledge of this approach was evident among workers surveyed in this research. As one worker from a regional hospital in the ACT explained:

A whole of hospital approach also sets the standard by which the social workers and other health professionals are expected to practice, in that observations and any potential conversations are not reliant on the curiosity and confidence of treating staff.

The emergency department social worker from Tasmania highlighted the consequences when not all staff are required to commit to the program. This social worker explained that the lack of direction from management enabled some staff in positions of authority to direct their teams not to participate in the screening, placing further limitations on the selective screening process.

Interagency collaboration

The SHRFV program and the NSW case-finding model, alongside international programs such as Kaiser Permanente, VEGA, and VIP, argue that representation from specialist family violence agencies be included in leadership structures from the beginning of any program, alongside networking and communication with other hospitals (McLean et al. 2017; Spangaro 2017; O'Campo et al. 2011; McKay et al. 2021). McLean et al. (2017) examined successful interagency collaboration in the DFA sector and found that good practice included shared vision and goals and formal agreements such as memoranda of understanding, agreements on policies and protocols, including in some cases, co-location of services, the appointment of community agency representatives on steering committees and joint training. Humphreys, Healy, Kirkwood, and Nicholson (2018b) argue that development and enhancement of relationships between community agencies and health settings is pivotal in working to address DFA. Mandel et al. (2021) state that siloed responses allow perpetrator manipulation of systems. Collaboration between agencies would undermine the perpetrator manipulation evident in the experiences of the women victim/survivors in this research, alongside enabling an exchange of information between the hospital workers and the family violence agencies, increasing the level and substance of support offered to victim/survivors.

The collaboration and inclusion of outside agencies at the leadership level would also work to address the anxiety felt by the social workers in this research, and the women victim/survivors who presented to emergency departments, concerned that there was not the necessary help, resources or support available and/or the knowledge within the health professionals to know what was available. The emergency department social workers highlighted that they did not have the necessary and sustainable relationships with community agencies needed for universal screening. One worker from a large metropolitan hospital in NSW stated:

We need to work on relationships with community agencies
... I have had to seek out the DV network, we weren't part of
that, no-one from the ED was involved in that. This is a huge
part of being able to do this work properly.

Accordingly, the women victim/survivors had little confidence that the health professionals they spoke to would have this knowledge, as indicated by Larissa, 'You need to have someone who knows what you are talking about and knows what to do and where to send you'.

Collaboration with outside agencies at the beginning of the process, and a commitment to these relationships, is necessary to address this issue. The inclusion of community agencies and relationships with the workers from those agencies, also assists in a less fragmented response to decisions around risk and mandatory reporting, through consultation and shared decision making to support safety and accountability (Humphreys et al. 2018b). Therefore, good practice would ensure representation of and partnership with community DFA agencies from the onset of a program.

Inclusion of lived experience

The programs discussed above reiterated the importance of community partnerships and networking, however, this research based on feminist research, centralises the voices and experiences of women victim/survivors in advocating for and working toward systemic change. In the focus group discussions, the women argued that it was necessary for victim/survivors to be included in the development and facilitation of programs. The women

stated that victim/survivor input into the planning and implementation of such a program would bring insights into the ways in which abuse is experienced by the women, and the ways in which the perpetrator is able to weaponise the health responses. Therefore, good practice would also include the centralisation of the experiences of women victim/survivors at all levels of the program, especially women severely impacted by intersectional oppression, such as Aboriginal and Torres Strait Islander women. As was demonstrated in the previous chapter, these insights are often overlooked for women seeking health assistance. Based on the women's experiences and the commitment to centralise their voices, good practice would ensure victim/survivor representation at all levels of development and implementation of a screening program, beginning at the leadership level.

Evaluation and data sharing

As previously discussed, debates around the effectiveness of universal screening arise in part from a misunderstanding of the aims and objectives of such a program. Therefore, having clear aims and objectives and building in evaluation to measure progress as well as identifying areas in need of improvement, is good practice for universal screening programs (Fanslow and Kelly 2016; VEGA 2018; NSW Ministry of Health 2019). The VIP annual evaluation process measures both internal and external factors. Internal areas include those factors within the hospital itself, such as commitment and support for the program, adoption of policies, procedures, support for staff and measuring knowledge pre and post-training, alongside staff reflections on the effectiveness of supervision and peer support. External factors incorporate the number of women screened, the percentage of those identified, referrals made and the success of referral pathways alongside sustainability of relationships with outside agencies. The results of these evaluations inform cyclical improvement to systems, procedures, national guidelines around training and legislation (Gear et al. 2020). This evaluation, based on the infrastructure self-audit file in the Delphi instrument, is built into national legislation, and includes domains that capture service delivery snapshots (Gear et al. 2020).

As previously discussed, the SHRFV program in Victoria completed a second evaluation in November 2021, following the initial evaluation in 2015 (Kearney and Gleeson 2015a). The second evaluation was implemented through the development of the System Audit Family Violence Evaluation (SAFE) project, which was directly informed by the VIP evaluation audit

tool (McKay et al. 2021). This evaluation covered 18 of the 88 hospitals where the SHRFV program had been implemented, however the evaluation was conducted without many of the advantages that exist for the VIP model. To reiterate, in Victoria, there is no standardised system for sharing health records or data capture, across different hospitals. This impacted on the ability of the second SHRFV evaluation to secure reliable information on the numbers of women screened, support offered and referral information (McKay et al. 2021). The SHRFV evaluation was able to measure the impact of the domains that were within the control of the program, such as the high adoption of SHRFV policies and procedures, and support for staff (McKay et al. 2021).

Support for health professionals

Building in procedures and resources to support health professionals, such as supervision and mentoring, is necessary for good practice (Fanslow and Kelly 2016; Royal Women's Hospital 2020). I am including these as elements of good macro practice even though they speak to and influence capacity building for individual staff because supervision and mentoring requires commitment from management and leadership within the hospital. Elements of the SHRFV program and the VIP model emphasise the importance of support for workers at all levels, including supporting staff through training, supervision in practice, confidence in using the tool and reflection on practice. Alongside this is the importance of attending to personal support for health professionals to deal with the emotional load discussed previously and which relates to listening to a woman's experience, offering a response, dealing with a perpetrator, and potentially reflecting on their own experiences of DFA (Fanslow and Kelly 2016; McLindon et al. 2018; Royal Women's Hospital 2020).

Second component

The domains of the macro foundations described above comprise the first component of good practice in screening for DFA in a hospital setting. I have argued that it is critical, at this macro level, for the experiences and voices of women victim/survivors to be centralised to address the nuanced, intersectional, and subtle ways in which perpetrators hold power over victim/survivors and weaponise the health system, alongside other crucial factors. I now

examine the second component of good practice by beginning with the importance of building capacity within the health professionals themselves.

Building capacity and competency

The screening programs previously discussed in this chapter emphasise the importance of the foundations to be in place prior to rolling out capacity building and training for staff (Royal Women's Hospital 2020; Fanslow and Kelly 2016; Feder, Davies, Baird, Dunne, Eldridge, Griffiths, Gregory, Howard, Johnson, Ramsay, Rutterford and Sharp 2011; McCaw 2018). The aims of capacity building are for health professionals to become competent in acquiring knowledge specific to DFA, including understanding definitions, myths, indicators and known impacts of DFA on health, understanding the protocols and skills necessary for introducing screening questions, responding to disclosures, and conducting the conversation (Fanslow and Kelly 2016; Royal Women's Hospital 2020). The programs also emphasise assessment of risk and an understanding of referral processes and pathways (McLean et al. 2017; Royal Women's Hospital 2020). The SHRFV program states that the goal of training is not for health professionals to become DFA experts, but for them to know enough to detect indicators, be confident to enquire, manage a disclosure, and respond supportively (Royal Women's Hospital 2020).

Across existing programs there are clear differences in the commitment to the professional development of staff (i.e., content, frequency, and the extent of that training) and the processes by which that new knowledge is embedded in staff practice. Information from the women victim/survivors, the emergency department social workers who had experience in the VIP model, and the managers of the family violence agencies, demonstrated that they were concerned about the lack of existing knowledge amongst health professionals in the Australian context, which also aligns with the findings of the VRCFV and other research (State of Victoria 2016a; Cleak et al. 2021).

Of all the programs outlined above, the VIP model offers the most comprehensive professional development program, whereby staff are required to complete three levels of training, beginning with core training, moving to in-service training, and undertaking annual refresher programs thereafter. Core training consists of an eight-hour, face to face, full day training for all workers, with role plays and reflections on the content and learning in small

groups of no more than 15 staff at any one session (Fanslow and Kelly 2016). The evaluations of the VIP demonstrate that embedding new knowledge for staff via a follow-up process consisting of supervision, support, and auditing of patient case histories, ensures consolidation of that new knowledge, increases staff confidence in translating new knowledge to practice, and increases confidence with the subject matter and the ability to ask the questions and have the conversations (Fanslow and Kelly 2016). The VIP evaluation report states that reinforcement and consolidation of the training is a vital step in sustaining that knowledge and working towards cultural change, an approach which is consistent with other established protocols for new health interventions when they are introduced into hospitals and health settings (Fanslow and Kelly 2016).

By comparison, training attached to programs within the Australian context offers less time for training, and less face-to-face content with greater numbers of staff completing training at the same time and less intense follow-up processes to assist with the consolidation of that learning (NSW Ministry of Health 2019; Royal Women's Hospital 2020). The recent evaluation of the SHRFV program recommended exploring options for expanded mandated family violence training for some health professionals, as well as a system for ongoing and updated training (McKay et al. 2021).

Managers of the family violence agencies were firm that commitment to training, and ensuring that this training was reinforced, was extremely important. The manager of a family violence agency in Victoria stated:

It needs to be done. It needs to be thought through and needs to be done properly. I worry that when the government announces training for all EDs, they are talking about online modules, not in-depth training that does more than identify different types of FV and outline the legislation and stock responses.

Notwithstanding the complexities of bringing hospital staff together for training, the VIP model has prioritised time for training and has structures in place to enable reflection and embedding of that training with clinical staff immediately following that training. This is an

important component of good practice in capacity building and a demonstration of commitment from the hospital to the program.

Inclusion of lived experience

As previously stated in this chapter, good practice for screening centres victim/survivor experience and knowledge at all levels of the program. The women participants had experienced the consequences of presenting to health professionals who lacked the knowledge and understanding necessary to identify and support them. The women spoke of the importance of the health professionals not only having a good understanding of DFA, but also the skills and confidence necessary to convey that understanding and to emotionally support a conversation of this nature. They talked of how necessary it was for health professionals to understand intersectional complexities, risk, the potential escalation of risk at the time of separation, and to take into consideration and respect a woman's own self-assessment of this risk for herself and her children. They argued that this was an important factor to be considered in any discussions and decisions to do with mandatory reporting.

For these reasons, I argue that women victim/survivors need be involved in the training, in content development, delivery and evaluation of that training. The inclusion of lived experience will assist in ensuring that participants are conscious of how their responses may be experienced by victim/survivors and that attention is paid to the consequences of perpetrator tactics.

Community agency participation

Family violence agency's participation in the development and delivery of training to health professionals is important to good practice for several reasons, the first of which is that these workers hold specialist knowledge which is essential to the development of training. In this research, the managers of the family violence agencies expressed concern with the lack of knowledge held by health professionals and the emergency department social workers expressed concern around the lack of relationship with DFA agencies, which affected their ability to offer support and referral options. Community agency participation will assist with practice content, increase confidence in referral, and provide networking opportunities.

Content

Content within the training is an important factor for good practice in a screening program. Robinson, Myhill and Wire (2018) found that practitioners display a 'spectrum' of understanding resulting in frequent misidentification that has profound consequences for victim/survivors. From this research, it is clear that capacity building for health professionals needs to include more than the basics of DFA knowledge. To be aware of and mitigate perpetrator tactics and manipulation, and understand the re-traumatising consequences of medical model responses, capacity building needs to include specific content. Based on the information from the women victim/survivors' experiences, the emergency department social workers and the managers of family violence agencies, I now discuss important areas of training content for inclusion in good practice.

Attention to macro and systemic influences

The experiences of the women victim/survivors, when presenting for health assistance, reflect information from the literature previously discussed, around the consequences of current medical model discourses when dealing with women, and specifically women living with DFA. As demonstrated through a comment by one of the women victim/survivors, Di stated, 'The medical system, I was so terrified of being told I was insane'.

I have already discussed gender-blind practices, and these combined with gender-biased normative expectations of victim/survivor, perpetrator, good women/bad women, good mothers/bad mothers and mad women and their relationship to reproductive roles, need to be addressed in any training. Health professionals need to understand the role of the health system and the pathologisation of gendered responses to ensure that practice does not enable further control over the victim/survivor.

Trauma and trauma presentation

In the previous chapter, the women spoke of the consequences for them when health professionals had limited understanding of trauma and how this manifested in a victim/survivor's presentation to an emergency department. As Zoe recounted:

Definitely a need for massive education with health professionals, not just on family violence, but presenting with trauma and referring to people who know about family violence too.

The health professionals (to whom the women presented) demonstrated expectations of behavioural presentations of traumatised women, which included an adherence to social expectations about how victims 'should' act. The women recounted that when they presented with heightened emotions combined with fear and frustration, the ways in which health professionals interpreted their behaviour enabled perpetrators to manipulate, invite collusion and blame the victim. This response, and the systems that support responses such as this, led to the medicalising, individualising and pathologising of the women's trauma reactions. Capacity building for health professionals in a good practice model needs to include an understanding of trauma and trauma presentations, including certain behaviours as acts of resistance against gendered oppression and ensuring that they attend to the social expectations and systemic dynamics that enable and disguise this. As previously discussed, trauma informed practice focuses on what has happened to a victim/survivor, not on what is wrong with her (Sweeney et al. 2018). As the women's experiences also demonstrated, health professionals need to understand that trauma presentations differ when they intersect with diversity and various social locations (Wilkin and Hillock 2014).

[Social location and intersectionality](#)

As previously discussed, the intersections of patriarchy and gender, race, heteronormative assumptions, and colonialist attitudes influenced the ways in which the social workers perceived and responded to DFA and its consequences. These responses demonstrated that without worker capacity to understand, identify, reflect upon, and resist these personal and systemic biases, the perpetrators found fertile ground to manipulate responses and ensuing treatments from both workers and systems. Therefore, any training in a good practice model must increase awareness of the complex consequences of intersectionality, of the ways in which perpetrators exploit this and how to avoid collusion with this exploitation.

Managing risk and mandatory reporting

In the discussions with the women victim/survivors, as well as the responses from the emergency department social workers and the managers of family violence agencies, there were references to the tension in balancing legislated mandatory reporting requirements for health professionals and the risks for a woman and her children when living with or dealing with DFA. All states and territories within Australia have their own legislative requirements that outline the threshold for mandatory reporting in situations where the actions of a perpetrator present a potential risk to children and non-offending parents. In the previous chapters, I have explored concerns by the women victim/survivors around their fears of child welfare services becoming involved. These fears were often exacerbated when used as a controlling tactic by the perpetrator, especially in situations where systemic discrimination continued to play a role in the removal of children, such as was the case for Aboriginal woman, Rhiannon, who said, 'One of my biggest fears was that my children would be taken off me. That fear never left me'.

It was also evident in the responses of the emergency department social workers that many did not have a clear understanding of the legislative threshold for mandatory reporting in their jurisdiction, some believing that a report was necessary in all circumstances if DFA was identified or suspected, regardless of the circumstances. As one emergency department social worker from a large metropolitan hospital in Victoria explained, 'If a mother discloses, we don't necessarily want to be contacting child protection, but the staff expect her to be able to stop it and then she can't'.

In Victoria, health professionals (along with other human services workers) are legislated to conduct a risk assessment in cases where DFA is identified, using the MARAM framework discussed previously. The current (June 2022) Draft National Plan to End Violence Against Women and Children 2022–2023 outlines the possibility of the development of a national adoption of a MARAM-like risk assessment process (COAG 2022). The MARAM framework uses four key elements when assessing risk, including identifying evidence-based risk factors, information sharing if relevant to gain further information, judgement by the professional, and the victim's own assessment (Family Safety Victoria 2020). Capacity building for health professionals in Australian screening programs includes professional development on many of the evidence-based risk factors for DFA (NSW Ministry of Health 2019; Royal Women's Hospital 2020). However, the experiences of the women victim/survivors and the

responses from the emergency department social workers clearly demonstrate elements that need to be addressed to manage mandatory reporting requirements in a good practice model. These include respect for a victim/survivor's self-assessment of risk, and knowledge of existing protective behaviours alongside understanding the risk associated with separation and available community supports to hold risk and address safety during this time.

The MARAM states that 'the agency, dignity and intrinsic empowerment of victim/survivors must be respected by partnering with them as action decision making participants in risk assessment and management' (Family Safety Victoria 2020:11). The experiences of the women victim/survivors clearly demonstrated that this did not occur during their presentations to emergency departments. The women explained the risks for them should they be made to leave the relationship without adequate supports in place with no assurance for the safety of themselves and their children. The women spoke of how this often meant that staying with the perpetrator was the safer choice and they were unsure as to whether health professionals understood that a quick decision could have placed them at greater risk. The women explained that a conversation around this and supports for safety planning would have assisted them at the time. As Lina explained:

I went with my gut that it was too dangerous to stand up to him and too dangerous to leave, so safety planning would have been good until I was in a position to be able to leave him.

As previously stated, separation is known as a time of increased risk (State of Victoria 2016a). Assessing risk is more nuanced than placing expectations on a victim/survivor to leave the perpetrator, which many social workers in this study expressed. Assessing risk also includes a health professional having some understanding of safety planning, including assessing protective behaviours already discussed, alongside other behaviours identified by the women. These included women's experiences of working to ensure that the children were out of sight and hearing should the perpetrator escalate his behaviour, placing themselves in danger to protect the children, waiting until the perpetrator had calmed down (which may have taken days) to ensure that the children were safe before seeking medical attention, and

staying in the situation until they were satisfied leaving the perpetrator would be as safe and as minimally disruptive to the children as possible. Sandra recounted:

I would be saying, it's ok, mummy's ok. You take your brother and go upstairs, that was my role through the whole thing, trying to protect the boys, trying to stop them from hearing what they were hearing and trying to stop them from seeing anything.

Humphreys, Thiara, Sharp and Jones (2015) argue that many practitioners work from a 'failure to protect' (Humphreys et al. 2015:131), position when assessing risk in a DFA situation. This position does not recognise many of a victim/survivor's protective behaviours, and treats her as responsible for the perpetrator's choices, holding her to account rather than the perpetrator. A rush to premature reporting by a health professional is a symptom of a 'failure to understand' (Humphreys et al. 2015:131) the many protective behaviours enacted by women as well as the ways in which victim/survivors are held responsible for perpetrator behaviour (Humphreys et al. 2015). This resonated strongly in the interviews with the experienced emergency department social workers and the managers of the family violence agencies. Therefore, training within a good practice model would include capacity building to ensure that health professionals understand the increased risks associated with separation, alongside identifying and validating protective behaviours already employed by the women victim/survivors, and centring perpetrator behaviour. It is important to keep in mind that the role of a health professional in a screening program is not to become a DFA specialist worker. Health professionals need to be able to identify risk and discuss safety planning, which may include a referral to a DFA specialist who will continue to work with the woman victim/survivor around the risks.

Professional judgement of the health professional

This thesis has highlighted the role of the belief system of health professionals, including social workers, regarding mainstream normative expectations of women, mothers and DFA. Mandel et al. (2021) argue there are higher expectations of women than men as parents and that women are more closely interrogated and scrutinised. It has been previously argued in

this research that perpetrator manipulation and gendered systemic bias within the medical model removes the perpetrator from view and focuses attention and judgement on women victim/survivors. This is further compounded in situations where an intersectional lens is missing. Therefore, capacity building for good practice in screening needs to enable health professionals to build their knowledge and reflect on those issues in order that their risk assessments are informed, educated and gender aware.

Holding the perpetrator to account

This research, based on feminist critical theory, has also examined the need for a deeper understanding of the presence and role of perpetrator tactics and manipulation, and the ways in which these lead to collusion with health professionals. Stark (2009) argues that the most significant factor in whether a professional will identify and respond effectively (regardless of systems, practices, or assessment tools) sits with their ability to understand the role and consequences of coercive control and recognise patterns of control, rather than looking for incidents of abuse. Building the capacity of health professionals needs to centre the experiences and voices of the women victim/survivors about the behaviours and tactics of the perpetrator and what these signify, particularly those reflecting coercive control. Such practice holds the perpetrator to account, not the victim/survivor.

Mandel et al. (2021) argue the need for systems and workers to be ‘domestic violence informed’ (Mandel et al. 2021:8), which involves considering perpetrator behaviours and the role of gender in understanding patterns of system manipulation (Mandel et al. 2021). However, Hill (2021) notes that at the present time, systems ‘remove the perpetrator from view and foreground the victim, where she becomes the subject to interrogate’ (Hill 2021:19). This is evident in medical model responses when those responses separate a victim/survivor’s emotional distress that stems from abuse and focuses instead on victim/survivor mental ill health (Moulding, Franzway, Wendt, Zufferey and Chung 2021). As discussed in the previous chapter, it is these practices and the beliefs they are based upon that act as barriers to disclosure for a victim/survivor, barriers to enquiry for a health professional, and negative social responses from the health system and those who work within this system. Good practice involves incorporating this ‘domestic violence informed’ (Mandel et al. 2021:8), understanding in any capacity building for health professionals.

Screening tools

This chapter has focused on the components of screening programs that demonstrate good practice, which alongside the development of systems and processes, centres on capacity building of health professionals to increase understanding of the macro influences of the medical model, recognise trauma presentations in the context of DFA, and deal with risk and mandatory reporting. Capacity building also calls for ‘domestic violence informed’ (Mandel et al. 2021:8) practices to focus attention on challenging negative responses in order to address the consequences of perpetrator tactics and systemic and personal bias. The actual ‘tool’ or set of questions and associated actions that flow from the answers to those questions are effective if the other components described above are in place. While the screening tool itself is one part of such a program, the experiences of the women victim/survivors demonstrate that the questions asked and the way they are asked are important for several reasons. Good practice, therefore, would involve incorporating the experiences of women victim/survivors in designing a screening tool, especially taking into consideration the ways in which perpetrators weaponise cultural practices and expectations. The women and the family violence agency managers outlined several issues that need to be considered to deal with the complex and nuanced conversations between the health professionals and the women presenting for assistance.

What should be asked?

The women victim/survivors and the emergency department social workers with experience of working in the VIP model, alongside the managers of the family violence agencies, were clear that the questions in the tool and the ways in which they were asked, helped to build trust with the woman and could either encourage or silence further discussion. The women spoke of the need for the health professional to be able to set the scene, provide a safe and confidential space, convey that the conversation was important, and that the worker was confident to have the conversation.

The VIP and the SHRFV program use framing statements to set the scene and introduce DFA, prior to commencing the screening questions (Fanslow and Kelly 2016; Royal Women’s Hospital 2020). The use of framing statements helps prepare the woman and the health professional for the questions that follow (Royal Women’s Hospital 2020). Both programs offer professional development on the use of framing statements and give several

examples (Fanslow and Kelly 2016; Royal Women's Hospital 2020). These statements normalise DFA and possible impacts on health. This signifies to a woman that the health professional knows about DFA, that the woman has not been singled out for these questions, and that this is a safe place to have the conversation. Framing statements begin by acknowledging that DFA is common and affects many women, and this is why the hospital asks female patients about their relationships (Fanslow and Kelly 2016; Royal Womens Hospital 2020).

As previously stated, many of the women victim/survivors did not know if it was safe to talk about what was going on at home, did not necessarily realise that what was happening to them was DFA, and they did not know if the health professional knew enough to understand their situation or whether information would be shared with the perpetrator. The women were also anxious about what would happen if they talked about their situation. When asked how best to address these issues, the women had several suggestions, including beginning with generalist terminology and not framing it as family violence. Di suggested:

We know that what goes on at home, and in relationships in general, impacts on the health of our patients, so we routinely ask about any worrying behaviours that might be affecting you.

The women agreed that a statement such as this could then elicit a conversation on the kinds of behaviours that might be concerning or worrying her. If the health professional was trained in understanding the kinds of behaviours and tactics used by perpetrators, this would then give them the ability to identify coercive control in the examples given by the woman. This would need to be followed up with a statement that could address anxieties around what would happen should she discuss what is going on at home. Lena suggested that women need to know why the questions are being asked, and need a simple statement such as, 'by asking you questions about what is happening for you, we are enquiring about your safety and can offer information and support should you need this'.

Framing statements such as these would also address some of the concerns expressed by the emergency department social workers, such as not knowing how to introduce the topic of DFA, and not wanting the women to feel that the hospital was unsafe or they were

untrustworthy. Framing statements referring to hospital policy which requires seeing patients on their own could also be used to ask the perpetrator to leave the room and/or the vicinity, which would assist those health professionals who were not comfortable asking the perpetrator to leave the room.

Once the issue of concerning or controlling behaviours is introduced in a private setting away from the perpetrator or other family members, evidence suggests that a series of short prompting questions, with associated actions (dependent on the answers to those questions), are best for use in busy emergency departments (Power et al.2011; O’Campo et al. 2011). Three of the screening programs previously discussed in this chapter, the VIP, the NSW Pilot project and the SHRFV, use/d a series of short prompting questions, which are modified versions of the programs discussed in the literature review of this thesis, namely the HITS or the DVIT screening tool (Fanslow and Kelly 2016; NSW Ministry of Health 2019; Royal Women’s Hospital 2020). These tools are all brief; they ask about behaviours or other acts of aggression from a partner that may have happened to the woman in the past 12 months. A comparison of the screening questions from the three programs discussed above can be seen in Table 2: Comparison of screening tool questions, below.

Table 2 Comparison of screening tool questions

SHRFV (Vic)	VIP (NZ)	NSW Pilot Project
Are you feeling safe at home? Are you ever afraid of someone in your family or household? Has someone in your household ever put you down, humiliated you or tried to control what you can or cannot do? Has someone in your household ever threatened to hurt you? Are you worried about your children or someone else in your family or your household? Would you like any help with this now?	Is everything ok at home? or Does anyone in your home make you feel bad? Within the past year, did anyone scare you or threaten you, or someone you care about? (If so, who did this to you?) Within the past year, did anyone ever try to control you, or make you feel bad about yourself? Within the past year have you been hit, pushed or shoved, slapped, kicked, choked or otherwise physically hurt? (If so, who did this to you?) Within the past year has anyone forced you to have sex, or do anything sexual, in a way you did not want to? (If so, who did this to you?) When did this happen (the last time?)	How often does your partner /ex-partner: Hit/physically hurt you? Insult you? Threaten you? Scream/swear at you?

The programs acknowledge that depending on the situation, the health professional may need to adapt some of these questions (Fanslow and Kelly 2016; NSW Ministry of Health 2019; Royal Women's Hospital 2020). As can be seen, safety and fear in current relationships is a theme. Hill (2019) explains that questions around safety and 'incidents' of abuse will not elicit information on patterns and systems of entrapment that constitute coercive control. Therefore, screening tool questions need to take this into account. This fits with the information from the women victim/survivors who said that being asked a basic question around safety such as, 'do you feel safe' or 'are you afraid', would not elicit a 'yes' response.

For them, it was not a question of feeling unsafe or feeling afraid, but a much more subtle sense that something was not right, as indicated by Lina:

I may not have answered to 'do I feel safe', the answers would have come back yes – but the answers to 'does this worry you' and 'does that worry you' would have told a different story. I wouldn't have known I was telling them I was abused, I thought everyone lived like that.

For the women victim/survivors, asking a general question such as, 'are things okay at home?' or 'does anyone make you worried or upset?', may enable a conversation more so than the questions in Table 2 around 'do you feel safe?' or 'are you afraid of anyone?', or 'how often does your partner/ex-partner hurt/threaten/scream at you?'. Feder et al. (2009) argue that asking a single question, such as 'are you safe at home?' is not effective and is unlikely to result in disclosures of violence. This was reinforced by the women participants, as reflected in Caroline's comment, 'I knew things weren't right. I think they would have had to choose their words carefully with me'.

The women also discussed the impact of only asking about current relationships or relationships within a 12-month timeframe. Questions such as these excluded women who had left a relationship and were still dealing with abusive behaviours and/or were still contending with their own or their children's health and behavioural issues. These questions also fail to take into account diverse kinship arrangements. Many of the women victim/survivors had experienced an increase in risk from the perpetrator since separation, and others were still dealing with emerging health impacts during recovery, while some had the experience of being two or three years separated from their abusive partner yet were still dealing with abuse by the perpetrator through contact with the children, child support, or other means such as legal and medical systems.

Validating statements

The VIP and the SHRFV programs follow up the framing questions with validating or affirming statements before offering information (Fanslow and Kelly 2016; Royal Women's Hospital 2020). These validating statements ensure that the woman knows she is believed, and that

this is not her fault. For the women victim/survivors, these validating or affirming statements would address many of their areas of concern, and the consequences of perpetrator tactics that kept them from talking about their situation. As Penny explained, 'It's about her knowing this is not all in her head. I went in there thinking this was my fault'.

The final process in screening is to provide information if it is safe to do so, or to inform the woman of supports available now or in the future, regardless of any forthcoming disclosure. The VIP, the NSW case finding and the SHRFV programs discuss the need to follow hospital procedures if the women and/or the children are at imminent risk, otherwise offering information about support services, or referrals to hospital social workers or community agencies.

The managers of the family violence agencies, the women victim/survivors, and the emergency department social workers with experience of screening programs all reiterated that it was vital for the women to know that the hospital was a safe place, assistance was available at the time of presentation and in the future should the woman require it. Christie stated that she might not have acted the first time she was asked about it, but it was important to know that the assistance was there if she decided to act on this sometime in the future. She explained:

I think it's better to try – to ask rather than not ask and at least give the women the opportunity even for the first ten times she might say 'no I'm fine', or she may just think it's normal.

The women stated that having the conversation and planting the idea that assistance and support were available was extremely important, regardless of the woman's intention to act on her situation at that presentation.

Conclusion

This chapter has brought together information from the women victim/survivors, the emergency department social workers and the managers of family violence agencies, along with examples of current screening programs, to outline the components of good practice in

a screening program for DFA within a hospital setting. Good practice requires commitment from all levels of the hospital, policies, procedures, staff support and training and a screening tool. It also needs to ensure that these processes and any capacity building incorporate an in-depth understanding of perpetrator tactics, patterns of coercive control and the ways in which current systems enable and continue control over the victim/survivor. Good practice needs to move beyond organisational performance and toward cultural change. Importantly, good practice centres the lived experiences of victim/survivors at all levels of the program, including leadership roles, advisory roles, participation in the development and facilitation of training and the design of the screening tool itself. The information from the women victim/survivors in this research is valuable in exploring necessary areas of knowledge content for health professionals, so that responses and support are timely, safe, trauma informed and do not strengthen the control of the perpetrator or gender-blind medical model practice.

The thesis now concludes, and the following chapter summarises the research, highlighting new information the project adds to the debate on screening practices in health settings, making the argument for the introduction of universal screening for all women presenting to emergency departments of public hospitals across Australia.

Chapter 10. Conclusion

This chapter makes the case for universal screening for DFA in emergency departments of public hospitals in Australia. I present an overview of research rationale, methods, and findings. I use the research questions to guide the discussion and conclude with a personal reflection.

As previously stated, my research was informed by my professional and personal experiences of DFA. In my professional role as a social worker, I have often been the first worker to identify the presence of DFA in the lives of the women I have worked with. When working within hospitals and health settings it was unusual to find any reference to the presence of DFA in the case notes and/or the health records of women victim/survivors. Without identification, diagnosis and treatment focused on an expectation that the woman needed to adjust to her situation through some form of corrective action. This usually involved a diagnosis of mental illness and medication to correct her deficits or pathology. Typically, responses were not trauma informed and did not concentrate on what had happened to the woman, but rather on what was wrong with her. Responses and treatment did not consider the connections between health presentations, DFA, or macro-oppressions, and did not attend to risk or safety. These reflections, while anecdotal, motivated me to do this research. I sought to further understand what was happening for women victim/survivors when presenting for health assistance and what informed the practice of health professionals in these responses, in the hope of providing ways forward to address injustice.

During much of my professional life, I was also living and dealing with DFA, and my own experiences of seeking health assistance contributed to my understanding that responses from health professionals signalled the need for further investigation. I was aware that health professionals did not always identify DFA, however, even in presentations where DFA was identified or disclosed, responses continued to individualise and pathologise. My hunch was that responses were based not only on a lack of knowledge around DFA, but also a lack of critical analysis and understanding of systemic macro contributions, including the historic role of the medical model in assessing, diagnosing and pathologising women victim/survivor presentations.

In my own final presentation to an emergency department, my distress at the future implications and ongoing physical limitations resulting from an injury sustained through a

physical assault was interpreted by health professionals as a mental health issue. I had made it quite clear at this final presentation that this was a result of DFA, however, my presentation was not written up as DFA and no support was offered. This was at a major women's hospital, and the response I received demonstrated to me that the problem was not just about the inability of a health professional to identify DFA, it was also about the diagnosis and treatment that followed, and the understanding on which this was based. I was left wondering if a universal screening program would assist with identification and guide a supportive response. Would this produce a different outcome for women experiencing DFA? Prior to undertaking this research, I did not understand the extent to which contemporary medical responses continue to support patriarchal narratives and enable perpetrator manipulation and control over victim/survivors of DFA and health professionals.

To explore this, I wanted to understand what was happening in emergency departments for women victim/survivors of DFA and put forward some suggestions for change. Was my hunch right? Were women being asked about DFA and if not, what responses and treatment did they receive and why? If, on the other hand, DFA was identified, what responses followed on from this and why? I wanted the experiences of women victim/survivors to inform better practice, however, I also wanted to know how health professionals identified DFA, the nature of their practice and what informed their practice.

What I did

To investigate these issues, I explored the current situation regarding screening in hospital settings for DFA in Australia and internationally. I examined screening models, comparing components of different programs, including the tools used and outcomes. I explored emergency department social workers' knowledge of DFA and screening programs, alongside knowledge from managers of family violence agencies. Most importantly, I spoke to women victim/survivors who presented for health assistance while experiencing DFA, to examine the consequences of the responses they received. From this information I analysed what was happening, identified contributing factors and what was needed to improve practice which would increase support and safety for women and their children.

How I did it

This research is underpinned by a feminist critical approach, based on feminist critical theory, which focuses on gender and gendered inequality, theorises DFA as the gendered expression of power in society, and analyses intersecting social locations, identifying, and validating the material differences and structural responses to these (Skinner et al. 2012; Denzin and Lincoln 2018). The background chapter explored the importance of gender, power, control, and intersectionality and adopted the definition of DFA outlined in the *Family Violence Protection Act 2008* (Vic). This definition articulates the gendered nature of DFA, the importance of power and control in understanding DFA, centres intersecting social locations and the complexities that arise from these in the language and the understanding of the Act. The language was important, as this has the power to include and exclude certain actions and meanings. I argued that making patterns of control and the presence of coercive control visible was critical in a definition. Language was also important in naming the issue. I argued that understanding abuse as ‘violence’ conjures up certain actions in the minds of victim/survivors, health professionals and the general community, minimising and making controlling behaviours invisible. Using the term ‘abuse’ as a descriptor, and ensuring that this included the domestic sphere, while allowing for wider constructions of family and kin, was important to this research and to acknowledging the diverse experiences of the women victim/survivors.

In the literature review, I examined Australian and international screening programs, exploring the differences between models of selective enquiry used in various jurisdictions across Australia, and international universal screening models. This exploration also considered challenges to the implementation of universal screening, arguing that those based on specific geographical, cultural and social-economic circumstances were not applicable to the Australian context. I presented research that demonstrated the flaws in data used for cost comparisons between selective and universal screening models, including the difficulties in calculating the costs of generational trauma and lost opportunities for women and children when practice fails to address safety and wellbeing. Other practical difficulties, such as the realities of busy, crisis driven environments and the increased burden on health professionals, were also contested as these can be addressed in the design and associated processes of a screening program.

As previously stated, this research is based within a feminist critical theoretical paradigm, which directed the research design and the methods employed. A commitment to privileging the voices of women victim/survivors was central to the methodology. Therefore, alongside the online surveys and one-to-one interviews, focus groups were chosen as a way of bringing the voices and experiences of women victim/survivors to this research.

For the first stage of this research, I developed and distributed the online survey to 105 emergency department social workers across Australia, from which I received 35 completed surveys. The second stage of this research involved interviews with 10 self-selecting emergency department social workers who had completed the initial online survey, as well as interviews with five experienced managers of family violence agencies and the facilitation of four focus groups of women victim/survivors, comprising 25 focus group participants in total.

Why I did it

I have previously discussed my professional and personal motivations for this research. I now discuss the 'why' for the methodology outlined in the previous section. The online surveys and one-to-one interviews with emergency department social workers were included to understand how workers conceptualised DFA, their knowledge of clinical and risk indicators that could lead them to identify the potential presence of DFA and the ways in which they would respond if DFA was detected. The surveys and interviews also explored participant perceptions on the role of screening programs. The interviews with the managers of family violence agencies provided an understanding of their perspectives on the role of health professionals and the hospital system in identifying DFA and supporting women victim/survivors, alongside their understanding of screening programs.

The use of the focus groups was employed to hear the voices of women victim/survivors. As a feminist critical researcher, I was committed to centralising their contributions, highlighting their words and the meaning behind their words, and in doing so, demonstrate that this research valued their subjective knowledge. The women victim/survivors were encouraged to see their participation in this research as an 'act of resistance' that would be used to advocate for systemic change for women victim/survivors presenting for assistance to emergency departments. As previously discussed, this research

has contributed to conference presentations, professional development content for hospital social workers and consultation information for screening program development as well as informing submissions to parliamentary enquiries, as a beginning of this advocacy work.

Research Questions

To recap, the research questions guiding this research were:

1. What is the nature of screening for domestic and family abuse in emergency departments of Australian public hospitals?
2. Why is it important to universally screen for DFA in emergency departments of Australian public hospitals?

To answer these questions, the research explored three sub questions:

- What happens for women victim/survivors when they present to an emergency department for any reason while living with or dealing with DFA? In other words, what are their experiences and what are the consequences of this, for them?
- How do social workers and other health professionals working in emergency departments identify and respond to DFA (in screening and non-screening environments)? I wanted to compare these responses to the experiences of the women victim/survivors, to identify and understand any differences in the perceptions of current practice. Using this information, I also wanted to explore,
- What are the important factors to take into consideration for good practice in the implementation of a universal screening program?

I now discuss the findings of this research, using the research questions as a guide for this discussion.

What is the nature of screening for DFA in emergency departments of Australian public hospitals?

This research found that notwithstanding the work and attention given to this area of practice in recent years, Australian hospital screening programs are based on various models of selective enquiry. The majority rely on evidence-based high-risk health areas such as mental health, reproductive/maternal and child health, and drug and alcohol services. Programs in emergency departments are limited in their scope and reach, with restrictive eligibility criteria such as limited aged range, specific staff designated to conduct the screening, not all eligible women being screened and/or limited hours of operation. These criteria exclude and restrict the potential number of victim/survivor participants screened, and health professionals who can screen. This research demonstrated that screening programs within Australia rely on health professionals having the confidence, curiosity, knowledge, skills and understanding to detect clinical indicators of DFA. This meant that health professionals often relied on women's disclosures and as a result, women received different and varied responses depending on the knowledge and confidence of the health professional, the hospital to which they presented, or where they lived in Australia.

The screening tools used in Australia are also problematic in that they pose questions which exclude categories of women, including those who are no longer living with the perpetrator or those with kinship and relationship arrangements other than heterosexual or nuclear families. The tools use questions based on the assumption that women will articulate their fear of the perpetrator and/or would know they were dealing with DFA. The questions on current screening tools do not focus on coercive control and would not have led to the identification of DFA in the presentations of many of the women victim/survivors who contributed to this research.

The draft National Plan to End Violence Against Women and Children 2022–2032 argues for screening to continue within the existing selective health areas and not universal screening in emergency departments (COAG 2022). At the time of writing (June 2022), identification rates for DFA within screening programs used in hospitals and emergency departments in Australia are below prevalence rates of DFA within the community, operate in ways which exclude vulnerable populations of women, and do not incorporate exploration or explanation of coercive control.

Why is it important to universally screen for DFA in emergency departments of Australian public hospitals?

A review of the literature demonstrated that DFA affects the health of women victim/survivors in many ways, and that health professionals have a responsibility to address this (WHO 2020). The literature also shows that women victim/survivors present at emergency departments more often than women who are not dealing with DFA and for a range of reasons other than physical assault, however these presentations remain under-identified (Laing 2003; Little 2005; Roberts et al. 2006; Rhodes et al. 2011; Webster et al. 2012; State of Victoria 2016c; NSW Ministry of Health 2019). I have argued that emergency departments are in a unique position to assist women living and dealing with the effects of DFA, for several reasons. Emergency departments may be the only accessible health facility after hours and on weekends, which are peak periods for the perpetration of DFA, and are financially and geographically available to victim/survivors who are likely to be dealing with economic abuse or for those who live in regional and rural locations with limited access to health facilities. These factors are very important in the Australian context, with presentations to emergency departments free for Australian citizens or specific visa holders, and the geographic realities of this large country (State of Victoria 2016a; Department of Health 2022). Failure to screen every woman who presents is a lost opportunity to contribute to women's safety and wellbeing, and that of their children.

New information from the women victim/survivors in this research demonstrates that emergency departments are also often the health setting of choice for perpetrators when seeking assistance for victim/survivors. Perpetrators use emergency departments because they can control several factors, including using different emergency departments for separate presentations over time (in jurisdictions where health records are not linked), as well as opting for times when there are less staff, and/or staff are extremely busy, resulting in less scrutiny of their narrative and presentation. This is very important information, because it tells us that perpetrators are aware that health professionals in emergency departments are unlikely to identify the presence of DFA. Perpetrators 'work the system' in emergency departments, by knowing when staff are busy and relying on the fact that many emergency departments do not share information. Hence, staff are unlikely to look for patterns in prior presentations.

As previously discussed, evaluations demonstrate that rates of identification in a universal screening model, such as the VIP in NZ, are considerably higher than those from models of selective enquiry (NSW Ministry of Health 2019; Gear et al. 2020; McKay et al. 2021). Universal screening does not rely on the ability or confidence of a health professional to pick up on clinical indicators, or on the ability of the health professional to resist collusion with the perpetrator, as there is an expectation that the health professional asks all women all questions. Evaluations from Australian selective screening model programs show a low rate of health professional compliance in asking the questions (NSW Ministry of Health 2019; McKay et al. 2021). To summarise, universal screening identifies DFA at rates higher than selective screening and women living with or dealing with DFA are more likely to experience impacts on their health and more likely to attend emergency departments (or be taken to them) for a range of reasons other than for health consequences of physical abuse. The information from the women victim/survivors, alongside the emergency department social workers working in non-screening environments, contributed new and significant material which supports the introduction of universal screening in emergency departments of public hospitals. Not offering universal screening for women in emergency departments is a lost opportunity to identify, address risk and respond to women who are experiencing DFA.

What happens for women victim/survivors?

The women victim/survivors in this research experienced a range of abuse which impacted on their health in various ways. The women presented for health assistance while living with the abuse, often unaware that they were experiencing DFA and therefore unaware of the connection between this and their health issues. Reasons for not knowing they were subject to DFA included a focus on the presence of physical abuse, manipulation and gaslighting tactics by the perpetrator, leading the woman to believe that she was responsible for the perpetrator's behaviour and for what the women called, 'the difficulties at home'. The women relied on the ability of the health professional to identify the DFA and 'join the dots' between health issues and abuse. This did not happen for the women victim/survivors in this research. DFA was not identified during any presentations to an emergency department or to a hospital department where selective screening programs were in place. As a result of this,

diagnosis and treatment were bereft of any understanding of gendered abuse and its consequences.

Every woman in this research had their emotional distress resulting from DFA diagnosed as mental illness. Intersecting oppressions were not considered in any of the presentations, resulting in further oppression and risk for these women. Examples of this included those who had recently given birth being diagnosed with post-natal depression and Aboriginal women having their economic abuse re-framed as culturally appropriate behaviour. The responses they received led to pathologising, deficit-based, pharmacological treatments, and often gave perpetrators an opportunity to rehearse their narrative and strengthen their control (especially in circumstances where the perpetrator was able to pivot the conversation to focus on the woman's apparent mental illness). This lack of awareness on behalf of the health professionals strengthened the controlling tactics of the perpetrator and added to the confusion and re-traumatisation of the victim/survivor, placing them and their children at greater risk. The women spoke of how they and their children remained in a dangerous situation longer than they otherwise may have, had they known what was happening to them and/or known of available supports.

This research also found that responses from health professionals had consequences for the women which continued post-separation and throughout the recovery period. These included damage to self-esteem and confidence impacting on her ability to make decisions or resist the mental health diagnosis. These responses enabled the perpetrator to continue undermining the mother-child relationship and weaponise other systems against the parenting capacities of the victim/survivor, including the legal system. This research found that women experiencing DFA who present to emergency departments are unlikely to have their DFA identified, unlikely to have the connection made between their health issues and the abuse, however, are likely to be diagnosed with a mental health issue and receive responses that contribute to ongoing trauma and increased risk.

How do emergency department social workers and other health professionals identify and respond to DFA?

The emergency department social workers from both screening and non-screening environments were aware that they were not identifying DFA at rates which could be

expected given the prevalence within the community, and all workers expressed the need to improve on these rates.

The information from this research supported findings from the literature indicating that health professionals have limited knowledge of DFA and trauma, exhibit beliefs similar to those held in the general community including looking for signs of physical abuse as an indicator of the presence of abuse and expectations of victim and perpetrator behaviour and presentation based on normative gendered expectations. The exception to this were those who had experience in screening programs, and in particular, those with experience in the VIP universal screening program in NZ. The emergency department social workers from non-screening environments demonstrated these beliefs through several responses, including relying on the presence of police or evidence of physical injuries to indicate abuse, looking for an intrusive or controlling partner, expectations that a victim/survivor would be aware they were experiencing abuse and therefore able to disclose this, or that a victim/survivor would present as fearful and/or demure. The experiences of the women victim/survivors reinforced these findings, as those who presented with trauma reactions demonstrating resistance, for example, through frustration, anger or heightened emotions, and those accompanied by rational, caring partners showing 'concern' for the mental health of their partner and/or safety for children, the focus was on the victim/survivor's inappropriate behaviour, there was no investigation of potential DFA.

The impact of workers' adherence to assumptions of acceptable gendered social norms was also demonstrated through responses to victim/survivors from diverse social locations, including not asking about the possibility of abuse in same sex relationships, not identifying instances of DFA in presentations of Aboriginal women, and typification of victim/survivors in terms of prior welfare involvement in a woman's family of origin. Workers' understanding that once identified, a woman would have to leave a perpetrator or risk a mandatory report to child welfare demonstrated a lack of awareness around potential risk and protective behaviours, the aims of universal screening and thresholds for mandatory reporting.

The emergency department social workers revealed a lack of awareness of the importance and consequences of the presence of coercive control in relation to the identification of DFA. This was an important finding in this research, which led me to view victim/survivor and health professional behaviour through the lens of perpetrator control.

Health professionals' lack of education, training and knowledge of DFA, is not new information, but was reinforced through the responses of the emergency department social workers in this research. However, through the surveys and interviews this research found that the combination of the extent to which health professionals adhere to historic patriarchal interpretations of women's resistance to gendered violence as mental illness, and the ways in which perpetrators weaponise these interpretations intersect, and result in a 'failure to enquire' on behalf of health professionals. The emergency department social workers did not demonstrate an awareness of this macro-level influence on their responses to women who are experiencing DFA, nor how this enabled further control of the women by the perpetrator and the health system. This research demonstrates that these two factors must be addressed in the development and facilitation of a universal screening program.

What are important factors for good practice?

In Australia, recent investigations have found that health systems (including public hospitals) have failed to adequately address and work with women in the areas of prevention, early intervention, crisis response and recovery from DFA (Queensland Government 2016; State of Victoria 2016a). Notwithstanding the enormous amount of work that has been carried out in recent years in programs such as the SHRFV program in Victoria and the NSW case-finding model, among others, the VRCFV found that service responses to DFA need to better reflect the experiences of victim/survivors at all levels (State of Victoria 2016a). As previously discussed, information from the emergency department social workers revealed a lack of awareness of the influence of historical gender-blind biases present within the medical model and contemporary health system responses. This must be interrogated and addressed within the structures and practices of screening programs. This research has shown the consequences for women victim/survivors when health professionals practice without this insight, which leads to a focus on women's emotional behaviour, reinforced by perpetrator narratives. This results in disbelief, invalidation, and re-traumatisation for women victim/survivors, who are judged as a woman, a partner and mother. This is important information, because from the experiences of the women victim/survivors and the information from emergency department social workers, current screening practices do not incorporate the contribution of perpetrator tactics to macro gendered oppressions within the

health system responses. Health responses supported and emboldened the perpetrator in both screening and non-screening environments, secondarily traumatising women victim/survivors and increasing surveillance and control of the women by both the system and the perpetrator. This understanding needs to be included in the design and implementation of screening programs. This research argues that universal screening programs is needed in emergency departments and points to specific inclusions that need to be incorporated to increase safety for women victim/survivors and change the culture of health responses.

Recommendations from the research

National

The review of the literature demonstrated that best practice to improve health responses to DFA, strives for cultural and systemic change. This necessitates the inclusion of a whole of systems approach, beginning with commitment, coordination, and funding at a national level (Campbell, Coben, McLoughlin, Dearwater, Nah, Glass, Lee and Durborrow 2001; Wills, Ritchie and Wilson 2008). A comparison of the evaluation data from screening programs in both Australia and NZ shows that in NZ, with national coordination in legislation, definitions, record keeping, training, and data collection, there is consistency in the knowledge base of health professionals. This has led to national uniformity in screening programs, the tools used and relationships with community agencies. This national response allows visibility and understanding of trends through the evaluation data, which captures changes in attitudes of health professionals and the culture of the hospital. This is not possible at present within the Australian context due to our fragmented, disconnected and siloed systems and responses. A standardised national universal screening program would address this, as would nationally consistent training, service delivery standards, policy, legislation, record keeping and risk assessment processes. The women victim/survivors discussed the difficulties that arose for them in accessing assistance in this disparate system, as did the managers of the family violence agencies and those social workers with experience working in the NZ model. It is important that any work at a national level include the voices and experiences of women victim/survivors to ensure that the reality of negotiating system access is at the forefront of any planning.

One of the outcomes of this research was mapping the way in which perpetrators weaponise the health system and health professionals, therefore it is important to understand at a national level how this occurs, and address this at all stages of a program. For example, this research found that perpetrators rely on siloed and fragmented systems to continue to exert control over the victim/survivor, the health professionals, and responses. Addressing this by enabling hospital emergency departments to share records, and information, would assist in alleviating some of those siloed responses.

Alongside these practicalities, a national approach would have the ability to understand, monitor and work towards cultural change in the attitudes, values, and knowledge of health professionals. This research has demonstrated that women victim/survivors and health professionals share many of the deeply entrenched beliefs and gendered understandings of DFA as those found in the community. These values are reproduced and sustained throughout the health system and medical model responses, therefore implementing a universal screening program at a national level will provide an opportunity to make these visible and challenge them. For example, modelling and mandating systems to become DFA informed, as described in this thesis, would contribute to cultural change and changes in service responses and delivery.

Organisational

Information in this research examined different models of enquiry including universal, case finding and sensitive enquiry models. Although these programs differed in how they were delivered, most outlined the importance of a whole of hospital systems approach, and commitment for the programs at all levels of hospital administration (NSW Ministry of Health 2019; Gear et al. 2020; McKay et al. 2021). Contributions from this research in terms of recommendations for good practice at an organisational level include the importance of victim/survivor representation and input across all levels of the program within the hospital. This will assist hospital policies, procedures, training, and screening tools to focus on the importance of understanding DFA as coercive control, and how this may present, rather than developing tools that look for incident-based episodes of DFA. The contributions from women victim/survivors to this research proposed making visible, the perpetrator tactics at these systems and organisational levels. Understanding the ways in which perpetrators rely on

gendered medical responses to DFA is important because without this, these gendered systems responses to women victim/survivors cannot be interrogated and/or challenged, unless they are made visible. This research demonstrates the importance of the inclusion of women victim/survivors at leadership levels of screening programs, alongside representatives of community agencies to ensure that programs understand intersectional complexities for women victim/survivors of DFA and are culturally inclusive, as well as ensuring that local knowledge for referral and support options is accurate and up to date.

Other information from the participants in this research highlighted practical considerations for screening programs at the organisational level. Evidence from existing screening programs in Australia demonstrated that most eligible women are not being screened (NSW Ministry of Health 2019; McKay et al. 2021). This reveals that there is more to be done in terms of organisational expectations of staff to screen DFA, as exists for screening in areas such as smoking and diabetes.

The women victim/survivors and the workers also discussed the physical layout of most emergency departments as an issue to consider when implementing a universal screening program. The need for a safe space where a confidential conversation can occur is very important. This needs to be taken into consideration as a priority in the design of new emergency departments and in any redevelopment of existing departments.

Individual/health professional

The information from the women victim/survivors and the emergency department social workers demonstrated the gaps in knowledge of health professionals. As well as an understanding of DFA, definitions, myths, impacts on all levels of health, indicators of this and how to conduct a respectful conversation, this research demonstrated that processes to train and support workers needs to attend to worker and system responses that enable perpetrators to weaponise the workers, their responses, and the system against the victim/survivor. This would entail professional development to assist health professionals in several areas, including gaining an understanding of abuse as a pattern of control and the consequences of tactics used by the perpetrator to maintain this control, including the ability of a victim/survivor to disclose and a health professional to enquire. This research has demonstrated that professional development must also cultivate awareness of the ways in

which perpetrators invite collusion with health professionals and weaponise worker and system responses, alongside critical reflection for the health professionals, of normative gendered expectations of victim and perpetrator presentation and an awareness of the influence of medical model responses to women's emotional distress. The women's experiences demonstrate that the response from a health professional has the capacity to re-traumatise a victim/survivor, therefore the voices and experiences of victim/survivors need to be included in the planning and facilitation of professional development for health professionals to understand the importance of believing and validating a woman's experience.

These issues, and those discussed in the sections above, need to be considered and included in the development and implementation of a universal screening program in emergency departments, or the risk will be the continuation of system and perpetrator control of women experiencing DFA.

Personal reflection

When I began this research, I came to it with a professional and personal interest. Professionally, I knew that women victim/survivors were not being identified as often as they could be when presenting for health assistance. Because of this, I knew that DFA was not named, and the responses and treatments were all about what was wrong with the woman, not what had happened to her and how to address her trauma and her emotional, cultural, and physical safety. Personally, I knew many of the barriers to disclosure in a health setting as I had not discussed my situation on many occasions, however, after disclosing and receiving the same response, I realised that this situation was more complex than the ability of a health professional to identify the presence of DFA. It is about that, but then it is also about what happens next and why.

There were several findings that surprised me from this research. The first was that none of the women victim/survivors had DFA identified in their presentations to emergency departments or other health sites of assistance, including where selective screening had occurred, even though health professionals nominated similar scenarios as indicators. The second was that as a result of health help-seeking behaviour, every single woman victim/survivor in this research was given a mental illness diagnosis. The responses they

received were gendered, through the interpretation of their distress or health issue and lacked any intersectional lens. Women were diagnosed with mental illness through nothing more than being pre- or post-birth, or through being seen as 'hysterical' or a 'drama queen', many of these pathologies being initiated by the perpetrator and picked up by the health professional. Those not initiated by the perpetrator were enabled by a gender-blind health system response. I cannot sit with that thought for too long at any one time because the injustice of it is just too much.

The extent to which the power of perpetrator tactics was aided in health settings through male, white, colonial, western, heteronormative social norms surprised me. As a feminist critical social worker, I am aware of privileged social norms, but having example after example played out in the descriptions of the women's experiences, then reinforced in the responses from the emergency department social workers, was overwhelming. I was shocked at the degree to which perpetrators were able to manipulate and collude with health professionals, and the lack of awareness of this from health professionals.

I was also taken by surprise at the wide range of DFA knowledge between different emergency department social workers. I did not expect such a difference between those who had never worked in screening environments and those who had, and again between those who had worked in the VIP model and those who only had experience in Australian screening programs. Some of the responses were so articulate and nuanced, whereas others were not aware of their myth-laden answers and the damage this does to victim/survivors. The overall lack of awareness from the majority of health professionals in terms of a mental illness diagnosis being the 'go to' for women's emotional responses to gendered violence, and the ways in which this strengthens perpetrator control, reinforced the importance of addressing this in DFA education and training for all social workers and health professionals and in screening program content.

Finally, I was not expecting to find such a reluctance in Australia to embrace universal screening in emergency departments. I looked for solid reasons as to why universal screening should not happen, but the arguments against this in Australia did not stand up to scrutiny. Selective screening leads to low rates of identification. This research has demonstrated that emergency departments are essential sites of health assistance for women experiencing DFA and every time we do not ask the questions, we are missing an opportunity to have a

conversation or plant a seed of an idea for her that she may be dealing with DFA and that she is worthy of the support available.

More than this though, hearing the women's stories, and remembering my own final emergency department presentation, is to experience a tsunami of injustice. Women's experiences of abuse are not being identified, and on top of that, the responses they receive label them as deficient, as the 'other', and judge them as mad/bad women/mothers. These responses lead to treatment that not only denies them agency and control over their lives, but also increases the control of the perpetrator and the systems the women turn to for assistance, increasing the risk to them and their children.

Universal screening will not be a panacea for all women presenting for assistance while living with or dealing with DFA, however, the introduction of such a program, and attention to good practice which incorporates the components outlined in this thesis, could address the key experiences of women victim/survivors, the low rates of identification in current screening practices, and gaps in the knowledge of health professionals, including for workers who think they 'just know'.

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Appendix 1: Notice of Ethics approval number 36/14



Human Research Ethics Committee (HREC)
Research and Innovation
office NH&MRC Code:
EC00237

Notice of Approval

Date: **12 August 2014**

Project number: **36/14**

Project title: ***Domestic Violence Screening in Australian Public Hospital Emergency Departments: extent, models and impacts***

Risk classification: **Low risk**

Chief investigator: **A/Prof Suellen Murray**

Approved: From: **12 August 2014** To: **31 December 2015**

Terms of approval:

1. Responsibilities of investigator

It is the responsibility of the above investigator to ensure that all other investigators and staff on a project are aware of the terms of approval and to ensure that the project is conducted as approved by HREC. Approval is only valid whilst investigator holds a position at RMIT University.

2. Amendments

Approval must be sought from HREC to amend any aspect of a project including approved documents. To apply for an amendment use the request for amendment form, which is available on the HREC website and submitted to the HREC secretary. Amendments must not be implemented without first gaining approval from HREC.

3. Adverse events

You should notify HREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.

4. Plain Language Statement (PLS)

The PLS and any other material used to recruit and inform participants of the project must include the RMIT university logo. The PLS must contain a complaints clause including the above project number.

5. Annual reports

Continued approval of this project is dependent on the submission of an annual report. Annual reports for each calendar year must be submitted by December 31 of each year from when the application is approved.

6. Final report

A final report must be provided at the conclusion of the project. HREC must be notified if the project is discontinued before the expected date of completion.

7. Monitoring

Projects may be subject to an audit or any other form of monitoring by HREC at any time.

8. Retention and storage of data

The investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

9. Special conditions of approval

Nil.

In any future correspondence please quote the project number and project title above.

A/Prof Barbara
Polus, Chairperson

Appendix 2: Sample email to social work department

Sample email to Social Work Department for Qualtrics survey participants

Dear _____,

My name is Christine Craik and I am a Social Worker doing some postgraduate research at RMIT University, into routine screening for domestic and family abuse for women during emergency department presentations. We know that domestic and family abuse is a huge public health issue in Australia, affecting approximately one third of the adult female population and that this has huge implications for the health of those women. As part of this research, I am conducting an online survey into emergency department screening and/or identification procedures, and I am writing to ask for your assistance in getting to the right person in your emergency department to participate this survey. This survey asks questions of the social worker to determine whether or not routine screening for domestic and family abuse is a usual practice for many triage processes in emergency departments across the country, and what happens in that department if there is no routine screening program. This survey is also interested in exploring the extent to which these screenings may have been tried in the past.

In order to do this, I am trying to get this online survey to the social worker allocated or responsible for emergency department work on a day to day basis in your hospital. It may be a social worker who deals with patients in the emergency department on a day to day basis however it may be another health professional in the emergency department who you think would be the right person to complete this survey. If possible, could you please forward this attachment to the health professional who you think would be the appropriate person, and include me in that email in order that I can follow this up?

This on-line survey should only take 10 to 15 minutes to complete and it is anonymous. Please read the attached invitation to participate in the research project, and don't hesitate to contact me should you have any queries at all about this survey.

Yours sincerely,

Christine Craik
Principal Research Student

School of Global, Urban and Social Studies
RMIT University.

GPO Box 2476 Melbourne VIC 3001

Appendix 3: Participant Information Form – online survey



INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

*Domestic Violence Screening in Australian Public Hospital Emergency Departments:
Extent, Models and Impacts.*

Investigators

Senior Investigator:

Associate Professor Suellen Murray
College of Design and Social Context
RMIT University, GPO Box 2476, Melbourne, Vic, 3001.

Associate Supervisor:

Associate Professor John Whyte
College of Design and Social Context
RMIT University, GPO Box 2476, Melbourne, Vic, 3001.

Principle Research Student:

Ms. Christine Craik
College of Design and Social Context
RMIT University, GPO Box 2476, Melbourne, Vic, 3001.

Dear potential research participant,

You are invited to participate in a research project being conducted by RMIT University. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the content, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

My name is Christine Craik, and I am a Masters by Research student at RMIT University. My supervisors are Associate Professor Suellen Murray and Associate Professor John Whyte. This project has been approved by the RMIT Human Ethics Research Committee.

Why have you been approached?

I am approaching you to participate in this research project through your position in an emergency department of an Australian public hospital. I understand you are the most appropriate person to answer the questions for this survey.

What is the project about? What are the questions being addressed?

The aim of this project is to gain an understanding of the extent of routine screening for domestic violence for women in emergency departments within Australia. I am investigating:

- Who is screening?
- How are they doing this?
- What (if known) are the impacts of this on patients and staff?

In the first stage of this research, I am contacting around 100 of the 200 public hospitals with an emergency department throughout Australia and conducting an online survey. In the second half of the research, I plan to interview senior hospital staff about domestic violence screening and women who have experienced domestic violence.

If I agree to participate, what will I be required to do?

I am asking you to take up to fifteen minutes to fill out an online survey about the experiences of your hospital with routine screening for domestic violence for women who present to your emergency department. It may be that your hospital has never considered running such a program, has considered it and made a decision not to run a program, has run a pilot project or a program in the past, or is currently doing so. I am interested in all these possibilities. I would also like the opportunity to follow up the survey with an interview should you agree to do so.

What are the possible risks or disadvantages? What are the benefits associated with participation?

There are no more risks associated with this research than in your normal day to day activities. There is no direct benefit to you as a result of your participation. You may be interested in the research findings in order that you have a better understanding about how many hospitals are routinely screening women for domestic violence in their emergency departments and the ways in which they are doing this. The results of this survey will be presented in my thesis and available through the RMIT University Research Repository in due course.

What will happen to the information I provide?

Research data will be kept securely at RMIT for 5 years after completion of the project before being destroyed. Results will be published in my research thesis and lodged with the RMIT University on-line Research Repository. All participants and hospitals will be anonymous and confidentiality of the data will be retained.

Because of the nature of the data collection, we will not obtain written informed consent from you. Instead, it is assumed that you have given consent by your completion and return of the survey.

This project will use an external site to create, collect and analyse data collected in a survey format. The site we are using is Qualtrics. If you agree to participate in this survey, the responses you provide to the survey will be stored on a host server that is used by Qualtrics. No personal information will be collected in the survey, so none will be stored as data. Once we have completed the data collection and analysis, we will import the data we collect to the RMIT server, where it will be stored securely for five years. The data on the Qualtrics host server will then be deleted and expunged.

Users should be aware that the World Wide Web is an insecure public network that gives rise to the potential risk that the user's transactions are being viewed, intercepted or modified by third parties, or that data which the user downloads may contain computer viruses or other defects.

What are my rights as a participant?

As a participant, you have the right to withdraw from participation at any time and you have the right to have any questions answered at any time.

Who should I contact if I have any questions?

If you have any questions, please do not hesitate to contact Christine at RMIT University, or her Supervisor, Associate Professor Suellen Murray.

Yours sincerely,

Christine Craik
Masters by Research student
BSW, MSoc Pol & Mgt

Associate Professor Suellen Murray
Senior Supervisor
PhD, MPhil, Grad Dip Arts, BA Spp, Scc

If you have any concerns about your participation in this project, which you do not wish to discuss with the researchers, then you can contact the Ethics Officer, Research Integrity, Governance and Systems, RMIT University, GPO Box 2476V VIC 3001.

Appendix 4: Sample email to Qualtrics Survey participants

Sample email to participants for Qualtrics survey:

Dear _____,

Thank you so much for agreeing to participate in this on-line survey into routine screening of women for domestic and family abuse in emergency departments of Australian public hospitals. This survey is about trying to determine whether or not this is a usual practice for many triage processes in emergency departments across the country and also exploring the extent to which these screenings may have been tried in the past, alongside what you do and what you think works and would not work. As I said on the phone, this survey should only take 10 to 15 minutes of your time.

Please read the invitation to participate in the research project and don't hesitate to contact me should you have any queries at all about this survey.

You will notice at the conclusion of this survey, I am asking if you would be willing to participate in a follow up interview for the second phase of this research. If you could give some consideration to this, it would be much appreciated.

Yours sincerely,

Christine Craik
Principal Research Student

School of Global, Urban and Social Studies
RMIT University.

GPO Box 2476 Melbourne VIC 3001

Appendix 5: Qualtrics online survey questions

Qualtrics online survey questions:

1. How would you describe the type of hospital you work in?
 - a) Generalist
 - b) Women's
 - c) Trauma
 - d) Small rural multi-purpose
 - e) Paediatric
 - f) Other
2. How would you describe the location of your hospital?
 - a) Metropolitan (city/suburban)
 - b) Regional
 - c) Remote
3. How would you describe the size of your hospital?
 - a) Large
 - b) Medium
 - c) Small
4. In which State or Territory is your hospital located?
 - a) VIC
 - b) NSW
 - c) ACT
 - d) QLD
 - e) NT
 - f) WA
 - g) SA
 - h) TAS
5. What is your professional background?
 - a) Social work
 - b) Nursing
 - c) Allied health
 - d) Medical practitioner
 - e) Management
 - f) Other
6. What is your gender?
 - a) Female
 - b) Male
7. How does your ED identify the possible presence of domestic and family abuse amongst presenting patients?

Space for freely written answers

8. Does your ED offer routine screening for domestic and family abuse to female patients who present for treatment?
- a) Yes
 - b) Not at present but has in the past
 - c) No
9. If no, has your ED ever considered screening for domestic and family abuse?
- a) Yes
 - b) No
 - c) Unsure
10. If yes, when and for approximately how long, did this occur?
Space for freely written answers
11. How was this screening done?
- a) Stand-alone screening tool/questionnaire
 - b) Screening tool alongside staff training
 - c) Screening tool alongside staff training and mentoring
 - d) Screening tool alongside staff training, mentoring and community agency participation
 - e) Other
12. If your hospital did consider screening for domestic and family abuse, and the program did not go ahead, or has since ceased, what were the reasons behind this decision?
- a) Costs
 - b) Perceived risks
 - c) Time constraints for ED staff
 - d) Lack of staff
 - e) Not considered relevant
 - f) Other
13. If you answered yes to a current screening program, how long has this been part of your ED practice?
- a) Less than 6 months
 - b) Between 6 months and 2 years
 - c) It is an established practice of over 2 years
14. If you answered yes to a current screening program – what is included in this screening?
- a) Stand-alone screening tool/questionnaire
 - b) Screening tool alongside staff training
 - c) Screening tool alongside staff training and mentoring
 - d) Screening tool alongside staff training, mentoring and community agency participation
 - e) Other
15. Have there been any evaluations of this screening program?

- a) Yes
 - b) No
 - c) Unsure
16. If yes, what were the recommendations to this evaluation?
- a) Plans to cease the screening
 - b) Plans to continue the screening in its current form
 - c) Other
17. Were the recommendations implemented?
- a) Yes, and for what reasons
 - b) No, and for what reasons
 - c) Other
18. If there are plans to cease current screening in your ED, for what reasons is this happening?
- a) Not proving worthwhile
 - b) Too costly
 - c) Referral agencies and workers not keeping up with demand
 - d) Don't know
 - e) Other
19. Are you willing to participate in a follow up interview on this topic?
- a) Yes
 - b) No
20. If yes, can you please put your email address in the space provided.
21. Thank you for participating in this survey, do you have any further comments about this issue?

Appendix 6: Notice of Ethics approval No. 19459



Human Research Ethics Committee (HREC)
Research and Innovation
office NH&MRC Code:
EC00237

Notice of Approval

Date: **14 August 2015**

Project number: **19459**

Project title: ***Domestic Violence Screening in Australian Public Hospital
Emergency Departments: extent, models and impacts***

Risk classification: **More than low risk**

Chief investigator: **A/Prof Suellen Murray**

Status: **Approved**

Approval period: From: **14 August 2015** To: **31 July 2017**

The following documents have been reviewed and approved:

Title	Version	Date
19459 Murray appn	FINAL	14 August 2015
ED social workers PICF		29 June 2015
Experts PICF		29 June 2015
Recruitment flyer		14 August 2015
Women PICF		29 June 2015
Protocol to deal with confidentiality and other related matters		14 August 2015

The following documents have been noted:

Title	Version	Date
Draft focus group questions for ED social workers		29 June 2015
Draft interview questions for experts in key organisations		29 June 2015
Draft focus group questions for women support group participants		29 June 2015

The above application has been approved by the RMIT University HREC as it meets the requirements of the *National statement on ethical conduct in human research* (NH&MRC, 2007).

Terms of approval:

1. Responsibilities of chief investigator

It is the responsibility of the above chief investigator to ensure that all other investigators and staff on a project are aware of the terms of approval and to ensure that the project is conducted as approved by HREC. Approval is valid only whilst the chief investigator holds a position at RMIT University.

2. Amendments

Approval must be sought from HREC to amend any aspect of a project. To apply for an amendment use the request for amendment form, which is available on the HREC website and submitted to the HREC secretary. Amendments must not be implemented without first gaining approval from HREC.

3. Adverse events

You should notify the HREC immediately (within 24 hours) of any serious or unanticipated adverse effects of the research on participants, and unforeseen events that might affect the ethical acceptability of the project.

4. Annual reports

Continued approval of this project is dependent on the submission of an annual report. Annual reports must be submitted by the anniversary of approval (14 August) of the project for each full year of the project. If the project is of less than 12 months duration then a final report only is required.

5. Final report

A final report must be provided within six months of the end of the project. HREC must be notified if the project is discontinued before the expected date of completion.

6. Monitoring 7. Retention and storage of data

Projects may be subject to an audit or any other form of monitoring by the HREC at any time.

The investigator is responsible for the storage and retention of original data according to the requirements of the *Australian code for the responsible conduct of research* (section 2) and relevant RMIT policies.

8. Special conditions of approval

Nil.

In any future correspondence please quote the project number and project title above.

A/Prof Barbara
Polus Chairperson

RMIT HREC

Appendix 7: ED Workers Participant Information Form



INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

Domestic Violence Screening in Australian Public Hospital Emergency Departments: Extent, models and impacts

Investigators:

Senior Investigator:
Associate Professor Suellen Murray
College of Design and Social Context
RMIT University, GPO Box 2476 Melbourne VIC 3001

Associate Supervisor:
Associate Professor John Whyte
College of Design and Social Context
RMIT University, GPO Box 2476 Melbourne VIC 3001

Principle Research Student:
Ms. Christine Craik
College of Design and Social Context
RMIT University, GPO Box 2476 Melbourne VIC 3001

Dear potential research participant,

You are invited to participate in a research project being conducted by RMIT University. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

My name is Christine Craik and I am a PhD Candidate at RMIT University. My supervisors are Associate Professor Suellen Murray and Associate Professor John Whyte. This project has been approved by the RMIT Human Research Ethics Committee.

Why have you been approached?

I am approaching you to participate in this research project because you have indicated either via email or through the on-line survey that you would be interested in an interview for this second stage of the research.

What is the project about? What are the questions being addressed?

The aim of this project is to gain an understanding of the extent of routine screening for domestic violence for women in emergency departments of Australian public hospitals, how it is occurring and barriers to its implementation.

I am investigating:

- Who is screening currently or has done so in the past?
- How has this been done?
- What factors have sustained these programs and what has impeded their implementation and continuation?

In this second stage of the research, I will be interviewing several self-selecting social workers with experience of social work services in emergency departments; holding focus groups discussions with women who have experiences of living in domestic violence relationships, and interviewing experts in the field of domestic violence service and policy.

If I agree to participate, what will I be required to do?

I will be contacting you for either a face to face or phone interview to discuss your knowledge of routine screening for domestic violence for women presenting to public hospital emergency departments. I anticipate the interview will take approximately 30 minutes.

Written informed consent will be sought from you to participate in the research. I will seek your consent to audio record the interview in order to decrease any possible distractions involved in taking notes during the interview.

What are the possible risks or disadvantages? What are the benefits associated with participation?

There are no more risks to participation in this research than in your normal day-to-day activities. This is a confidential and non-identifying interview. There is no direct benefit to you as a result of your participation.

What will happen to the information I provide?

The audio recording will be uploaded to my computer and deleted from the recording device. All digital information will be kept on a password protected computer and written data kept securely at RMIT University in my office in a locked filing cabinet for 5 years after completion of the project, before being destroyed. Results will be published in my research thesis and lodged with the RMIT University online Research Repository. All participants will be anonymous and confidentiality of the data will be retained.

What are my rights as a participant?

As a participant, you have the right to:

- withdraw from participation at any time
- request that any recording cease
- have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant, and
- have any questions answered at any time

Whom should I contact if I have any questions?

If you have any questions, please do not hesitate to contact Christine at RMIT University or the Senior Investigator Associate Professor Suellen Murray.

Yours sincerely,

Ms Christine Craik
PhD Candidate
BSW, MASocPol.

Associate Professor Suellen Murray
Senior Supervisor
PhD, MPhil, Grad Dip Arts, BAppSc.

If you have any concerns about your participation in this project, which you do not wish to discuss with the researchers, then you can contact the Ethics Officer, Research Integrity, Governance and Systems, RMIT University, GPO Box 2476V VIC 3001.

Appendix 8: ED Workers Interview questions

Interview Questions for self-selecting emergency department social workers:

1. Can you tell me what you know about screening practices in EDs for domestic and family abuse violence in Australia?
2. If you are not aware of any screening practices, can you tell me how you and other health professionals are able to identify a woman as a victim/survivor during her presentation to the ED?
3. Do you see routine screening for women in EDs as effective? In what way/s?
4. Do you see any impediments or drawbacks to the use of routine screening in EDs for domestic and family abuse? In what way/s?
5. Do you have anything else you would like to add?

Appendix 9: Verbal consent sheet for ED social workers

Verbal consent sheet for ED worker interviews:

Thank you for agreeing to participate in this interview, as you know, this research is for my PhD, looking in to routine screening program for all women who present to EDs of public hospitals within Australia.

We know that domestic and family abuse has an enormous impact on the mental and physical health of victim/survivors and we also know that many women look to health professionals to deal with these effects, including those in EDs of public hospitals.

With this interview, I want to explore your perceptions of routine screening programs for domestic and family abuse, for use in EDS. I want to understand what you think about such programs, any experiences you have had with such programs and what issues (if any) you see with the implementation of such programs in EDs.

I just need to let you know that I take your personal security very seriously, and as such will protect your confidentiality seriously. I will use the information you give me in such a way that it will not identify you in any way, and the recordings and subsequent transcripts of the interview will be stored on my computer, protected by a password prior to use in the thesis.

Are you happy to proceed?

Appendix 10: PICF for managers of family violence agencies



INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

Domestic Violence Screening in Australian Public Hospital Emergency Departments: Extent, models and impacts

Investigators:

Senior Investigator:
Associate Professor Suellen Murray
College of Design and Social Context
RMIT University, GPO Box 2476 Melbourne VIC 3001

Associate Supervisor:
Associate Professor John Whyte
College of Design and Social Context
RMIT University, GPO Box 2476 Melbourne VIC 3001

Principle Research Student:
Ms. Christine Craik
College of Design and Social Context
RMIT University, GPO Box 2476 Melbourne VIC 3001

Dear potential research participant,

You are invited to participate in a research project being conducted by RMIT University. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

My name is Christine Craik and I am PhD Candidate at RMIT University. My supervisors are Associate Professor Suellen Murray and Associate Professor John Whyte. This project has been approved by the RMIT Human Research Ethics Committee.

Why have you been approached?

I am approaching you to participate in the research project through your position as a Manager of a Family Violence agency and your experience in this field.

What is the project about? What are the questions being addressed?

The aim of this project is to gain an understanding of the extent of routine screening for domestic violence for women in emergency departments of public hospitals within Australia and the reasons as to why this practice is often resisted in Australian emergency departments.

I am investigating:

- Who is screening currently or has done so in the past?
- How has this been done?
- What factors have sustained these programs and what has impeded their implementation and continuation?
- How female survivors of domestic violence would feel about participating in a screening program when presenting to an emergency department?

In the first stage of this research, I am contacting around 100 of the over 200 public hospitals with an emergency department throughout Australia and conducting an on-line survey. Following on from this stage, I will be conducting interviews with self-selecting senior hospital staff, Managers of family violence agencies and facilitating focus groups with female survivors of domestic violence.

If I agree to participate, what will I be required to do?

I am asking you to participate in an interview where I would be asking you to reflect on this issue based on your experience and on your knowledge of the women who use your services.

What are the possible risks or disadvantages? What are the benefits associated with participation?

There are no more risks to participation in this research than in your normal day-to-day activities. This is a confidential and non-identifying interview. There is no direct benefit to you as a result of your participation. You may be interested in the research findings in order that you have a better understanding about how many hospitals are routinely screening for women for domestic violence in their emergency departments and the ways in which they are doing this. The results of this survey will be presented in my thesis and available through the RMIT Research Repository in due course.

What will happen to the information I provide?

Research data will be kept securely at RMIT for 5 years after completion of the project, before being destroyed. Results will be published in my research thesis and lodged with the RMIT University on-line Research Repository. All participants and hospitals will be anonymous and confidentiality of the data will be retained.

Because of the nature of data collection, we will not obtain written informed consent from you. Instead, there will be a verbal consent form read out to you at the beginning of the interview. No personal information will be collected in the interview so none will be stored as data.

Participants should be aware that the World Wide Web is an insecure public network that rise to the potential risk that a user's transactions are being viewed, intercepted or modified

by third parties or that data which the user downloads may contain computer viruses or other defects.

What are my rights as a participant?

As a participant, you have the right to withdraw from the participation at any time and you have the right to have any questions answered at any time.

Whom should I contact if I have any questions?

If you have any questions, please do not hesitate to contact Christine at RMIT University or the Senior Investigator Associate Professor Suellen Murray.

Yours sincerely,

Ms Christine Craik
PhD Candidate
BSW, MASocPol.

Appendix 11: Interview questions for managers of family violence agencies

Interview Questions for Managers of Family Violence Agencies:

1. Do you consider routine screening for domestic and family abuse for in in public hospital emergency department as an effective intervention? In what ways/s or not?
2. Can you see impediments or drawbacks in using routine screening in EDs, to assist women in identifying domestic and family abuse?
3. What would be important some of the main issues that need to be addressed in order for this type of program to be successful?
4. Do you have any other thoughts or reflections on this matter?

Appendix 12: Verbal consent form for managers of family violence agencies

Verbal consent sheet for Managers of FV Agencies:

Thank you for agreeing to participate in this interview, as you know, this research is for my PhD, looking in to routine screening program for all women who present to EDs of public hospitals within Australia.

We know that domestic and family abuse has an enormous impact on the mental and physical health of victim/survivors and we also know that many women look to health professionals to deal with these effects, including those in EDs of public hospitals.

With this interview, I want to explore your perceptions of routine screening programs for domestic and family abuse, for use in EDs. I want to understand what you think about such programs, any issues or impediments you see with the implementation of such programs in EDs.

I just need to let you know that I take your personal security very seriously, and as such will protect your confidentiality seriously. I will use the information you give me in such a way that it will not identify you in any way, and the recordings and subsequent transcripts of the interview will be stored on my computer, protected by a password prior to use in the thesis.

Are you happy to proceed?

Appendix 13: Invitation to Participate in Domestic Violence Research

Invitation to participate in domestic violence research

My name is Christine Craik. I am an experienced social worker and have worked in the domestic/family violence area for some years now. I am currently doing my PhD in this area. I am also a survivor of a long-term domestic violence relationship.

My research is looking at routine screening as a way in which public hospital emergency departments might identify and support women who are experiencing domestic/family violence.

As part of my research, I would like to talk to other women who have also experienced domestic/family violence.

I plan to hold group discussions with women in already established domestic violence support groups.

If any women would like to be part of this research – please read on...

I want to talk to women in support groups about...

- How you think the abuse has impacted on your health and how you think this could possibly be addressed if you presented to an emergency department of a public hospital
- Even if you have never been to any health professional about anything health related around your abuse, I would very much value your input
- I would facilitate the discussion about this and ask everyone in the group to contribute as much or as little as they are comfortable with
- You are free to stop at any time during the discussion, this is completely voluntary and there is no obligation to continue if you are becoming uncomfortable
- The focus groups discussions are completely confidential and your group facilitator will also be present for continued support

If you are willing to participate in this research, please let your group facilitator know you are interested. For more information please feel free to contact me on

Thank you

Appendix 14: Verbal consent sheet for women focus group participants

Verbal consent sheet for women participants in focus groups:

Thank you for agreeing to participate in this focus group discussion, as you know, this research is for my PhD, looking in to routine screening program for all women who present to EDs of public hospitals within Australia.

We know that domestic and family abuse has an enormous impact on the mental and physical health of women victim/survivors and we also know that many women look to health professionals to deal with these effects, including those in EDs of public hospitals.

With this discussion, I want to explore your experiences of the impact of the abuse on your health, where you presented (or not) for assistance with this, and what happened for you there. I want to understand what you think about the idea of screening in ED settings and any input you might have into what might work and what might get in the way.

You need to know that you can contribute as much or as little as possible. This is all voluntary and there is not obligation on your part to continue. If the content of the discussion becomes upsetting to you, please feel free to stop, take a break, let me know. Your facilitator is here to support you through this, and I am also available to talk to afterwards should you feel you need this.

I just need to let you know that I take your personal security very seriously, and as such will protect your confidentiality seriously. I will use the information you give me in such a way that it will not identify you in any way, and the recordings and subsequent transcripts of the interview will be stored on my computer, protected by a password prior to use in the thesis.

After this discussion, I will type up a transcript from the recording, and send this back to your facilitator to pass on to you all. Please let me know if you are uncomfortable with anything I have typed out, or if you think I have not represented your comments in the way you meant them to be understood.

Are you happy to proceed?

Appendix 15: Questions to guide the discussions in the focus groups

Questions to guide the women focus group discussions

Thank you so much for having me here today.

- Verbal consent
- Info about the research – including consent to record – noting that once transcripts are done I would like to be able to feed this back to you so you can be reassured that I am representing what you have said the way you wish that to be.... Arranging with the group facilitator for this feedback to occur.
- Please share as much or as little as you feel comfortable to do so.
- Reminding them too that participating in this process is more than me just getting information from them, I want this to be a valuable discussion for them as well, and for them to get something positive out of participating today.
- Reminding them that they can step away if they need to at any time during the discussion – please see your facilitator if this is the case once you are out of the room (i.e. don't just leave the building).

A little about myself... social worker – working in this field for some time.

Also a survivor of a long-term DV relationship...may sound odd that I was living that way while I was working in this field and perhaps we can talk through this discussion about how that happens.

I know you are all survivors – any concerns, any triggers, share only what you are comfortable to share.

1. **Thinking back to your experiences, how do you think the abuse you lived with/ or maybe are still dealing with – affected your health?**
2. **Have you ever sought assistance from a health professional for these issues and if so, who did you go to and what was that like for you?**
3. **Have you ever presented at an ED of a public hospital for any health issue at any time during your adult life and why was that?**
4. **Did you disclose your experiences of abuse at this time?**
5. **Were you asked about your abuse at this time (ie did a health professional pick up on this/identify this?)**
6. **Do you think it would have been helpful to have been asked about your situation at this time? If so why – if not why....**
7. **How would be the most appropriate/least confronting way for a health professional to approach you about these issues?**
8. **In what ways may this not be helpful**
9. **Do you think overall that routine screening n presentation to EDs would assist in dealing/confronting/exposing FV as an issue in the community? And how?**
10. **Is there anything else you would like to add?**

We have covered a lot today and you have been so generous with your time and experiences, I can't thank you all enough.

Appendix 16: Debriefing guide

Debriefing Guide

Before we finish, I want to make sure that you are feeling ok about having done this and ok about some of the memories and thoughts this might have brought back up for you. You don't have to answer this.... Contribute as much or as little here as you like.... But I want you to have a think about

What was the hardest part of this discussion today for you and why was that difficult for you?

What was the best part of the discussion today for you and why was that the best?

What good thing or sign of hope will you take with you about today's discussion?

How has this overall research process been for you?

